NATIONAL QUALITY FORUM

MEASURE WORKSHEET

This document summarizes the evaluation of the measure as it progresses through NQF's Consensus Development Process (CDP). The information submitted by measure developers/stewards is included after the Brief Measure Information, Preliminary Analysis, and Pre-meeting Public and Member Comments sections.

To navigate the links in the worksheet: Ctrl + click link to go to the link; ALT + LEFT ARROW to return

Purple text represents the responses from measure developers.

Red text denotes developer information that has changed since the last measure evaluation review.

Brief Measure Information

NQF #: 3593

Corresponding Measures:

De.2. Measure Title: Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Co.1.1. Measure Steward: Centers for Medicare & Medicaid Services

De.3. Brief Description of Measure: 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.

1b.1. Developer Rationale: Current estimates suggest that 10 million individuals requiring assistance to perform ADLs or IADLs are living in the community, including in private or group homes.1 Eiken (2017)2 reported that more than 3.7 million individuals receive Medicaid-funded HCBS. Federal and state governments finance over 60 percent of paid HCBS costs in the United States through the Medicaid program.2 HCBS are expected to grow because of the aging U.S. population and the current move away from institutional-based care.3 As significant continued growth is expected in cost and utilization of HCBS, including through managed care contracting, greater scrutiny on quality also is expected.

Documenting personal priorities related to functional needs is a key aspect of person-centered service planning for individuals receiving HCBS. Existing literature suggests that using a person-centered approach in developing service plans can lead to higher satisfaction and more engagement of individuals in their care.4,5 This approach also may lead to lower costs.4 There are, however, measurement gaps and other barriers limiting the ability to assess this key aspect of developing a quality service plan. A 2015 inventory of functional assessment tools used by state Medicaid programs for HCBS found that there was no standardization across or within states, and at least 124 tools were in use at that time.8 In most but not all cases, the information used to determine functional eligibility also was used to inform the creation of specific service plans for eligible

individuals; nevertheless, at least 21 states had functional assessment tools for specific populations that were not also used for service planning.9

A comprehensive scan funded by the Medical and Children's Health Insurance Program Payment and Access Commission related to HCBS and behavioral health found that most state-level quality measurement activity related to HCBS in Medicaid was based on CMS reporting requirements for 1915(c) waivers.6 These measures generally are process oriented and intended to demonstrate state and provider compliance with a range of policies and procedures. One of six key domains is "service plan," for which the focus is ensuring that plans reflect needs and personal goals and that participants receive services laid out in plans. This concept is slightly different than determining whether the recipient's personal priorities related to needs are captured in the assessment. The NQF conducted a broader environmental scan of HCBS quality measurement across all payers.7 The resulting recommendations prioritized "assessment"—the level to which the HCBS systems and providers support the person in identifying their goals, needs, preferences, and values—as one of three subdomains within the person-centered planning and coordination domain for which quality measurement can be improved.

The absence of measures for the concept of documenting personal priorities for HCBS recipients with functional needs reflects a gap at the measurement level. The proposed measure supports a person-centered approach by encouraging providers to elicit the values and preferences of the individual served. The FASI-based performance measure provides a uniform, standardized approach to identifying personal priorities and measuring functional needs across all community-based settings, thus promoting continuity of quality care.

1. Kaye HS, Harrington C. Long-term services and supports in the community: Toward a research agenda. Disability and Health Journal. 2015;8(1):3-8. Retrieved from http://proxygw.wrlc.org/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2014-55175-002&site=eds-live&scope=site&authtype=ip,uid&custid=s8987071.
2. Eiken S. Medicaid long-term services and supports beneficiaries in 2013. Centers for Medicare & Medicaid Services; 2017. Retrieved from https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltss-beneficiaries-2013.pdf.
3. Ng T, Harrington C, Musumeci M, Reaves E. Medicaid home and community-based services programs: 2012 data update. Kaiser Family Foundation; 2015. Retrieved from https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2012-data-update.
4. Kim KM, Fox MH, White GW. Comparing outcomes of persons choosing consumer-directed or agency-directed personal assistance services. Journal of Rehabilitation. 2006;72(2):32-43. Retrieved from https://www.scopus.com/inward/record.uri?eid=2-s2.0-33746260088&partnerID=40&md5=58a765b4ec9338cd00fa66c8d4613cf9.
5. Ratti V, Hassiotis A, Crabtree J, Deb S, Gallagher P, Unwin G. The effectiveness of person-centered planning for people with intellectual disabilities: A systematic review. Research in Developmental Disabilities. 2016;57:63–84. Retrieved from http://www.sciencedirect.com/science/article/pii/S089142221630138X.
6. Hartman L, Lukanen E. Quality measurement for home and community-based services (HCBS) and behavioral health in Medicaid. Medicaid and CHIP Payment and Access Commission; 2016:1–30. Retrieved from https://www.macpac.gov/publication/quality-measurement-for-home-and-community-based-services-and-behavioral-health-in-medicaid.
7. Caldwell J, Kaye HK. Quality in home and community-based services to support community living: Addressing gaps in performance measurement. National Quality Forum; 2016:1–59. Retrieved from https://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-

Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx.

8. Medicaid and CHIP Payment and Access Commission. June 2016 report to congress on Medicaid and CHIP, Functional assessments for long-term services and supports. Retrieved from https://www.macpac.gov/publication/june-2016-report-to-congress-on-medicaid-and-chip.
9. Medicaid and CHIP Payment and Access Commission. Inventory of the state functional assessment tools for long-term services and supports. 2017. Retrieved from https://www.macpac.gov/publication/inventory-of-the-state-functional-assessment-tools-for-long-term-services-and-supports.

S.4. 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.

S.6. 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.

S.8. Denominator 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.

De.1. Measure Type: Process

S.17. Data Source: Electronic Health Records, Instrument-Based Data, Paper Medical Records

S.20. Level of Analysis: Other

IF Endorsement Maintenance – Original Endorsement Date: Most Recent Endorsement Date:

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? Not applicable.

To maintain NQF endorsement endorsed measures are evaluated periodically to ensure that the measures still meet the NQF endorsement criteria ("maintenance"). The emphasis for maintaining endorsement is focused on how effective the measure is for promoting improvements in quality. Endorsed measures should have some experience from the field to inform the evaluation.

Criteria 1: Importance to Measure and Report

1a. Evidence

1a. Evidence. The evidence requirements for a ***structure, process or intermediate outcome*** measure are that it is based on a systematic review (SR) and grading of the body of empirical evidence where the specific focus of the evidence matches what is being measured. For measures derived from patient report, evidence also should demonstrate that the target population values the measured process or structure and finds it meaningful.

The developer provides the following evidence for this measure:

- **Systematic Review of the evidence specific to this measure?** ☐ **Yes** ☒ **No**
- **Quality, Quantity and Consistency of evidence provided?** ☐ **Yes** ☒ **No**

- **Evidence graded? ☐ Yes ☒ No**

Evidence Summary

- This new process measure assesses 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.
- Developer provides a logic model depicting the relationship between processes individuals receiving HCBS, assessment of needs, assessment of personal priorities related to those needs, and both short- and long-term outcomes of person-centered delivery of HCBS and better quality of life.
- Developer presented findings from a targeted literature review of studies found in academic journals, gray literature, and federal/state agency reports published within the last 20 years.
    - Using PubMed, Scopus, Google, Google Scholar, and other personal libraries, the developer search for pertinent articles using the following search terms: performance measures, person-centered supports and services, functional assessment, personal priorities, home and community-based service, and community-based long-term services and supports.
    - Developer notes that studies presented evidence that person-centered approaches to patient care leads to improvement in overall satisfaction with quality of life as well as physical outcomes, such as functional status, activities of daily life, and frailty.
    - Studies demonstrate that processes that involve eliciting and documenting personal preferences/priorities are consistent with efforts to provide person-centered supports and services in HCBS programs.
- Developer asserts that using standardized functional assessment items to capture personal priorities and needs is a valuable component of shared decision-making and improved person-centered services.

Guidance from the Evidence Algorithm

(Box 1) à Process measure (Box 3) à Measure assesses performance on a process à(Box 7) Empirical evidence submitted without systemic review and grading of the evidence à (Box 8) All studies included in the body of evidence à(Box 9) Benefits outweigh risks à MODERATE

Preliminary rating for evidence: ☐ High ☒ Moderate ☐ Low ☐ Insufficient

1b. Gap in Care/Opportunity for Improvement and 1b. Disparities

Maintenance measures – increased emphasis on gap and variation

1b. Performance Gap. The performance gap requirements include demonstrating quality problems and opportunity for improvement.

- In June and July of 2018, the developers tested the measure in 10 organizations in five different states located in geographically diverse regions.
- Developer notes that the tests demonstrate a significant performance gap in the documentation of personal priorities for HBCS participants
- Developer presented FASI field testing data grouped by HCBS program type.
- Out of 684 unique individuals, 675 had a FASI need (denominator); 296 individuals had as many personal priorities (up to three) as FASI needs (numerator).
- Developer presented the following data:
    - Total number of Individuals in programs serving those who are older adults

        - Total sample in denominator: 122
        - Missing total personal priorities: 1
        - Mean number of personal priorities: 1.96
        - Standard deviation for number of personal priorities: 2.10
        - Performance Measure Score:33.6
    - Total number of individuals in programs serving those with a physical disability
        - Total sample in denominator: 120
        - Missing total personal priorities:0
        - Mean number of personal priorities: 1.98
        - Standard deviation for number of personal priorities:1.79
        - Performance Measure Score:35.8
    - Total number of individuals in programs serving those with an intellectual or developmental disability
        - Total sample in denominator:277
        - Missing total personal priorities:1
        - Mean number of personal priorities:2.38
        - Standard deviation for number of personal priorities: 1.84
        - Performance Measure Score:45.1
    - Total number of individuals in programs serving those with an acquired brain injury
        - Total sample in denominator: 124
        - Missing total personal priorities: 0
        - Mean number of personal priorities:2.37
        - Standard deviation for number of personal priorities:2.10
        - Performance Measure Score: 49.3
    - Individuals in programs serving those with mental health or substance use disorders
        - Total sample in denominator:82
        - Missing total personal priorities:0
        - Mean number of personal priorities:2.30
        - Standard deviation for number of personal priorities:2.04
        - Performance Measure Score:50.8

Disparities

- Developer analyzed differences in performance measure scores based on race and ethnicity.
    - Individuals included in the analysis were organized into three groups: individuals who were African American or Black; individuals who were American Indian, Alaskan Native, Asian, or Other; and individuals who were White.
    - Individuals who did not designate race or those whose race was unknown were kept in a separate category.
    - Ethnicity categories were Hispanic and Not Hispanic.
    - The results of the analysis indicated significant differences in scores by race and by ethnicity (Pearson chi2(3) = 17.785 Pr = 0.000 and Pearson chi2(1) = 7.6642 Pr = 0.006, respectively).

- Developer noted that the results require further analysis because in some cases, the numbers were small.

- Developer presented the following results (Total number of individuals= 674):

Table 4. Identifying Personal Priorities for FASI Needs: Denominator, Numerator, and Score by Race

- Individuals Who Were White
  - Denominator-Denominator: Has a need identified by the FASI (% of sample): 411 (61.0)
  - Numerator: Has as many personal priorities as needs, up to 3 maximum: 197
  - Performance measure score, %: 47.9
- Individuals Who Were African American or Black
  - Denominator: Has a need identified by the FASI (% of sample): 125 (18.6)
  - Numerator: Has as many personal priorities as needs, up to 3 maximum: 42
  - Performance measure score, %: 47.9
- Individuals Who Were American Indian, Alaskan Native, Asian, or Other
  - Denominator: Has a need identified by the FASI (% of sample): 95 (14.1)
  - Numerator: Has as many personal priorities as needs, up to 3 maximum: 31
  - Performance measure score, % 32.6
- Individuals Whose Race Was Unknown
  - Denominator: Has a need identified by the FASI (% of sample): 43 (6.4)
  - Numerator: Has as many personal priorities as needs, up to 3 maximum: 26
  - Performance measure score, %: 60.5
- All Individuals
  - Denominator: Has a need identified by the FASI (% of sample): 674 (100)
  - Numerator: Has as many personal priorities as needs, up to 3 maximum: 296
  - Performance measure score, %: 43.9

*1 individual from the IDD program was missing information on race and ethnicity. Pearson c hi2(3) = 17.785, Pr = 0.000.

Table 5. Identifying Personal Priorities for FASI Needs: Denominator, Numerator, and Score by Ethnicity

- Individuals Who Were Hispanic
  - Denominator: Has a need identified by the FASI (% of sample): 22 (3.3)
  - Numerator: Has as many personal priorities as needs, up to 3 maximum: 16
  - Performance measure score, %: 72.7
- Individuals Who Were Not Hispanic
  - Denominator: Has a need identified by the FASI (% of sample): 652 (96.7)
  - Numerator: Has as many personal priorities as needs, up to 3 maximum: 280
  - Performance measure score, %: 42.9
- All Individuals
  - Denominator: Has a need identified by the FASI (% of sample): 674 (100)
  - Numerator: Has as many personal priorities as needs, up to 3 maximum
  - Performance measure score, %: 43.9

*1 individual from the IDD program was missing information on race and ethnicity. Pearson chi2(1) = 7.6642, Pr = 0.006.

Questions for the Committee:

- Is there a gap in care that warrants a national performance measure?
- Are you aware of additional evidence that disparities exist in this area of healthcare?

Preliminary rating for opportunity for improvement: ☐ High ☒ Moderate ☐ Low ☐ Insufficient

Committee Pre-evaluation Comments:
Criteria 1: Importance to Measure and Report (including 1a, 1b, 1c)

1a. Evidence to Support Measure Focus: For all measures (structure, process, outcome, patient-reported structure/process), empirical data are required. How does the evidence relate to the specific structure, process, or outcome being measured? Does it apply directly or is it tangential? How does the structure, process, or outcome relate to desired outcomes? For maintenance measures–are you aware of any new studies/information that changes the evidence base for this measure that has not been cited in the submission? For measures derived from a patient report: Measures derived from a patient report must demonstrate that the target population values the measured outcome, process, or structure.

- Evidence is not super-robust, and no systematic review done, but what there is seems appropriate.
- The evidence seems to apply directly. I wonder about the numerous surveys that must be used to glean the evidence. Does the developer foresee a time when there is concordance in reporting, including patient preferences? Recording Patient Preferences and incorporating them into the Service Plan is very important to patients and careers/family members.
- Empirical data submitted; measure is valued by the target population
- This is a new process measure, so evidence is limited to a targeted literature review. Developer asserts using standardized functional assessment items to capture personal priorities and need is valuable to shared decision-making process.
- The evidence base provided by the Measure Developer was based mostly on a targeted literature review of studies addressing person-centered supports and services, functional assessment, and the importance of personal priorities for individuals in the HCBS community. Input was received through an online survey by reviewers and Technical Expert Panel (TEP) members that included self-advocates and advocacy group representatives. There was only a 41.7% agreement on the statement "Performance on this measure provides important information for assessing whether groups of HCBS recipients are receiving high-quality services.
- Limited if any empirical data presented - mostly expert opinion attesting to the importance of patient-driven prioritization for targeting functional status improvements
- Measure developers reported conducting a targeted review of the literature. They did not conduct a systematic review nor grade the papers in their targeted review. Most of the cited papers, by title, appeared relevant to supporting the relationship between this process measure and outcomes, such as satisfaction and functional status. The overall number of studies cited was small. Overall, the data were promising - and given the importance of expanding the number of patient-centered measures, the measure developers provided a reasonable start.
- I would rate this as low-mod; missing solid empirical evidence - although logically the case is made - more evidence is needed to demonstrate mandated use at a national level to link to actual outcomes of quality care. The tool is a very helpful metric.
- A national performance measure is needed for personal priorities. The evidence is clearly stating that including personal preferences increases satisfaction and improves outcomes. "Stakeholders in community-based medical and social service settings during interviews strongly affirmed that services are of higher quality when based on the person's preferences versus identified by the providers." Provider burnout is not discussed in this measure but the with the conclusion of "Providers also expressed higher levels of satisfaction with services based on person-centered frameworks." It becomes clear that patient personal preferences is a link that can reduce costs, improve outcomes and increase engagement of providers. Difficulty to develop this measure should not become justification for not implementing. To flip the healthcare system and redesign it to improve outcomes while eliminating excess costs of care, starting with the patient perspective is the key to unlocking new processes, procedures and policies that will create maximum impact. As stated this is a new measure and the evidence exists to support its development and implementation.

- Low. I seem to be stuck on the accuracy/reliability of personal preference via testimony of severely mentally disabled, brain injury and intellectual disability (which constitutes 65% of the sample). That is, are they competent in communicating. Are they eligible for informed consent? Generally, not specific to measure. All testing seems to be focused on the number of items while my concern is the validity of reporting by the individuals. I cannot see evidence to ensure reporting is accurate

1b. Performance Gap: Was current performance data on the measure provided? How does it demonstrate a gap in care (variability or overall less than optimal performance) to warrant a national performance measure? Disparities: Was data on the measure by population subgroups provided? How does it demonstrate disparities in the care?

- Gap is well documented; disparities are addressed and interesting- merits discussion. Problem with few Hispanic/Latino individuals in the sample.
- Let us look at disparities. I do not think equity can be measured by lumping Indigenous Americans in with Asian Americans. Could the developers explain their rational for this move?
- Gap is demonstrated. Disparities data included and showed significant differences
- Performance gap is based on test results for the measure in 10 organization in 5 states. Findings revealed variation in documentation. There were 684 unique individuals, 675 had a FASI need and 296 had as many personal priorities. In terms of disparities, there was variation in data by race and ethnicity. Performance Measure scores across groups was typically below 50% except for Hispanics and cases where race was unknown. Such variations suggest the occurrence of inadequate documentation which could translate into missed opportunities to address specific needs of some HBCS recipients..
- Unclear given the response of the TEP i.e. only a 41.7% agreement on the statement "Performance on this measure provides important information for assessing whether groups of HCBS recipients are receiving high-quality services."
- Performance gap demonstrated; disparities found, especially among Native populations
- Performance data showed a measurement gap and significant differences by race and ethnicity. The sample size for Hispanic individuals was small.
- The data provided does support a need. Personal priority setting, although important and key to self-management and empowerment, clouds the gap metric a bit. Would rate this as moderate and needs more definition. It clearly has great value in measuring and reporting social determinants of care.
- There are mounds of research on how personal preferences dictate choices for care. Going back to the beginning of healthcare, doctors described their abilities as art and science. Historically, the healthcare system was built to be doctor centric, with their skills becoming siloed, and not transferred across healthcare systems. Today, research shows that the patient perspective impacts satisfaction and ethnicity provides glimpses into differences of patients wants. The following research articles shares data to validate this point: Racism in healthcare: Its relationship to shared decision-making and health disparities: A response to Bradby ME Peek, A Odoms-Young, MT Quinn… - Social science & …, 2010 - ncbi.nlm.nih.gov Shared decision-making and parental experiences with health services to meet their child's special health care needs: Racial and ethnic disparities MP Jolles, PJ Lee, JR Javier - Patient education and counseling, 2018 – Elsevier Personalized strategies to activate and empower patients in health care and reduce health disparities J Chen, CD Mullins, P Novak… - Health Education & …, 2016 - journals.sagepub.com

Moderate. Quite light on Latino representation (3%) with 97% of sample from the serious mental illness, intellectually disabled and brain injury cohorts

Criteria 2: Scientific Acceptability of Measure Properties

2a. Reliability: Specifications and Testing

2b. Validity: Testing; Exclusions; Risk-Adjustment; Meaningful Differences; Comparability; Missing Data

2c. For composite measures: empirical analysis support composite approach

Reliability

2a1. Specifications requires the measure, as specified, to produce consistent (reliable) and credible (valid) results about the quality of care when implemented. For maintenance measures – no change in emphasis – specifications should be evaluated the same as with new measures.

2a2. Reliability testing demonstrates if the measure data elements are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period and/or that the measure score is precise enough to distinguish differences in performance across providers. For maintenance measures – less emphasis if no new testing data provided.

Validity

2b2. Validity testing should demonstrate the measure data elements are correct and/or the measure score correctly reflects the quality of care provided, adequately identifying differences in quality. For maintenance measures – less emphasis if no new testing data provided.

2b2-2b6. Potential threats to validity should be assessed/addressed.

Composite measures only:

2d. Empirical analysis to support composite construction. Empirical analysis should demonstrate that the component measures add value to the composite and that the aggregation and weighting rules are consistent with the quality construct.

Complex measure evaluated by Scientific Methods Panel? ☐ **Yes** ☒ **No**

NQF Staff Evaluation Summary:

This measure was reviewed by the Scientific Methods Panel and discussed on the call. A summary of the measure and the Panel discussion is provided below.

Reliability

- Developer conducted reliability testing for each critical data element:
  1) Definition of need:
     - 675 forms were analyzed to evaluate concordance between the field test and reviewers' indication of whether or not individuals documented a FASI-based need.
     - Results overall and by program type indicated 100% agreement between the field test and determination of whether a FASI-based need was identified.
  2) Identifying the total number of personal priorities:
     - Developer assigned pairs from the same organization to review 534 records independently.
     - The developer evaluated consistency between raters in determining the number of needs noted in each record using the Bland-Altman limits of agreement (LOA), which are defined as the average difference between two reviewers plus 1.96 times the standard deviation of the differences.

- LOA for total pairs of records: between 3.47 and 2.58 (The LOA are defined by the lower and upper values and define the range between which 95% of values should fall)
- Percentage of records that fell within the LOA by HBCS program type ranged from 90.6% to 95.3%, indicating high agreement.
- 71% of records that fell outside of the LOA were from one reviewer (Reviewer A). Excluding this reviewer, only 2.9% of total records fell outside of the LOA (with 95% confidence intervals).

3) Identifying whether the individual had at least as many personal priorities as needs, up to three personal priorities.
   - Developer used a Kappa statistic (an inter-rater agreement statistic calculated with a 95% confidence interval) to determine concordance between the number of identified priorities and the reviewers' assessment of whether the numerator definition was met.
   - Across the 672 forms analyzed, results indicated a strong agreement that was statistically significant ($\kappa = 0.9723$, $p < 0.001$).
   - For records that had been determined to indicate at least one FASI-based need (denominator), the developer analyzed the IRR with which reviewers determined whether or not the records met the definition of the performance measure.
   - Developer analyzed 532 individuals with two abstractions forms to calculate the level of agreement between two reviewers (Kappa).
   - Results indicated good agreement that was statistically significant ($\kappa = 0.6804$, $p < 0.001$). Percent agreement levels by HBCS program type ranged from moderate to strong.

Validity

- The data element reliability testing method used by the developer may be used for validity as well.
- Face validity testing
  - Forty-six HCBS quality stakeholders, including reviewers from the performance measure test, were surveyed on a series of questions to assess the face validity of this measure. After reviewing at least 10 forms, or at the end of data collection, reviewers were asked to complete a one-time feedback form on a secured, online survey.
  - In addition, a technical expert panel composed of 23 subject matter experts and stakeholders was convened and preliminary results were presented. Following the TEP, members also completed the online feedback form.
  - **Critical Data Elements**
    - Face facility of the critical data elements was tested by summarizing percent agreement of applicable survey questions on the reviewer and TEP feedback forms.
    - **Identifying needs on FASI**. Reviewers and TEP members indicated whether they thought that the performance measure definition of need was valid. The performance measure denominator, "All individuals 18 years or older who received HCBS with documented functional needs determined by a FASI within the reporting period," had a high level of endorsement for the reviewers (89%) and TEP members (92%).
    - **Identifying the total number of personal priorities by assessors**. Reviewers and TEP members were asked to consider whether they agreed that the assessors should identify at least three personal priorities. A total of 87% of reviewers strongly agreed or agreed that the reviewers will assess the FASI to identify three personal priorities, whereas 75% of the TEP members strongly agreed or agreed with this statement.

- **Identifying whether the individual had at least as many personal priorities as needs, up to three personal priorities**. Reviewers and TEP indicated to what extent they agreed with identifying at least three priorities from any of the functional areas. A total of 78% of reviewers strongly agreed or agreed that the personal priorities can be any number from the three sections for a total of at least three, and 83% of TEP members strongly agreed or agreed with this statement.

- **Systematic Assessment of Face Validity**
  - Face validity of the performance measure as a measure of quality and person-centered supports and services was tested by summarizing percent agreement of applicable survey questions on the reviewer and TEP feedback forms. The results demonstrated that strong agreement was found on all high-quality questions regarding the performance measure's ability to determine aspects of high-quality HCBS care.

Questions for the Committee regarding reliability:

- Do you have any concerns that the measure can be consistently implemented (i.e., are measure specifications adequate)?
- The NQF staff is satisfied with the reliability testing for the measure. What concerns does the Committee have related to reliability?

Questions for the Committee regarding validity:

- Do you have any concerns regarding the validity of the measure (e.g., exclusions, risk-adjustment approach, etc.)?
- The NQF staff is satisfied with the reliability testing for the measure. What concerns does the Committee have related to validity?

Preliminary rating for reliability: ☐ High ☒ Moderate ☐ Low ☐ Insufficient
Preliminary rating for validity: ☐ High ☒ Moderate ☐ Low ☐ Insufficient

Committee Pre-evaluation Comments:
Criteria 2: Scientific Acceptability of Measure Properties (including all 2a, 2b, and 2c)

2a1. Reliability-Specifications: Which data elements, if any, are not clearly defined? Which codes with descriptors, if any, are not provided? Which steps, if any, in the logic or calculation algorithm or other specifications (e.g., risk/case-mix adjustment, survey/sampling instructions) are not clear? What concerns do you have about the likelihood that this measure can be consistently implemented?

- IRR seems fine with good Kappa values.
- No concerns
- No concerns
- No concerns noted.
- Unsure how the comparative reliability and validity relates to heterogeneity of the Five HCBS program types 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.

- Data element reliability demonstrated; no measure score level reliability testing performed
- Data elements are clearly defined. The measure does not require risk adjustment. No concerns about consistent implementation.
- no concerns
- As stated "the results demonstrated that strong agreement was found on all high-quality questions regarding the performance measure's ability to determine aspects of high-quality HCBS care." When asking about preferences, there may be a tendency to think that there are many options. One person mentioned a patient's desire to swim as a result of care. For reliability purposes, we need to be able to bucket preferences at a higher level, like exercise, to capture priorities. This will also help the provider discuss up front that they may not be able to swim but do other activities. By having a consistent high-level option, implementation can be consistent.
- Moderate for what was tested

2a2. Reliability - Testing: Do you have any concerns about the reliability of the measure?

- no
- no
- No concerns
- No concerns noted, the test results indicate strong inter-rater reliability and moderate to strong percent agreement.
- Unsure how the comparative reliability and validity relates to heterogeneity of the Five HCBS program types 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.
- Reliability testing was dependent upon the rater as a specific rater was found to explain significant proportion of unreliable results; given the complexity of the FASI instrument, this does raise some concerns about the reliability of the measure (although provided testing results are reassuring)
- Test-retest reliability was conducted and adequate. No concerns.
- no concerns; would ask if there was any comparison to the home health OASIS data metrics
-)? Results overall and by program type indicated 100% agreement between the field test and determination of whether a FASI-based need was identified.)? Results overall and by program type indicated 100% agreement between the field test and determination of whether a FASI-based need was identified. At this point, this is a strong start for the measure.
- In the broader sense the reliability of the testimony for patient preference

2b1. Validity -Testing: Do you have any concerns with the testing results?

- Face validity only, but assessment was systematic and no concerns.
- no
- No concerns
- No concerns noted.
- Unsure how the comparative reliability and validity relates to heterogeneity of the Five HCBS program types 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. "Because this measure is not routinely implemented in HCBS programs, there is not sufficient experience to identify what counts as a meaningful difference in the score across program types. However, chi-square results indicated a statistically significant difference in the performance measure scores ($c2=13.60$, $p<0.01$). Table 11 shows that the highest performance measure score is from the brain injury and intellectual/developmental disabilities program types (50.8% and 49.3%, respectively), whereas the lowest performance measure scores are from frail elderly and physical disability program types (33.6% and 35.8%, respectively)."

- No empiric validity testing; all face validity assessments which concerns me for this high burden measure (although the measure intent is important)
- Face validity was evaluated and support by stakeholder and technical expert panel review. Good support for face validity. Would expect further validity testing in the future. No concerns.
- No concerns
- As stated this is a positive first step toward a measure for personal preferences. After review of the report, I concur with the conclusion that " we concluded that there was overall good agreement among the reviewers and TEP members with the performance management definitions, the method to determine personal priorities, and the decision that personal priorities can be any number from the three sections for a total of at least three."
- Similar to reliability

2b2-3. Other Threats to Validity (Exclusions, Risk Adjustment) 2b2. Exclusions: Are the exclusions consistent with the evidence? Are any patients or patient groups inappropriately excluded from the measure? 2b3. Risk Adjustment: If outcome (intermediate, health, or PRO-based) or resource use performance measure: Is there a conceptual relationship between potential social risk factor variables and the measure focus? How well do social risk factor variables that were available and analyzed align with the conceptual description provided? Are all of the risk-adjustment variables present at the start of care (if not, do you agree with the rationale provided)? Was the risk adjustment (case-mix adjustment) appropriately developed and tested? Do analyses indicate acceptable results? Is an appropriate risk-adjustment strategy included in the measure?

- This measure is not risk-adjusted
- I do not see risks. Exclusions seem appropriate.
- n/a
- Again, this is a new measure, however, the exclusions appear to be appropriate.
- Studies identified in the Evidence highlight the importance of assessing mental status. In one study referenced by the Measure Developer, Respondents were deemed cognitively capable to participate by passing the Orientation-Memory-Concentration Test (OMCT). In another, To be eligible, participants needed to be English speaking, have ang in the facility Mini-Mental State Exam (MMSE) score greater than 13, have long-stay status, and residency more than 1 week at the time of the study.
- N/A
- Exclusions are minimal and appropriate. The measure is not risk adjusted.
- Not clear on the risk adjustment; if I understand correctly, none is used. I would like to understand that in light of co-morbidity with these clients.

- Additional risk- adjustment strategy needs to be included in this measure. At this early stage, it is important that developers do not pre-suppose what patients want across social strata. It is stated that " Less agreement was demonstrated when the reviewer was asked about whether the services were of high quality if personal priorities were identified. This latter point is well taken, because this measure identifies whether the individual was asked about his/her personal priority and not whether the services provided were based on those priorities." This demonstrate that there is variable between provider expectations, what is delivered and what is wanted. It is a gap that the person's priority is not aligned with goals and service plans. Additional work is needed to close this gap.
- Limited Latino representation

2b4-6. Threats to Validity (Statistically Significant Differences, Multiple Data Sources, Missing Data) 2b4. Identification of Statistically Significant and Meaningful Differences: How do analyses indicate this measure identifies meaningful differences about quality? 2b5. Comparability of Performance Scores when more than One Set of Specifications: If multiple sets of specifications: Do analyses indicate they produce comparable results? 2b6. Missing data and Minimizing Bias/no response: Does missing data constitute a threat to the validity of this measure?

- no threats I could identify
- No
- N/a
- Missing data does constitute a threat to the validity of measure, but it appears to be relatively low in the tests performed by the developer.
- Unsure how the comparative reliability and validity relates to heterogeneity of the Five HCBS program types 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.
- 6% missing data/non-FASI paired test forms - details not available so hard to see if this represents potential bias missing sample
- It should be possible to access data electronically. Missing data should not be a problem.
- No concerns
- At this point in the development of the measure, missing data does not constitute a threat to the validity of the measure. The team found 36 measure test abstraction forms that could not be paired with FASI field test forms (Table 12). Without being able to match the measure test data to the FASI field test data, the team was unable to determine their program type, which is the unit of analysis. In addition, four abstraction forms were missing data indicating whether an individual had a functional need. It is concluded that FASI field test records were a result of incorrect form and assessor identifiers and not a result of data missing from the fields on the abstraction form related to identifying the critical data elements. This does not negate the validity of the data but overtime, it could be expected to be reduced by increasing the consistency of inputs.
- None

Criterion 3. Feasibility

Maintenance measures – no change in emphasis – implementation issues may be more prominent

3. **Feasibility** is the extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.
   - Developer notes that measure is abstracted from a record by someone other than person obtaining original information.
   - An electronic method drawing on FASI is available, though developer notes that some organizations may yet rely on paper versions.
   - Developer notes:

     The FASI set recently was field tested in HCBS programs and found to be a reliable and valid assessment of function. CMS will make the FASI readily available to all HCBS providers through the Data Element Library (DEL). All data elements come from defined fields in the FASI. If provider organizations implement the FASI into their electronic health records (EHRs), then all data elements will be in defined fields in an electronic record. If the paper form is uploaded to the EHR or if the HCBS programs use paper forms, the data can be abstracted for the defined fields on a data abstraction form.

Questions for the Committee:

- Are the required data elements routinely generated and used during care delivery?
- Are the required data elements available in electronic form, e.g., EHR or other electronic sources?
- Is the data collection strategy ready to be put into operational use?
- If an eCQM, does the eCQM Feasibility Score Card demonstrate acceptable feasibility in multiple EHR systems and sites?

Preliminary rating for feasibility: ☐ High ☒ Moderate ☐ Low ☐ Insufficient

Committee Pre-evaluation Comments:
Criteria 3: Feasibility

Feasibility: Which of the required data elements are not routinely generated and used during care delivery? Which of the required data elements are not available in electronic form (e.g., EHR or other electronic sources)? What are your concerns about how the data collection strategy can be put into operational use?

- Would be good to have information on the FASI- how prevalent is its use, how much time it takes.
- The challenge with this measure is will it be utilized by facilities or systems that have EHRs that differ from the few that easily can extract the data.
- Seems feasible
- No concerns about data collection strategy
- "…reviewers reported that certain aspects of the FASI and measure instructions were difficult to understand, including the association between functional needs and priorities with service planning, acronyms used, and uses of performance measures." "Reviewer and TEP members expressed concern about whether individuals served were actively involved in identifying personal priorities. Reviewers felt that those assessing individuals in the field needed more training on eliciting personal priorities and shared decision-making practices." "Administrative burden (accessibility of information, time to complete measure)." "TEP members and reviewers affirmed the need to identify personal priorities as

a quality measure but felt that further training on methods to encourage discussions with individuals being served is necessary." Lastly, it is very unclear how the FASI data that is obtained from patient interviews is subsequently integrated into a comprehensive patient-centered care plan is constructed by patients, caregivers and healthcare providers delivering the healthcare needed by the targeted individual.

- They have demonstrated feasibility through the test data, but it does represent a high burden data collection and matching measure for programs
- FASI data can be accessed electronically as long as part of the EHR. It appears that some settings complete the FASI on paper. The level of burden for manual abstraction is not clear and may be a concern.
- No concerns on process; well thought out and clear. I do want to understand the cost to the health system/payor for implementation; I am not clear on the actual expense.
- There is some concern about the collection of personal priorities and "whether individuals served were actively involved in identifying personal priorities. Reviewers felt that those assessing individuals in the field needed more training on eliciting personal priorities and shared decision-making practices." It is imperative that "CMS will make the FASI readily available to all HCBS providers through the Data Element Library (DEL). All data elements come from defined fields in the FASI. If provider organizations implement the FASI into their electronic health records (EHRs), then all data elements will be in defined fields in an electronic record." But the data elements collected must be able to be tied to care options.
- Moderate

Criterion 4: Usability and Use

Maintenance measures – increased emphasis – much greater focus on measure use and usefulness, including both impact/improvement and unintended consequences

4a. Use (4a1. Accountability and Transparency; 4a2. Feedback on measure)

4a. Use evaluate the extent to which audiences (e.g., consumers, purchasers, providers, policymakers) use or could use performance results for both accountability and performance improvement activities.

4a.1. Accountability and Transparency. Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

Current uses of the measure

Publicly reported? ☐ Yes ☒ No

Current use in an accountability program? ☐ Yes ☒ No ☐ UNCLEAR

OR

Planned use in an accountability program? ☒ Yes ☐ No

Accountability program details

- Developer notes that CMS intends to share information about the measure to support states in evaluating programs within the 1915 HCBS Waiver program.

4a.2. Feedback on the measure by those being measured or others. Three criteria demonstrate feedback: 1) those being measured have been given performance results or data, as well as assistance with interpreting the measure results and data; 2) those being measured, and other users have been given an opportunity to provide feedback on the measure performance or implementation; 3) this feedback has been considered when changes are incorporated into the measure

Feedback on the measure by those being measured or others

- Developer outlines CMS plans to share information with those being measured should the measure be implemented.

Additional Feedback: N/A

Questions for the Committee:

- How have (or can) the performance results be used to further the goal of high-quality, efficient healthcare?
- How has the measure been vetted in real-world settings by those being measured or others?

Preliminary rating for Use: ☒ Pass ☐ No Pass

4b. Usability (4a1. Improvement; 4a2. Benefits of measure)

4b. Usability evaluate the extent to which audiences (e.g., consumers, purchasers, providers, policymakers) use or could use performance results for both accountability and performance improvement activities.

4b.1 Improvement. Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated.

Improvement results

- Measure has not been implemented and therefore year-over-year results are not available.

4b2. Benefits vs. harms. Benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

- Developer notes that most reviewers agree or strongly agree that the information needed to implement the measure is readily available (96%).
- Developer notes that most reviewers agree or strongly agree that the documents needed are clear (91%)
- Developer notes that most reviewers agree or strongly agree that the time needed was reasonable (87%)

Unexpected findings (positive or negative) during implementation N/A

Potential harms

Additional Feedback:

- Developer's note:
- Unexpected benefits are not yet well understood because this measure has not been implemented. However, the immediate benefit is that the reviewers have increased awareness that HCBS recipients with documented functional needs should have their personal priorities better documented. Furthermore, reviewers commented that the priorities should be person-centered and should be written collaboratively by both the assessor and the individual receiving services. Thus, the practice of identifying personal priorities has increased awareness of person-centered practices.

Questions for the Committee:

- How can the performance results be used to further the goal of high-quality, efficient healthcare?

- Do the benefits of the measure outweigh any potential unintended consequences?

Preliminary rating for Usability and use: ☐ High ☒ Moderate ☐ Low ☐ Insufficient

Committee Pre-evaluation Comments:
Criteria 4: Usability and Use

4a1. Use - Accountability and Transparency: How is the measure being publicly reported? Are the performance results disclosed and available outside of the organizations or practices whose performance is measured? For maintenance measures - which accountability applications are the measure being used for? For new measures - if not in use at the time of initial endorsement, is a credible plan for implementation provided? 4a2. Use - Feedback on the measure: Have those being measured been given performance results or data, as well as assistance with interpreting the measure results and data? Have those being measured or other users been given an opportunity to provide feedback on the measure performance or implementation? Has this feedback has been considered when changes are incorporated into the measure?

- Measure is planned to be used for accountability- a new measure.
- I agree there are undetermined benefits that may be seen by implementing this measure. It may increase patient-centeredness by measuring assessment of patient preferences.
- Currently not publicly reported; will be used in CMS program
- This is a new measure. CMS plans to share the measure within the 1915 HCBS Waiver Program.
- "Interestingly, there was moderate to low agreement on whether performance on the measure provides important information about whether HCBS recipients are receiving high-quality care."
- Not yet in use
- The measure will be used for public reporting in the future. Preliminary data have been provided to those being measured with opportunity to provide feedback. The logic model incorporates appropriate actions for improvement.
- Yes -- well done!
- As of this version of the development, "measure testing focused on the reliability and face validity of the measure and did not include a method to give the participating organizations the results of the testing. The results of the testing were submitted to CMS to review and use to develop future activity. " It is unclear the timing for performance measure results and only states, " Measure testing focused on the reliability and face validity of the measure and did not include a method to give the participating organizations the results of the testing. The results of the testing were submitted to CMS to review and use to develop future activity. " A detailed plan is needed for the use and feedback on the measure.
- Pass

4b1. Usability – Improvement: How can the performance results be used to further the goal of high-quality, efficient healthcare? If not in use for performance improvement at the time of initial endorsement, is a credible rationale provided that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations? 4b2. Usability – Benefits vs. harms: Describe any actual unintended consequences and note how you think the benefits of the measure outweigh them.

- No problems I could identify
- No concern
- Benefits show increased awareness that HCBS recipients should have their personal priorities better documented. Benefit outweighs harm
- The measure is new and has not been implemented. One intent of the measure is to promote patient centered care and improve development of the care plan.

- Important to distinguish between the survey instrument and the use of performance measurement data for accountability, including public reporting, payment, and achievable quality improvements, especially in the context of a more comprehensive patient care plan that is managed by healthcare providers in a fully coordinated manner.
- The nature of the data collection and burden raises concerns for vulnerable populations; would be helpful to see some data about data collection burden/time to complete and processing time for facilities/programs
- There does not appear to be significant danger of unintended consequences of documenting patient priorities for HCBS. It is possible that the quality of documentation and capture of actual priorities may not reflect patient statements completely or accurately, however, this measure is a first step toward integrating the patient's priorities in their functional assessments. The benefits of this measure outweigh potential unintended consequences.
- No concerns.
- The benefits clearly outweigh the harms with measuring patient personal priorities for care. Patients depending on life-stage, cultural viewpoints, personal experiences have varying preferences, values, and goals. The measure was not evaluated over time, but preferences may start to indicate care evolves when the patient's point of view is included in care solutions. At this point, there was a " discrepancy on the reviewer and TEP member feedback on whether the performance measure provides important information for assessing whether HCBS recipients are receiving high-quality services." We have to remember that high quality services in this reports are from the perspective of the provider. It is their perception of what the person should want. Therefore, this measure needs to be implemented and refined so that we can flip the delivery of healthcare from pushing product to providing patient personal priorities.
- Moderate

Criterion 5: Related and Competing Measures

Related or competing measures

Developer lists the following measure as related:

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

Harmonization

- No harmonization points identified.

Committee Pre-evaluation Comments: Criterion 5: Related and Competing Measures

5. Related and Competing: Are there any related and competing measures? If so, are any specifications that are not harmonized? Are there any additional steps needed for the measures to be harmonized?

- One related measure identified, the CAHPS HCBS measures.
- not relevant
- 2967: CAHPS Home and Community Based Measures.
- The competing measure is 2967 CAHPs Home and Community-Based Service Measure.
- Just asking whether/if OASIS-generated data published on Medicare.gov for Home based services is affected and/or harmonized.

- CAHPS measures listed as potentially competing but agree with NQF staff that measure concepts/targets are distinct even though populations are similar
- There are not measures for harmonization.
- Described CAHPS survey, which is a separate metric for experience rating. Information from both could be of future interest.
- The existing measure is an outcome measure. This measure is a process measure. Additional review is needed to determine how they may be harmonized. Ideally, we need to only measure this once.
- None

Public and Member Comments

Comments and Member Support/Non-Support Submitted as of: 01/21/2021

- No NQF Members have submitted support/non-support choices as of this date.
- No Public or NQF Member comments submitted as of this date.

NQF Staff Scientific Acceptability Evaluation

Scientific Acceptability: Preliminary Analysis Form

Measure Number: 3593

Measure Title: Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Type of measure:

☒ **Process** ☐ **Process: Appropriate Use** ☐ **Structure** ☐ **Efficiency** ☐ **Cost/Resource Use**

☐ **Outcome** ☐ **Outcome: PRO-PM** ☐ **Outcome: Intermediate Clinical Outcome** ☐ **Composite**

Data Source:

☐ **Claims** ☒ **Electronic Health Data** ☐ **Electronic Health Records** ☐ **Management Data**
☐ **Assessment Data** ☒ **Paper Medical Records** ☒ **Instrument-Based Data** ☐ **Registry Data**
☐ **Enrollment Data** ☐ **Other**

Level of Analysis:

☐ **Clinician: Group/Practice** ☐ **Clinician: Individual** ☐ **Facility** ☐ **Health Plan**
☐ **Population: Community, County or City** ☐ **Population: Regional and State**
☐ **Integrated Delivery System** ☐ **Other**

Measure is:

☒ **New** ☐ **Previously endorsed (**NOTE: Empirical validity testing is expected at time of maintenance review; if not possible, justification is required.)

RELIABILITY: SPECIFICATIONS

1. **Are submitted specifications precise, unambiguous, and complete so that they can be consistently implemented?** ☒ **Yes** ☐ **No**

   Submission document: Specification items S.1-S.22

2. **Briefly summarize any concerns about the measure specifications.**
   - No concerns identified by NQF Staff

RELIABILITY: TESTING

Submission document: Measure specifications, testing attachment questions 1.1-1.4 and section 2a2

3. **Reliability testing level ☐ Measure score ☒ Data element ☐ Neither**
4. **Reliability testing was conducted with the data source and level of analysis indicated for this measure ☒ Yes ☐ No**
5. If score-level and/or data element reliability testing was NOT conducted or if the methods used were NOT appropriate, was **empirical VALIDITY testing** of **patient-level data** conducted?

   ☐ Yes ☐ No
6. **Assess the method(s) used for reliability testing**

   Submission document: Testing attachment, section 2a2.2

   3. Developer conducted reliability testing for each critical data element:
      a. Definition of need:
         i. 675 forms were analyzed to evaluate concordance between the field test and reviewers' indication of whether or not individuals documented a FASI-based need.
         ii. Results overall and by program type indicated 100% agreement between the field test and determination of whether a FASI-based need was identified.
      b. Identifying the total number of personal priorities:
         i. Developer assigned pairs from the same organization to review 534 records independently.
         ii. The developer evaluated consistency between raters in determining the number of needs noted in each record using the Bland-Altman limits of agreement (LOA), which are defined as the average difference between two reviewers plus 1.96 times the standard deviation of the differences.
         iii. LOA for total pairs of records: between 3.47 and 2.58 (The LOA are defined by the lower and upper values and define the range between which 95% of values should fall)
         iv. Percentage of records that fell within the LOA by HBCS program type ranged from 90.6% to 95.3%, indicating high agreement.
         v. 71% of records that fell outside of the LOA were from one reviewer (Reviewer A). Excluding this reviewer, only 2.9% of total records fell outside of the LOA (with 95% confidence intervals).
      c. Identifying whether the individual had at least as many personal priorities as needs, up to three personal priorities.
         i. Developer used a Kappa statistic (an inter-rater agreement statistic calculated with a 95% confidence interval) to determine concordance between the number of identified priorities and the reviewers' assessment of whether the numerator definition was met.
         ii. Across the 672 forms analyzed, results indicated a strong agreement that was statistically significant ($\kappa = 0.9723$, $p < 0.001$).
         iii. For records that had been determined to indicate at least one FASI-based need (denominator), the developer analyzed the IRR with which reviewers determined whether or not the records met the definition of the performance measure.
         iv. Developer analyzed 532 individuals with two abstractions forms to calculate the level of agreement between two reviewers (Kappa).

v. Results indicated good agreement that was statistically significant (κ=0.6804, p < 0.001). Percent agreement levels by HBCS program type ranged from moderate to strong.

7. **Assess the results of reliability testing**

   Submission document: Testing attachment, section 2a2.3

   4. Developers testing used an appropriate methodology and produced results within an acceptable range.

8. Was the method described and appropriate for assessing the proportion of variability due to real differences among measured entities? NOTE: If multiple methods used, at least one must be appropriate.

   Submission document: Testing attachment, section 2a2.2

   ☐ **Yes**

   ☐ **No**

   ☒ **Not applicable** (score-level testing was not performed)

9. Was the method described and appropriate for assessing the reliability of ALL critical data elements?

   Submission document: Testing attachment, section 2a2.2

   ☒ **Yes**

   ☐ **No**

   ☐ **Not applicable** (data element testing was not performed)

10. **OVERALL RATING OF RELIABILITY** (taking into account precision of specifications and all testing results):

    ☐ **High** (NOTE: Can be HIGH **only if** score-level testing has been conducted)

    ☒ **Moderate** (NOTE: Moderate is the highest eligible rating if score-level testing has not been conducted)

    ☐ **Low** (NOTE: Should rate **LOW** if you believe specifications are NOT precise, unambiguous, and complete or if testing methods/results are not adequate)

    ☐ **Insufficient** (NOTE: Should rate **INSUFFICIENT** if you believe you do not have the information you need to make a rating decision)

11. **Briefly explain rationale for the rating of OVERALL RATING OF RELIABILITY and any concerns you may have with the approach to demonstrating reliability.**

    From NQF Reliability algorithm (2019 NQF Measure Evaluation Criteria):

    (Box 1) Specifications implementable → (Box 2) Reliability testing complete → (Box 4) No score level testing → (Box 8) Patient-level data element testing → (Box 9) Appropriate testing → (Box 10) Moderate confidence → MODERATE

VALIDITY: ASSESSMENT OF THREATS TO VALIDITY

12. **Please describe any concerns you have with measure exclusions.**

    Submission document: Testing attachment, section 2b2.

    - No concerns identified by staff.

13. **Please describe any concerns you have regarding the ability to identify meaningful differences in performance.**

    Submission document: Testing attachment, section 2b4.

- No concerns identified by staff.

14. **Please describe any concerns you have regarding comparability of results if multiple data sources or methods are specified.**
    Submission document: Testing attachment, section 2b5.
    - No concerns identified by staff.
15. **Please describe any concerns you have regarding missing data.**
    Submission document: Testing attachment, section 2b6.
    - No concerns identified by staff.
16. **Risk Adjustment**

    16a. **Risk-adjustment method ☒ None ☐ Statistical model ☐ Stratification**

    16b. **If not risk-adjusted, is this supported by either a conceptual rationale or empirical analyses?**

    ☐ Yes ☒ No ☐ Not applicable

    16c. **Social risk adjustment:**

    16c.1 Are social risk factors included in risk model? ☐ Yes ☐ No ☒ Not applicable

    16c.2 Conceptual rationale for social risk factors included? ☐ Yes ☒ No

    16c.3 Is there a conceptual relationship between potential social risk factor variables and the measure focus? ☐ Yes ☒ No

VALIDITY: TESTING

17. **Validity testing level: ☒ Measure score ☒ Data element ☐ Both**
18. **Method of establishing validity of the measure score:**

    ☒ **Face validity**

    ☐ **Empirical validity testing of the measure score**

    ☐ **N/A (score-level testing not conducted)**
19. **Assess the method(s) for establishing validity**

    Submission document: Testing attachment, section 2b2.2
    - The data element reliability testing method used by the developer may be used for validity as well.
    - Face validity testing
        - Forty-six HCBS quality stakeholders, including reviewers from the performance measure test, were surveyed on a series of questions to assess the face validity of this measure. After reviewing at least 10 forms, or at the end of data collection, reviewers were asked to complete a one-time feedback form on a secured, online survey.
        - In addition, a technical expert panel composed of 23 subject matter experts and stakeholders was convened and preliminary results were presented. Following the TEP, members also completed the online feedback form.
        - **Critical Data Elements**
            - Face facility of the critical data elements was tested by summarizing percent agreement of applicable survey questions on the reviewer and TEP feedback forms.
            - **Identifying needs on FASI**. Reviewers and TEP members indicated whether they thought that the performance measure definition of need was valid. The performance measure denominator, "All individuals 18 years or older who received HCBS with documented functional needs determined by a FASI within the reporting period," had a high level of endorsement for the reviewers (89%) and TEP members (92%).

- **Identifying the total number of personal priorities by assessors**. Reviewers and TEP members were asked to consider whether they agreed that the assessors should identify at least three personal priorities. A total of 87% of reviewers strongly agreed or agreed that the reviewers will assess the FASI to identify three personal priorities, whereas 75% of the TEP members strongly agreed or agreed with this statement.
- **Identifying whether the individual had at least as many personal priorities as needs, up to three personal priorities**. Reviewers and TEP indicated to what extent they agreed with identifying at least three priorities from any of the functional areas. A total of 78% of reviewers strongly agreed or agreed that the personal priorities can be any number from the three sections for a total of at least three, and 83% of TEP members strongly agreed or agreed with this statement.

- **Systematic Assessment of Face Validity**
  - Face validity of the performance measure as a measure of quality and person-centered supports and services was tested by summarizing percent agreement of applicable survey questions on the reviewer and TEP feedback forms. The results demonstrated that strong agreement was found on all high-quality questions regarding the performance measure's ability to determine aspects of high-quality HCBS care.

20. **Assess the results(s) for establishing validity**

    Submission document: Testing attachment, section 2b2.3

    - The data element testing suggests that the measure has moderate empirical validity and good face validity. The score level validity results were appropriate as well.

21. **Was the method described and appropriate for assessing conceptually and theoretically sound hypothesized relationships?**

    Submission document: Testing attachment, section 2b1.

    ☒ **Yes**

    ☐ **No**

    ☐ **Not applicable** (score-level testing was not performed)

22. **Was the method described and appropriate for assessing the accuracy of ALL critical data elements?**

    NOTE that data element validation from the literature is acceptable.

    Submission document: *Testing attachment, section 2b1.*

    ☒ **Yes**

    ☐ **No**

    ☐ **Not applicable** (data element testing was not performed)

23. **OVERALL RATING OF VALIDITY taking into account the results and scope of all testing and analysis of potential threats.**

    ☐ **High** (NOTE: Can be HIGH only if score-level testing has been conducted)

    ☒ **Moderate** (NOTE: Moderate is the highest eligible rating if score-level testing has NOT been conducted)

    ☐ **Low** (NOTE: Should rate LOW if you believe that there **are** threats to validity and/or relevant threats to validity were **not assessed OR** if testing methods/results are not adequate)

☐ **Insufficient** (NOTE: For instrument-based measures and some composite measures, testing at both the score level and the data element level **is required**; if not conducted, should rate as INSUFFICIENT.)

24. **Briefly explain rationale for rating of OVERALL RATING OF VALIDITY and any concerns you may have with the developers' approach to demonstrating validity.**

    (Box 1) Potential threats to validity addressed → (Box 2) Empirical testing conducted → (Box 5) Empirical score level testing not conducted → (Box 9) Testing with patient-level data → (Box 10) Assessed all data elements → (Box 11) Moderate certainty that the data elements are valid → MODERATE

ADDITIONAL RECOMMENDATIONS

25. **If you have listed any concerns in this form, do you believe these concerns warrant further discussion by the multi-stakeholder Standing Committee? If so, please list those concerns below.**

    - No additional concerns from staff.

Developer Submission

NQF #: 3593

Corresponding Measures:

De.2. Measure Title: Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Co.1.1. Measure Steward: Centers for Medicare & Medicaid Services

De.3. Brief Description of Measure: 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.

1b.1. Developer Rationale: Current estimates suggest that 10 million individuals requiring assistance to perform ADLs or IADLs are living in the community, including in private or group homes.1 Eiken (2017)2 reported that more than 3.7 million individuals receive Medicaid-funded HCBS. Federal and state governments finance over 60 percent of paid HCBS costs in the United States through the Medicaid program.2 HCBS are expected to grow because of the aging U.S. population and the current move away from institutional-based care.3 As significant continued growth is expected in cost and utilization of HCBS, including through managed care contracting, greater scrutiny on quality also is expected.

Documenting personal priorities related to functional needs is a key aspect of person-centered service planning for individuals receiving HCBS. Existing literature suggests that using a person-centered approach in developing service plans can lead to higher satisfaction and more engagement of individuals in their care.4,5 This approach also may lead to lower costs.4 There are, however, measurement gaps and other barriers limiting the ability to assess this key aspect of developing a quality service plan. A 2015 inventory of functional assessment tools used by state Medicaid programs for HCBS found that there was no standardization across or within states, and at least 124 tools were in use at that time.8 In most but not all cases, the information used to determine functional eligibility also was used to inform the creation of specific service plans for eligible individuals; nevertheless, at least 21 states had functional assessment tools for specific populations that were not also used for service planning.9

A comprehensive scan funded by the Medical and Children's Health Insurance Program Payment and Access Commission related to HCBS and behavioral health found that most state-level quality measurement activity related to HCBS in Medicaid was based on CMS reporting requirements for 1915(c) waivers.6 These measures generally are process oriented and intended to demonstrate state and provider compliance with a range of policies and procedures. One of six key domains is "service plan," for which the focus is ensuring that plans reflect needs and personal goals and that participants receive services laid out in plans. This concept is slightly different than determining whether the recipient's personal priorities related to needs are captured in the assessment. The NQF conducted a broader environmental scan of HCBS quality measurement across all payers.7 The resulting recommendations prioritized "assessment"—the level to which the HCBS systems and providers support the person in identifying their goals, needs, preferences, and values—as one of three subdomains within the person-centered planning and coordination domain for which quality measurement can be improved.

The absence of measures for the concept of documenting personal priorities for HCBS recipients with functional needs reflects a gap at the measurement level. The proposed measure supports a person-centered approach by encouraging providers to elicit the values and preferences of the individual served. The FASI-

based performance measure provides a uniform, standardized approach to identifying personal priorities and measuring functional needs across all community-based settings, thus promoting continuity of quality care.

1. Kaye HS, Harrington C. Long-term services and supports in the community: Toward a research agenda. Disability and Health Journal. 2015;8(1):3-8. Retrieved from http://proxygw.wrlc.org/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2014-55175-002&site=eds-live&scope=site&authtype=ip,uid&custid=s8987071.
2. Eiken S. Medicaid long-term services and supports beneficiaries in 2013. Centers for Medicare & Medicaid Services; 2017. Retrieved from https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltss-beneficiaries-2013.pdf.
3. Ng T, Harrington C, Musumeci M, Reaves E. Medicaid home and community-based services programs: 2012 data update. Kaiser Family Foundation; 2015. Retrieved from https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2012-data-update.
4. Kim KM, Fox MH, White GW. Comparing outcomes of persons choosing consumer-directed or agency-directed personal assistance services. Journal of Rehabilitation. 2006;72(2):32-43. Retrieved from https://www.scopus.com/inward/record.uri?eid=2-s2.0-33746260088&partnerID=40&md5=58a765b4ec9338cd00fa66c8d4613cf9.
5. Ratti V, Hassiotis A, Crabtree J, Deb S, Gallagher P, Unwin G. The effectiveness of person-centered planning for people with intellectual disabilities: A systematic review. Research in Developmental Disabilities. 2016;57:63–84. Retrieved from http://www.sciencedirect.com/science/article/pii/S089142221630138X.
6. Hartman L, Lukanen E. Quality measurement for home and community-based services (HCBS) and behavioral health in Medicaid. Medicaid and CHIP Payment and Access Commission; 2016:1–30. Retrieved from https://www.macpac.gov/publication/quality-measurement-for-home-and-community-based-services-and-behavioral-health-in-medicaid.
7. Caldwell J, Kaye HK. Quality in home and community-based services to support community living: Addressing gaps in performance measurement. National Quality Forum; 2016:1–59. Retrieved from https://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx.
8. Medicaid and CHIP Payment and Access Commission. June 2016 report to congress on Medicaid and CHIP, Functional assessments for long-term services and supports. Retrieved from https://www.macpac.gov/publication/june-2016-report-to-congress-on-medicaid-and-chip.
9. Medicaid and CHIP Payment and Access Commission. Inventory of the state functional assessment tools for long-term services and supports. 2017. Retrieved from https://www.macpac.gov/publication/inventory-of-the-state-functional-assessment-tools-for-long-term-services-and-supports.

S.4. 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.

S.6. 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.

S.8. Denominator 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.

De.1. Measure Type: Process

S.17. Data Source: Electronic Health Records, Instrument-Based Data, Paper Medical Records

S.20. Level of Analysis: Other

IF Endorsement Maintenance – Original Endorsement Date: Most Recent Endorsement Date:

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? Not applicable.

To maintain NQF endorsement endorsed measures are evaluated periodically to ensure that the measures still meet the NQF endorsement criteria ("maintenance"). The emphasis for maintaining endorsement is focused on how effective the measure is for promoting improvements in quality. Endorsed measures should have some experience from the field to inform the evaluation. The emphasis for maintaining endorsement is noted for each criterion.

1. Evidence and Performance Gap – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. ***Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.***

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

NQF3593_MeasureEvidenceForm_2020-11-23.docx

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission? Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

1a. Evidence (subcriterion 1a)

NATIONAL QUALITY FORUM—Evidence (subcriterion 1a)

Measure Number (*if previously endorsed*)**:** 3593

Measure Title: Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here:

Date of Submission: **11/23/2020**

1a.1. This is a measure of: (*should be consistent with type of measure entered in De.1*)

Outcome

☐ Outcome:

☐ Patient-reported outcome (PRO):

PROs include HRQoL/functional status, symptom/symptom burden, experience with care, health-related behaviors. (A PRO-based performance measure is not a survey instrument. Data may be collected using a survey instrument to construct a PRO measure.)

☐ Intermediate clinical outcome (*e.g., lab value*):

☒ Process: **Measurement of the eliciting of personal priorities related to needs identified by FASI**

☐ Appropriate use measure:

☐ Structure:

☐ Composite:

1a.2 LOGIC MODEL Diagram or briefly describe the steps between the healthcare structures and processes (e.g., interventions, or services) and the patient's health outcome(s). The relationships in the diagram should be easily understood by general, non-technical audiences. Indicate the structure, process or outcome being measured.

The process of having an individual complete the FASI creates an opportunity for HCBS recipients to identify key personal priorities related to self-care, mobility, and instrumental activities of daily living (IADLs). Data from the FASI allow Medicaid and HCBS providers to act upon the identified needs, partnering with HCBS recipients to set goals, facilitate shared decision-making, improve services received, and increase the quality of life for these recipients.

Table 1 provides a conceptual model for this logic flow, describing the inputs, processes, and outcomes associated with use of the FASI to identify personal priorities.

Table 1. Conceptual Model for Impact of Improvement in Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs

Inputs	Processes	Output	Short-Term Outcomes	Long-Term Outcomes
Individual who is eligible for HCBS, and brings their needs and preferences	• HCBS program staff assesses individual using the FASI • FASI identifies and documents need(s) on self-care, mobility, and instrumental activities of daily living (IADL) sections • FASI elicits and documents personal priorities in self-care, mobility, and IADL sections	Process measure quantifies the percentage of individuals for whom personal priorities are elicited and documented in FASI when there is an assessed need	• HCBS programs may recognize that more training is needed for assessors to elicit the individual's priorities • May translate to individualized services to address priorities valued by the person receiving supports and services • May facilitate responsivity to these priorities by the assessor or case manager • May facilitate the individual's engagement in goal setting	• Lead to person-centered HCBS • Facilitate shared decision-making

1a.3 Value and Meaningfulness: IF this measure is derived from patient report, provide evidence that the target population values the measured ***outcome, process, or structure*** and finds it meaningful. (Describe how and from whom their input was obtained.)

Input was received through an online survey by reviewers and Technical Expert Panel (TEP) members that included self-advocates and advocacy group representatives. Reviewers and TEP members responded positively to the questions concerning the performance measure's value to quality improvement, person-centered supports, and services, and as a measure of quality care. Reviewers had an 87% agreement on the statement "Identifying personal priorities is an important step to creating person-centered services because it addresses the individual's needs," a 72% agreement on the statement "Identifying personal priorities is an important step to creating person-centered services because the assessor can create goals addressing the individual's needs," and a 70% agreement on the statement "Performance on this measure provides important information for assessing whether groups of HCBS recipients are receiving high-quality services." TEP members had an 83% agreement on the statement "Identifying personal priorities is an important step to creating person-centered services because it addresses the individual's needs," a 58% agreement on "Identifying personal priorities is an important step to creating person-centered services because the assessor can create goals addressing the individual's needs," and a 41.7% agreement on the statement "Performance on this measure provides important information for assessing whether groups of HCBS recipients are receiving high-quality services." See the table in section 2b1.3 of the testing attachment (validity testing) for more details about these results.

****RESPOND TO ONLY ONE SECTION BELOW -EITHER 1a.2, 1a.3 or 1a.4) ****

1a.2 FOR OUTCOME MEASURES including PATIENT REPORTED OUTCOMES - Provide empirical data demonstrating the relationship between the outcome (or PRO) to at least one healthcare structure, process, intervention, or service.

1a.3. SYSTEMATIC REVIEW (SR) OF THE EVIDENCE (for INTERMEDIATE OUTCOME, PROCESS, OR STRUCTURE PERFORMANCE MEASURES, INCLUDING THOSE THAT ARE INSTRUMENT-BASED) If the evidence is not based on a systematic review go to section 1a.4) If you wish to include more than one systematic review, add additional tables.

Not applicable

What is the source of the systematic review of the body of evidence that supports the performance measure? A systematic review is a scientific investigation that focuses on a specific question and uses explicit, prespecified scientific methods to identify, select, assess, and summarize the findings of similar but separate studies. It may include a quantitative synthesis (meta-analysis), depending on the available data. (IOM)

☐ Clinical Practice Guideline recommendation (with evidence review)

☐ US Preventive Services Task Force Recommendation

☐ Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*)

☐ Other

Systematic Review	Evidence
Source of Systematic Review: • Title • Author • Date • Citation, including page number • URL	*
Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR.	*
Grade assigned to the **evidence** associated with the recommendation with the definition of the grade	*
Provide all other grades and definitions from the evidence grading system	*
Grade assigned to the **recommendation** with definition of the grade	*
Provide all other grades and definitions from the recommendation grading system	*
Body of evidence: • Quantity – how many studies? • Quality – what type of studies?	*
Estimates of benefit and consistency across studies	*
What harms were identified?	*
Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR?	*

*cell intentionally left blank

_____

1a.4 OTHER SOURCE OF EVIDENCE

If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, please describe the evidence on which you are basing the performance measure.

The developer team conducted a targeted literature review of studies addressing person-centered supports and services, functional assessment, and the importance of personal priorities for individuals in the HCBS community. The team searched academic journal articles, gray literature, and federal and state agency reports published in the past 20 years using PubMed (US National Library of Medicine, National Institutes of Health), Scopus®, Google, Google Scholar, and personal libraries.

1a.4.1 Briefly SYNTHESIZE the evidence that supports the measure. A list of references without a summary is not acceptable.

A person-centered framework is the gold standard for high-quality care and services, including those provided in the context of the home and community.[1] A key strategy of a person-centered approach is the empowerment of the individual to communicate his/her personal preferences and create goals that inform the service plan. Specifically, the National Quality Forum (NQF) convened a multi-stakeholder committee to discuss quality in HCBS and to identify gaps in current quality measurements.[2] Members arrived at consensus regarding the characteristics of a high-quality system. One characteristic is that the system is person-driven and optimizes individual choice and control in the pursuit of self-identified goals as well as life preferences. The committee further developed measurement domains and subdomains to highlight important areas for quality measurement. One domain is person-centered planning and coordination. A subdomain is assessment—the level to which the HCBS system and providers support individuals in identifying their goals, needs, preferences, and values. The overall intent is to gather information that can inform a person-centered planning process.

In an expert-based consensus document, Zimmerman et al.[3] provided further support for the core values and principles associated with person-centered supports and services in the context of HCBS programs. The recommendations included specific domains and attributes that should be present in all HCBS settings; these included personhood, autonomy, independence, and choice, as well as meaningful life and engagement. Indicators of each domain and attribute required staff and providers to elicit the personal preferences of the individual served. A panel of experts rated the level of importance of each of these indicators to high-quality, person-centered supports and services at or above 8.8 out of 10. Abbott et al.[4] demonstrated that a large percentage of individuals receiving long-term services and supports (LTSS) indicated that it was important to solicit preferences and priorities about personal hygiene and self-care. The researchers also suggested that assessing preferences of recipients of LTSS assists in in building relationships, transitions of care, and quality improvement.

The Patient-Centered Care Improvement Guide reports that a person's priorities often are inadequately considered during his or her hospital experience even when clinical outcomes are deemed adequate.[5] Stakeholders in community-based medical and social service settings during interviews strongly affirmed that services are of higher quality when based on the person's preferences versus identified by the providers.[6] Providers also expressed higher levels of satisfaction with services based on person-centered frameworks.[7]

Several clinical studies demonstrate that eliciting and documenting an individual's personal preferences positively affect outcomes. Kim, Fox, and White[8] found that individuals receiving person-directed versus agency-directed personal assistance in the Kansas Medicaid waiver program for individuals with physical disability were more satisfied with care. In a study of nursing home participants using wheelchairs, individual wheelchair configuration, as compared with institutional configuration, demonstrated improved physical outcomes, specifically with regards to injury incidence and mobility[9]. Na et al. found that patient activation, as measured through self-care efficiency, patient-doctor communication, and health information seeking, is linked to improved functioning in activities of daily living[10]. Patients who actively identify, pursue, and adjust independent self-care goals realize an increased sense of autonomy and life-space mobility[11]. Within an older adult patient sample, Black et al. also found that progressive goal setting and attainment is associated with older adults' functional improvement and discharge destination[12]. Studies further indicate that integrating physical activity into person-centered priorities is associated with improved frailty status and decreased fall rates[13-14].

In summary, a person-centered approach to service planning has been demonstrated to improve participant outcomes including overall satisfaction with their quality of life and physical outcomes, such as functional status, activities of daily life, and frailty. Eliciting and documenting personal preferences and priorities is consistent with providing person-centered supports and services in HCBS programs. Upstream information about provider processes (in conjunction with state processes) that capture personal priorities associated with functional needs adds value to these efforts. Using standardized functional assessment items that capture personal priorities serves as an important stepping stone in the overall process of shared decision-making and improved person-centered services.

1a.4.2 What process was used to identify the evidence?

The developer team conducted a targeted literature review of studies using the following search terms: performance measures, person-centered supports and services, functional assessment, personal priorities, home and community-based service, and community-based long-term services and supports. The team searched academic journal articles, gray literature and federal and state agency reports published in the past 20 years using PubMed, Scopus, Google, Google Scholar, and personal libraries.

1a.4.3. Provide the citation(s) for the evidence.

1. Centers for Medicare & Medicaid Services. Medicaid program: State plan home and community-based services, 5-year period for waivers, provider payment reassignment, and home and community-based setting requirements for community first choice and home and community-based services (HCBS) waivers. Final rule. Federal register. 2014;79(11):2947. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/24443765.

2. Caldwell J, Kaye HK. Quality in home and community-based services to support community living: Addressing gaps in performance measurement. National Quality Forum; 2016:1–59. Retrieved from https://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx.
3. Zimmerman S, Love K, Cohen LW, Pinkowitz J, Nyrop KA. Person-centeredness in home- and community-based services and supports: Domains, attributes, and assisted living indicators. *Clinical Gerontology*. 2014;37(5):429–445. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC5635827.
4. Abbott K, Klumpp R, Leser K, Straker J, Gannod GC, Haitsma K. Delivering person-centered care: Important preferences for recipients of long-term services and supports. *Journal of the American Medical Directors Association*. 2018;19(2):169-173. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/29146223.
5. Frampton S, Guastello S, Brady C, Hale M, Horowitz S, Bennett Smith S, Stone S. Patient-centered care improvement guide. Derby, Connecticut: Planetree; 2008. Retrieved from http://www.ihi.org/resources/Pages/Tools/PatientCenteredCareImprovementGuide.aspx.
6. Kogan AC, Wilber K, Mosqueda L. Person-centered care for older adults with chronic conditions and functional impairment: A systematic literature review. *Journal of the American Geriatric Society*. 2016;64(1):e7. Retrieved from https://doi.org/10.1111/jgs.13873.
7. Van der Meer L, Nieboer AP, Finkenflugel H, Cramm JM. The importance of person-centered care and co-creation of care for the well-being and job satisfaction of professionals working with people with intellectual disabilities. *Scandinavian Journal of Caring Science*. 2018;32(1):76–81. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/28654162.
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9. Brienza DM, Karg PE, Bertolet M, Schmeler M, Poojary-Mazzotta, P, Vlachos H, Wilkinson D. A Randomized clinical trial of wheeled mobility for pressure injury prevention and better function. *Journal of the American Geriatrics Society*. 2018; 66(9), 1752–1759. doi: 10.1111/jgs.15495.
10. Na L, Kwong PL, Xie D, Pezzin LE, Kurichi JE, Streim JE. Functional impairments associated with patient activation among community-dwelling older adults. *Journal of Clinical Nursing*. 2018;97(11), 839–847. doi: 10.1111/jocn.14767.
11. Siltanen S, Rantanen T, Portegijs E, Tourunen A, Poranen-Clark T, Eronen J, Saajanaho M. Association of tenacious goal pursuit and flexible goal adjustment with out-of-home mobility among community-dwelling older people. *Aging Clinical and Experimental Research*. 2019;31(9), 1249–1256. doi: 10.1007/s40520-018-1074-y.
12. Black S, Nicholas C, Cotton S, Brock K. Determining discharge destination in geriatric evaluation and management units: Is progressive goal attainment a better early indicator of discharge destination than improvement in functional independence measure scores? *Geriatrics & Gerontology International*. 2018;18(7), 1058–1063. doi: 10.1111/ggi.13308.
13. Haider S, Grabovac I. Effects of physical activity interventions in frail and prefrail community-dwelling people on frailty status, muscle strength, physical performance, and muscle mass-a narrative review. *Journal of the American Geriatrics Society*. 2018;131(11–12), 244–254. doi: 10.1111/jgs.15312.
14. Sherrington C, Fairhall NJ, Wallbank GK, Tiedemann A, Michaleff ZA, Howard K, Clemson L, Hopewell S, Lamb SE. Exercise for preventing falls in older people living in the community. *Cochrane Database Systematic Review*. 2019;1, Cd012424. doi: 10.1002/14651858.CD012424.pub2.

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure *(e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)*

If a COMPOSITE *(e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.*

Current estimates suggest that 10 million individuals requiring assistance to perform ADLs or IADLs are living in the community, including in private or group homes.1 Eiken (2017)2 reported that more than 3.7 million individuals receive Medicaid-funded HCBS. Federal and state governments finance over 60 percent of paid HCBS costs in the United States through the Medicaid program.2 HCBS are expected to grow because of the aging U.S. population and the current move away from institutional-based care.3 As significant continued growth is expected in cost and utilization of HCBS, including through managed care contracting, greater scrutiny on quality also is expected.

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1. Kaye HS, Harrington C. Long-term services and supports in the community: Toward a research agenda. Disability and Health Journal. 2015;8(1):3-8. Retrieved from http://proxygw.wrlc.org/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2014-55175-002&site=eds-live&scope=site&authtype=ip,uid&custid=s8987071.
2. Eiken S. Medicaid long-term services and supports beneficiaries in 2013. Centers for Medicare & Medicaid Services; 2017. Retrieved from https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltss-beneficiaries-2013.pdf.
3. Ng T, Harrington C, Musumeci M, Reaves E. Medicaid home and community-based services programs: 2012 data update. Kaiser Family Foundation; 2015. Retrieved from https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2012-data-update.
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6. Hartman L, Lukanen E. Quality measurement for home and community based services (HCBS) and behavioral health in Medicaid. Medicaid and CHIP Payment and Access Commission; 2016:1–30. Retrieved from https://www.macpac.gov/publication/quality-measurement-for-home-and-community-based-services-and-behavioral-health-in-medicaid.
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8. Medicaid and CHIP Payment and Access Commission. June 2016 report to congress on Medicaid and CHIP, Functional assessments for long-term services and supports. Retrieved from https://www.macpac.gov/publication/june-2016-report-to-congress-on-medicaid-and-chip.

9. Medicaid and CHIP Payment and Access Commission. Inventory of the state functional assessment tools for long-term services and supports. 2017. Retrieved from https://www.macpac.gov/publication/inventory-of-the-state-functional-assessment-tools-for-long-term-services-and-supports.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(**This is required for maintenance of endorsement**. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

The scores from recent tests of the proposed measure indicate a sizeable gap in the performance of accountable programs in documenting personal priorities for HCBS participants. During June and July 2018, this performance measure was tested in 10 organizations in five different states located in geographically diverse regions of the country. These organizations serve different populations including individuals who are older adults and those with physical disabilities, intellectual/developmental disabilities, acquired brain injury, or mental health or substance use disorders. The FASI field testing demonstrated that functional needs differed depending on HCBS program type (e.g., individuals who are older adults had different types and numbers of needs than individuals with mental health or substance use disorders).

To reflect these differences, Table 1 presents the measure numerator, denominator, and performance score by HCBS program type. The sample consisted of 675 individuals who had a FASI need (denominator). A total of 296 individuals had as many personal priorities as FASI needs up to three (numerator). The measure score varied depending on the program type; the lowest score was seen in individuals who are older adults (34%) and the highest in individuals with acquired brain injury (51%). The relatively low scores across program types suggest there is room for improvement in identifying personal priorities of individuals in HCBS, a measure of person-centered supports and services. Table 2 presents across the five program types the minimum and maximum scores as well as scores by quintile; the mean is 43.9 percent.

Table 1. Identifying Personal Priorities for FASI Needs: Denominator, Numerator, and Score by Program Type

Measure Component Individuals in Programs Serving Those Who Are Older Adults

(row %) Individuals in Programs Serving Those With a Physical Disability

(row %) Individuals in Programs Serving Those With an Intellectual or Developmental Disability

(row %) Individuals in Programs Serving Those With an Acquired

Brain Injury

(row %) Individuals in Programs Serving Those With

Mental Health or Substance Use Disorders (row %) Total

(% of n)

Total unique individuals	122 (17.8)	120 (17.5)	231 (33.8)	126 (18.4)	85 (12.4)	684 (100)
Individual does not have a FASI-identified need	0 (0.0)	0 (0.0)	4 (44.4)	2 (22.2)	3 (33.3)	9 (100)
DENOMINATOR: Has a need identified by the FASI (% of sample)	122 (18.1)	120 (17.8)	227 (33.6)	124 (18.4)	82 (12.2)	675 (100)
NUMERATOR: Has as many personal priorities as needs, up to 3 maximum	41	43	112			

63

37

296

Performance measure score, % 33.6 35.8 49.3 50.8 45.1 43.9

Table 2. Identifying Personal Priorities for FASI Needs: Minimum, Maximum, and Quintile Scores Across the Five Program Types

Measure Score Minimum and First Quintile Second Quintile Third Quintile Fourth Quintile Maximum and Fifth Quintile

Performance measure score, % 33.6 35.8 45.1 49.3 50.8

The essential component of the performance measure is the number of personal priorities recorded by individuals in each program type. Table 3 provides descriptive statistics for this metric for individuals in the denominator of the performance measure.

Table 3. Descriptive Statistics for the Number of Personal Priorities by Program Type

Measure Component Characteristic Individuals in Programs Serving Those Who Are Older Adults Individuals in Programs Serving Those With a Physical Disability Individuals in Programs Serving Those With an Intellectual or Developmental Disability Individuals in Programs Serving Those With an Acquired Brain Injury Individuals in Programs Serving Those With Mental Health or Substance Use Disorders

Total sample in denominator 122 120 227 124 82

Missing total personal priorities 1 0 1 0 0

Mean number of personal priorities 1.96 1.98 2.38 2.37 2.30

Standard deviation for number of personal priorities 2.10 1.79 1.84 2.10 2.04

Quartiles for Number of Personal Priorities

Minimum* 0.0 0.0 0.0 0.0 0.0

0.25 0.0 0.0 1.0 0.0 0.0

Median 1.0 2.0 2.0 2.0 2.0

0.75 3.0 3.0 4.0 4.0 4.0

Maximum* 6.0 6.0 6.0 6.0 6.0

*The minimum number of personal priorities that can be recorded on the form is zero and the maximum is six.

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

Not applicable.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. ***(This is required for maintenance of endorsement****. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

Differences in performance measure scores based on race and ethnicity were investigated. To perform the analysis, the groups were collapsed to form three groupings: individuals who were African American or Black; individuals who were American Indian, Alaskan Native, Asian, or Other; and individuals who were White.

Individuals who did not designate race or those whose race was unknown were kept in a separate category. Ethnicity categories were Hispanic and Not Hispanic. The results indicated significant differences in scores by race and by ethnicity (Pearson chi2(3) = 17.785 Pr = 0.000 and Pearson chi2(1) = 7.6642 Pr = 0.006, respectively). However, caution in generalizing these scores is advised and further exploration is needed because in some cases the numbers were small. Tables 4 and 5 summarize the data.

Table 4. Identifying Personal Priorities for FASI Needs: Denominator, Numerator, and Score by Race

Measure Component	Individuals Who Were White	Individuals Who Were African American or Black	Individuals Who Were American Indian, Alaskan Native, Asian or Other	Individuals Whose Race Was Unknown	All Individuals*
Denominator: Has a need identified by the FASI (% of sample)	411 (61.0)	125 (18.6)	95 (14.1)	43 (6.4)	674 (100)
Numerator: Has as many personal priorities as needs, up to 3 maximum	197	42	31	26	296
Performance measure score, %	47.9	33.6	32.6	60.5	43.9

*1 individual from the IDD program was missing information on race and ethnicity. Pearson chi2(3) = 17.785, Pr = 0.000.

Table 5. Identifying Personal Priorities for FASI Needs: Denominator, Numerator, and Score by Ethnicity

Measure Component	Individuals Who Were Hispanic	Individuals Who Were Not Hispanic	All Individuals*
Denominator: Has a need identified by the FASI (% of sample)	22 (3.3)	652 (96.7)	674 (100)
Numerator: Has as many personal priorities as needs, up to 3 maximum	16	280	296
Performance measure score, %	72.7	42.9	43.9

*1 individual from the IDD program was missing information on race and ethnicity. Pearson chi2(1) = 7.6642, Pr = 0.006.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

Not applicable.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, **as specified**, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. ***Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.***

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area *(check all the areas that apply):*

De.6. Non-Condition Specific*(check all the areas that apply):*

De.7. Target Population Category *(Check all the populations for which the measure is specified and tested if any):*

S.1. Measure-specific Web Page *(Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)*

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure **Attachment:**

S.2b. Data Dictionary, Code Table, or Value Sets *(and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)*

Attachment **:** NQF3593_DataElementLibraryCodeSet_2020-11-06.xlsx

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Attachment **:** NQF3593_FASISetInstrument_2020-11-06.pdf

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Patient

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

S.4. Numerator Statement *(Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.*

***IF an OUTCOME MEASURE**, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).*

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.

S.5. Numerator Details *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

***IF an OUTCOME MEASURE,** describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).*

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).

S.6. Denominator Statement *(Brief, narrative description of the target population being measured)*

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.

S.7. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*

***IF an OUTCOME MEASURE**, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).*

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).

S.8. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

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.

S.9. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*

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

S.10. Stratification Information *(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)*

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, see https://www.medicaid.gov/medicaid/hcbs/authorities/1915-c/index.html.

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.

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (*Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)*

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.

S.15. Sampling *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)*

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

The intended sample for this measure is adult Medicaid beneficiaries aged 18 years or older who currently are receiving HCBS. Sampling should be representative of all HCBS recipients and stratified by HCBS program type. The source of the sample frame will be the state Medicaid agency, or an accountable entity delegated by the state Medicaid agency (e.g., state agency other than the Medicaid agency that operates the program, an MCO, a case management agency, state county).

Proxy responses are not applicable to the data abstraction form involved in this measure because it is completed by reviewers. Family members and caregivers are among the acceptable sources of information for clinicians (including case managers and other paid members of the services and supports team) who conduct the FASI assessment and make the final determination about how to complete the form.

S.16. Survey/Patient-reported data *(If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)*

Specify calculation of response rates to be reported with performance measure results.

Not applicable because individuals with incomplete or no FASI are excluded from denominator.

S.17. Data Source *(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).*

If other, please describe in S.18.

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

S.18. Data Source or Collection Instrument *(Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)*

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

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.

S.19. Data Source or Collection Instrument *(available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)*

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

S.20. Level of Analysis *(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)*

Other

S.21. Care Setting *(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)*

Home Care, Other

If other: Medicaid HCBS Program

S.22. COMPOSITE Performance Measure - Additional Specifications *(Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)*

Not applicable.

2. Validity – See attached Measure Testing Submission Form

FASI_PM1_MeasureTestingForm-637318104658528593.docx

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1, 2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1, 2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

Measure Testing (subcriteria 2a2, 2b1-2b6)

NATIONAL QUALITY FORUM—Measure Testing (subcriteria 2a2, 2b1-2b6)

Measure Number (*if previously endorsed*)**:**
Measure Title: Identifying Personal Priorities for Functional Assessment Standardized Items (FASI) Needs
Date of Submission: **8/3/2020**

Type of Measure:

Measure	Measure (continued)
☐ Outcome (*including PRO-PM*)	☐ Composite – *STOP – use composite testing form*
☐ Intermediate Clinical Outcome	☐ Cost/resource
☒ Process *(including Appropriate Use)*	☐ Efficiency
☐ Structure	*

*cell intentionally left blank

1. DATA/SAMPLE USED FOR ALL TESTING OF THIS MEASURE

Often the same data are used for all aspects of measure testing. In an effort to eliminate duplication, the first five questions apply to all measure testing. ***If there are differences by aspect of testing****, (e.g., reliability vs. validity) be sure to indicate the specific differences in question 1.7.*

1.1. What type of data was used for testing? (*Check all the sources of data identified in the measure specifications and data used for testing the measure. Testing must be provided for* ***all*** *the sources of data specified and intended for measure implementation.* ***If different data sources are used for the numerator and denominator, indicate N [numerator] or D [denominator] after the checkbox.***)

Measure Specified to Use Data From: (*must be consistent with data sources entered in S.17*)	Measure Tested with Data From:
☒ abstracted from paper record	☒ abstracted from paper record
☐ claims	☐ claims
☐ registry	☐ registry
☒ abstracted from electronic health record	☒ abstracted from electronic health record
☐ eMeasure (HQMF) implemented in EHRs	☐ eMeasure (HQMF) implemented in EHRs
☒ other: FASI may exist as paper form or in an EHR	☒ other: FASI may exist as a paper record or in an EHR

1.2. If an existing dataset was used, identify the specific dataset (*the dataset used for testing must be consistent with the measure specifications for target population and healthcare entities being measured; e.g., Medicare Part A claims, Medicaid claims, other commercial insurance, nursing home MDS, home health OASIS, clinical registry*).

The FASI field test dataset was used for identifying individuals for inclusion in the numerator and denominator.

1.3. What are the dates of the data used in testing?

FASI field test data were collected March 2017 through September 2017. These data were reviewed for testing this performance measure June 2018 through July 2018.

1.4. What levels of analysis were tested? (*testing must be provided for* ***all*** *the levels specified and intended for measure implementation, e.g., individual clinician, hospital, health plan*)

Measure Specified to Measure Performance of: (*must be consistent with levels entered in item S.20*)	Measure Tested at Level of:
☐ individual clinician	☐ individual clinician
☐ group/practice	☐ group/practice
☐ hospital/facility/agency	☐ hospital/facility/agency
☐ health plan	☐ health plan
☒ other: Medicaid HCBS program type	☒ other: Medicaid HCBS program type

1.5. How many and which measured entities were included in the testing and analysis (by level of analysis and data source)? (*identify the number and descriptive characteristics of measured entities included in the analysis (e.g., size, location, type); if a sample was used, describe how entities were selected for inclusion in the sample*)

This process measure was tested in five waiver program types in five different states (Colorado, Connecticut, Georgia, Kentucky, and Minnesota) located in geographically diverse regions of the country. The 10 organizations that collected data enrolled individuals who were receiving home and community-based services (HCBS) and supports through five Medicaid program types: (1) programs serving individuals who are frail elderly, (2) programs serving individuals who have physical disabilities, (3) programs serving individuals who have intellectual/developmental disabilities, (4) programs serving individuals who have brain injury, and (5) programs serving individuals who have serious mental illness. All five participating states offer all five of these HCBS program types; however, for the purposes of the original FASI field test in 2017, states selected which programs would participate in the field test. Table 1 describes the 10 data collection organizations by state, HCBS program type, and number of FASI field test records that were reviewed for testing this performance measure. The unit of analysis for the proposed measure is the HCBS program type.

Table 1*. Data Collection by HCBS Program Type and State

State	Individuals in Programs Serving Those Who Are Frail Elderly (col %)	Individuals in Programs Serving Those With a Physical Disability (col %)	Individuals in Programs Serving Those With an Intellectual or Developmental Disability (col %)	Individuals in Programs Serving Those With a Brain Injury (col %)	Individuals in Programs Serving Those With Serious Mental Illness (col %)	All Programs (col %)
Colorado	- -	- -	107 (46.3)	29 (23.0)	557 (67.1)	1193 (28.2)
Connecticut	49 (40.2)	15 (12.5)	- -	- -	9 (10.6)	73 (10.7)
Georgia	- -	65 (54.2)	- -	37 (29.4)	- -	102 (14.9)
Kentucky	73 (59.8)	40 (33.3)	- -	4 (3.2)	- -	117 (17.1)
Minnesota	- -	- -	124 (53.7)	56 (44.4)	19 (22.4)	199 (29.1)
TOTAL	122 (100)	120 (100)	231 (100)	126 (100)	85 (100)	6,684 (100)

*The number of table cells populated is more than the 10 organizations because some organizations collected data for more than one HCBS program type within the state. The total number of individuals for which data collected was usable was 684; as shown in other tables, 675 (of the 684) met the denominator definition for calculating the performance measure score.

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1.6. How many and which patients were included in the testing and analysis (by level of analysis and data source)? (*identify the number and descriptive characteristics of patients included in the analysis (e.g., age, sex, race, diagnosis); if a sample was used, describe how patients were selected for inclusion in the sample*)

Testing and analysis involved 675 unique individuals who were enrolled in HCBS under federal waiver programs within one of the five states at the time the FASI assessment was conducted. Waiver programs enable individuals who otherwise would need institutional residential services to live in the least restrictive environment of their choosing in the community. Five populations were represented in the testing and analysis. Those five populations included individuals who were frail elderly and those with physical disabilities, intellectual/developmental disabilities, brain injury, or serious mental illness. Table 1 under 1.5 above describes the state and HCBS program type for individuals whose FASI field test records were reviewed for testing this performance measure.

The sample demographic data are summarized in Table 2. Fifty-two percent of the sample were female with an average age of 53.7 years. Individuals self-reported race: 61% reported White, 30% African American, 3.3% Asian, 1% American Indian or Alaskan Native, and 9.8% Other. Approximately 7% of self-reported race designation was unknown or missing. Ninety-seven percent reported not Hispanic.

1.7. If there are differences in the data or sample used for different aspects of testing (e.g., reliability, validity, exclusions, risk adjustment), identify how the data or sample are different for each aspect of testing reported below.

***Table 2*. Sample Demographic Characteristics by Program Type**

Characteristic	Individuals in Programs Serving Those who Are Frail Elderly (sample %)	Individuals in Programs Serving Those with a Physical Disability (sample %)	Individuals in Programs Serving Those with an Intellectual or Developmental Disability (sample %)	Individuals in Programs Serving Those with a Brain Injury (sample %)	Individuals in Programs Serving Those with Serious Mental Illness (sample %)	TOTAL n (% of sample)
Sex	- -	- -	- -	- -	- -	- -
Female	84 (23.9)	63 (17.9)	100 (28.4)	55 (15.6)	50 (14.2)	352 (52.1)
Male	38 (11.8)	57 (17.7)	127 (39.3)	69 (21.4)	32 (9.9)	323 (47.9)
Age (mean, SD)	75.9 ± 6.3	51.5 ± 11.5	44.7 ± 14.4	49.5 ± 12.5	54.9 ± 11.8	53.7 ± 16.3
Race*	- -	- -	- -	- -	- -	- -
White	75 (18.3)	61 (14.8)	142 (34.6)	83 (20.2)	50 (12.2)	411 (60.9)
African American	25 (20.0)	50 (40.0)	17 (13.6)	26 (20.8)	7 (5.6)	125 (18.5)
Asian	16 (72.7)	1 (4.6)	3 (13.6)	1 (4.6)	1 (4.6)	22 (3.3)
American Indian or Alaskan Native	0 (0)	0 (0)	3 (42.9)	3 (42.9)	1 (14.3)	7 (1.0)
Other	6 (9.1)	3 (4.6)	39 (59.1)	4 (6.1)	14 (21.2)	66 (9.8)
Unknown or missing	0 (0)	5 (11.4)	23 (52.3)	7 (15.9)	9 (20.5)	44 (6.5)
Ethnicity*	- -	- -	- -	- -	- -	- -
Hispanic	0 (0)	1 (4.6)	11 (50)	4 (18.2)	6 (27.3)	22 (3.3)
Not Hispanic	122 (18.7)	119 (18.3)	215 (33.0)	120 (18.4)	76 (11.7)	652 (96.6)

*1 individual in the sample was missing information on race and ethnicity.

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1.8 What were the social risk factors that were available and analyzed? For example, patient-reported data (e.g., income, education, language), proxy variables when social risk data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate) which do not have to be a proxy for patient-level data.

Age, race, and ethnicity were available to the development team. See 1b.4 under Performance Gap for performance scores by race and ethnicity.

2a2. RELIABILITY TESTING

***Note**: If accuracy/correctness (validity) of data elements was empirically tested, separate reliability testing of data elements is not required – in 2a2.1 check critical data elements; in 2a2.2 enter "see section 2b2 for validity testing of data elements"; and skip 2a2.3 and 2a2.4.*

2a2.1. What level of reliability testing was conducted? (*may be one or both levels*)
☒ **Critical data elements used in the measure** (*e.g., inter-abstractor reliability; data element reliability must address ALL critical data elements*)
☐ **Performance measure score** (e.g., *signal-to-noise analysis*)

2a2.2. For each level checked above, describe the method of reliability testing and what it tests (*describe the steps—do not just name a method; what type of error does it test; what statistical analysis was used*)

Testing involved use of the FASI assessment data ("records") collected during the 2017 field test and documented service plans at the time of that testing. For the FASI field test, assessors interviewed and observed individuals enrolled in one of the five program types, talked with their primary caregivers and/or guardians, and reviewed case notes. Assessors then coded each of the FASI function items based on the person's usual need for assistance in the past 3 days as well as their most dependent performance in the past month. See S.2b for the standardized code set for recording both usual and most dependent need.

An important aspect of the FASI field test was the inclusion of open-ended items in which individuals could indicate personal priorities related to self-care, mobility, and instrumental activities of daily living (IADLs) in the next 6 months. Results of that initial field testing indicated that about half of individuals reported a personal priority in at least one of these three areas; about one-quarter indicated two personal priorities in at least one of these three areas.[1]

The organizations engaged by IBM Watson Health that participated in the FASI field test were invited to continue their participation by testing this performance measure. Record "reviewers" (case managers and agency administrators) were asked to: (1) review each previously completed FASI; (2) complete a performance measure data abstraction form for each record reviewed; and (3) provide feedback regarding the effectiveness of this FASI-based performance measure as an indicator of service quality provided to individuals receiving HCBS. Finally, a Technical Expert Panel (TEP) was convened to provide feedback on the results of the testing and garner subject matter expertise on this measure.

Reliability Testing Approach

Forms collected during the FASI field test were reviewed by two reviewers at the same organization. Each reviewer independently accomplished the following:

a. Determined whether the record had any self-care, mobility, or IADL functional needs denoted in the FASI and recorded the result on the data abstraction form. Functional need was defined as receiving a code of 5 or below, or 88 on the FASI for either usual performance in the past 3 days or most dependent performance in the past month.
b. Calculated the total number of personal priorities listed for each section and checked the appropriate box on the data abstraction form.
c. Indicated *yes* or *no* that there were at least three or more personal priorities noted on the data abstraction form. Personal priorities could include one or two from each of the three sections (self-care, mobility, IADL) for a total of at least three personal priorities. Note: During the analysis described below, the developer team concluded that individuals who had less than three FASI-based needs identified were less likely to report three personal priorities. This finding was endorsed by reviewer feedback and TEP member input. The proposed measure reflects this conclusion by presenting a revised numerator defined as requiring as many personal priorities as identified needs up to a maximum of three personal priorities. The method of testing presented in this document supports the reliability of the revised numerator because the process of data collection for these critical data elements is identical. Step 3 on the data collection form, which asks reviewers whether the individual had at least 3 personal priorities, was provided as a quality/validity check and is not considered one of the critical data elements in calculating the performance measure.

The data were collected using a digital, fillable PDF form that administrators uploaded at each site directly to a password-protected, secure ShareFile® maintained by IBM Watson Health. From there, it was transferred to George Washington University and imported to an analytic file.

Method of Reliability Testing for Each Critical Data Element

1. **Definition of need**. The development team evaluated the degree of concordance between reviewers' indication of a FASI-based need and functional need as determined by the FASI field test data. Reviewers in the current performance measure test reviewed FASI records and answered *yes* or *no* to the question, "Does the individual have documented needs determined by a Functional Assessment Standardized Items (FASI)?" For the performance measure data, the development team created a variable with a value of 1 if the individual was coded as "05" or below or "88" for either the usual or most dependent version of each item and a value of 0 for all other scores on each specified item on the FASI form (see S.2b. [data dictionary, code table, or value sets] for value labels). Summing across the FASI produced a range of FASI-based needs from 0 to 43. The developer team then created a dichotomous variable that was coded 0 if the individual had no needs or 1 if the individual had 1 or more FASI needs. The team matched each of the records reviewed during performance measure testing to the same record in the field test data set. A Kappa statistic was used to evaluate the concordance between the performance measure testing and FASI field testing to determine whether the individual had a FASI-based need. Concordance was evaluated for the entire sample and by program.

We did not calculate IRR for determination of a FASI-based need (i.e., reviewer response to the question, "Does the individual have documented needs determined by a Functional Assessment Standardized Items (FASI)?") because no meaningful disagreement occurred. This finding is described in Section 2a2.3.

2. **Identifying the total number of personal priorities**. The organizations assigned pairs of reviewers to review the same record from the FASI field test dataset. The result was 1,068 paired evaluations of 534 records. The developer team used Bland-Altman limits of agreement (LOA) to evaluate the consistency between rater pairs in determining the number of personal priorities identified for each record.

   The Bland-Altman LOA plot compares two measurements[2,3]; in this case, it is used for comparing

measurements from two different reviewers. The differences within each pair of reviewers are plotted against the averages of each pair. The Bland-Altman displays LOA, which are defined as the average difference plus 1.96 times the standard deviation of the differences. The LOA allows identification of outliers when looking at the relationship between the difference and the average using 95% confidence intervals. The developer team was able to recognize that one reviewer consistently was outside the limits of agreement.

3. **Identifying whether the individual had at least as many personal priorities as needs, up to three personal priorities.** The developer team evaluated the concordance between the number of priorities identified and the reviewers' assessment that the numerator definition had been met. This process involved comparing the number of priorities documented against the reviewers' assessment that the record indicated three or more priorities, reflecting the earlier definition of the numerator. The team calculated the total number of personal priorities across each of the three domains (self-care, mobility, and IADL) with values ranging from zero to six personal priorities. The team then created a dichotomous variable that was coded 1 if the individual had three or more personal priorities and 0 if they had fewer than three. This result was compared to the *yes* or *no* responses reviewers coded to the question: "Did the person who received CB-LTSS have at least 3 personal priorities related to self-care, mobility, or IADLs"? A Kappa statistic was used to evaluate the level of concordance between the two evaluations where the record met the description of the numerator. Kappa is an inter-rater agreement statistic, which is calculated with a 95% confidence interval.[4] Table 4 shows the range of quantitative values for Kappa and the corresponding strength of agreement.

TABLE 4. KAPPA VALUES AND DESCRIPTION

Value of Kappa	Strength of Agreement
<0.20	Poor
0.21-0.40	Fair
0.41-0.60	Moderate
0.61-0.80	Good
0.81-1.00	Very Good

We also examined the IRR with which reviewers determined if a record met the definition, or did not meet the definition, of this performance measure. For this analysis, the developer team examined the concordance between reviewers in each pair regarding their determination of whether the record indicated that the individual had at least as many personal priorities as needs, up to a total of three. These analyses were conducted for the records that had been determined to meet the criteria for the denominator—that is, there was at least one FASI-based need. The team calculated the total number of FASI-based needs identified from the FASI field test data (1 to 43). For each reviewer pair, the total number of personal priorities for each record was calculated (range 0 to 6). Then a dichotomous variable that indicated whether the number of personal priorities met the definition of the performance measure was created. The developer team tested the IRR of meeting and not meeting the numerator definition using Kappa (defined above).

1. Mallinson T, Dietrich CN, Harwood K, Maring J, Lyons L, Gaskin S, Gorsky A, Weaver J, Rivard P, Woodward R, Stokes T, Gold L. FASI Final Report to the Centers for Medicare & Medicaid Services under Contract HHSM-500-2010-0025i-T006. March 30, 2018.
2. Bland JM, Altman DG. Statistical methods for assessing agreement between two methods of clinical measurement. The Lancet. 1986;1(8476):307-310.
3. Bland JM, Altman DG. Measuring agreement in method comparison studies. AACN Advanced Critical Care. 1999;19:223-234.
4. Fleiss JL, Levin B, Paik MC. Statistical Methods for Rates and Proportions. 3rd ed. Hoboken: John Wiley & Sons; 2003.

2a2.3. For each level of testing checked above, what were the statistical results from reliability testing? (e.*g., percent agreement and kappa for the critical data elements; distribution of reliability statistics from a signal-to-noise analysis*)

Results of Reliability Testing for Each Critical Data Element

1. **Definition of need**. A total of 675 forms were analyzed to determine the agreement between the field test and performance measure determination that an individual had a FASI-based need. Results, overall and by HCBS program type, indicated 100% agreement between the two measures. The developer team did not calculate IRR for determination of a FASI-based need because no variation existed. Of the 554 pairs of records, 6 records concurred that no FASI-based need was present. There were 9 instances of nonconcurrence; these came from the same pair of reviewers and, in every instance, the second reviewer indicated there was no need. Rigorously matching the reviewer's responses against the FASI field test data substantiated that each of these 9 individuals had 8 or more FASI-based needs. The team believes the lack of concurrence of the second reviewer is due to a known error that occurred with the data abstraction form—a reviewer failed to reset the data form to conduct a new review and instead modified an existing form.
2. **Identifying the total number of personal priorities**. Bland-Altman LOA were used to evaluate the extent to which reviewers agreed in their assessment of the number of personal priorities identified for each individual. The LOA are defined by the lower and upper values and define the range between which 95% of values should fall; the LOA for the total pairs of records were between 3.47 and 2.58 (Table 5). The percentage of records that fell within the LOA ranged from 90.6% to 95.3% by HCBS program type, indicating high levels of agreement. On initial analysis, 9.5% of the total records fell outside of these LOA. Further scrutiny indicated that 71% of these records were from a single reviewer (Reviewer A) at one organization. Not counting this reviewer, only 2.9% of total records were outside these LOA (with 95% confidence intervals).

TABLE 5. AGREEMENT BETWEEN REVIEWERS IN ASSESSING THE NUMBER OF PERSONAL PRIORITIES

Measure Component Characteristic	Individuals in Programs Serving Those who Are Frail Elderly	Individuals in Programs Serving Those with a Physical Disability	Individuals in Programs Serving Those with an Intellectual or Developmental Disability	Individuals in Programs Serving Those with a Brain Injury	Individuals in Programs Serving Those with Serious Mental Illness	Total
Pairs of records	100	107	153	96	62	518
LOA range	–1.92 to 2.24	–5.17 to 2.80	–2.53 to 2.21	–4.48 to 2.60	–0.97 to 0.81	–3.47 to 2.58
% within LOA	92.0	95.3	94.8	90.6	91.9	90.5
% within LOA without reviewer A	92.0	100.0	94.8	100.0	91.9	97.1

3. **Identifying whether the individual had at least as many personal priorities as needs up, to three personal priorities**. Among the 675 forms available for analysis, three forms were missing information about one or more personal priorities and were dropped from the analysis. A total of 672 forms were analyzed to determine concordance between meeting the requirements of the numerator by count of priorities and by evaluation of the reviewer. Across all forms, results indicated a strong agreement that was statistically significant ($\kappa = 0.9723$, $p < 0.001$). Table 6 provides the results by HCBS program type.

TABLE 6. AGREEMENT BETWEEN COUNT OF PERSONAL PRIORITIES AND REVIEWER EVALUATION THAT THE DEFINITION OF THE NUMERATOR HAD BEEN MET

Measure Component Statistic	Individuals in Programs Serving Those who Are Frail Elderly	Individuals in Programs Serving Those with a Physical Disability	Individuals in Programs Serving Those with an Intellectual or Developmental Disability	Individuals in Programs Serving Those with a Brain Injury	Individuals in Programs Serving Those with Serious Mental Illness
Kappa (p-value)	0.96 (< 0.001)	1.00 (< 0.001)	0.96 (< 0.001)	0.98 (< 0.001)	0.95 (< 0.001)

We also conducted IRR for the concordance between reviewers' assessment that the record indicated at least as many personal priorities as needs, up to a total of three. These analyses were conducted for records that had been determined to meet the criteria for the denominator; that is, there was at least one FASI-based need. A total of 532 individuals with two abstraction forms were analyzed to determine the level of agreement (Kappa) between two reviewers. Results indicated good agreement that was statistically significant ($\kappa = 0.6804$, $p < 0.001$). Subsequent analysis was run to look at percent agreement by HCBS program type. Results ranged from moderate to strong levels of agreement (shown in Table 7).

TABLE 7. CONCORDANCE BETWEEN REVIEWERS' ASSESSMENT THAT THE RECORD HAD AT LEAST AS MANY PERSONAL PRIORITIES AS NEEDS, UP TO A TOTAL OF THREE

Measure Component Statistic	Individuals in Programs Serving Those who Are Frail Elderly	Individuals in Programs Serving Those with a Physical Disability	Individuals in Programs Serving Those with an Intellectual or Developmental Disability	Individuals in Programs Serving Those with a Brain Injury	Individuals in Programs Serving Those with Serious Mental Illness
Kappa (p-value)	0.72 (< 0.001)	.41 (< 0.001)	0.77 (< 0.001)	0.63 (< 0.001)	0.94 (< 0.001)

2a2.4 What is your interpretation of the results in terms of demonstrating reliability? (i.*e., what do the results mean and what are the norms for the test conducted?*)

Overall, these results indicated that reviewers were able to consistently identify whether an individual had a FASI-based need (denominator), identify the total number of personal priorities (preparatory to determining the numerator), and identify whether individuals met the requirements of the numerator as it was defined at the time of testing.

2b1. VALIDITY TESTING

2b1.1. What level of validity testing was conducted? (*may be one or both levels*)

☒ **Critical data elements** (*data element validity must address ALL critical data elements*)

☐ **Performance measure score**

☐ **Empirical validity testing**

☒ **Systematic assessment of face validity of performance measure score as an indicator** of quality or resource use (*i.e., is an accurate reflection of performance on quality or resource use and can distinguish good from poor performance*) **NOTE**: Empirical validity testing is expected at time of maintenance review; if not possible, justification is required.

2b1.2. For each level of testing checked above, describe the method of validity testing and what it tests (*describe the steps—do not just name a method; what was tested, e.g., accuracy of data elements compared to authoritative source, relationship to another measure as expected; what statistical analysis was used)*

Forty-six HCBS quality stakeholders, including reviewers from the performance measure test, were surveyed on a series of questions to assess the face validity of this measure. After reviewing at least 10 forms, or at the end of data collection, reviewers were asked to complete a one-time feedback form on a secured, online survey. The feedback form was designed to allow reviewers the opportunity to share opinions and experiences in completing data abstraction for the performance measure and to provide critique on its usability, appropriateness of content as a performance measure, and specifications of the measures (validity). In addition, a technical expert panel composed of 23 subject matter experts and stakeholders was convened and preliminary results were presented. Following the TEP, members also completed the online feedback form.

Critical Data Elements

Face facility of the critical data elements was tested by summarizing percent agreement of applicable survey questions on the reviewer and TEP feedback forms.

1. **Identifying needs on FASI**. Reviewers and TEP members indicated whether they thought that the performance measure definition of need was valid.
2. **Identifying the total number of personal priorities by assessors**. Reviewers and TEP members were asked to consider whether they agreed that the assessors should identify at least three personal priorities.

3. **Identifying whether the individual had at least as many personal priorities as needs, up to three personal priorities**. Reviewers and TEP indicated to what extent they agreed with identifying at least three priorities from any of the functional areas.

Systematic Assessment of Face Validity

Face validity of the performance measure as a measure of quality and person-centered supports and services was tested by summarizing percent agreement of applicable survey questions on the reviewer and TEP feedback forms.

2b1.3. What were the statistical results from validity testing? (*e.g., correlation; t-test*)

Results of Validity Testing for Each Critical Data Element

1. **Identifying needs on FASI**. The performance measure denominator, "All individuals 18 years or older who received HCBS with documented functional needs determined by a FASI within the reporting period," had a high level of endorsement for the reviewers (89%) and TEP members (92%). Additionally, reviewers (87%) and TEP members (100%) strongly agreed or agreed with the statement "documented functional needs will be based on receiving a 5 or below, or 88" indicating they considered the performance measure definition valid as a measure of function using the FASI scale (Table 8.)
2. **Identifying the number of personal priorities by assessors.** A total of 87% of reviewers strongly agreed or agreed that the reviewers will assess the FASI to identify three personal priorities, whereas 75% of the TEP members strongly agreed or agreed with this statement.
3. **Identifying whether the individual had at least three personal priorities.** A total of 78% of reviewers strongly agreed or agreed that the personal priorities can be any number from the three sections for a total of at least three, and 83% of TEP members strongly agreed or agreed with this statement.

We concluded that there was overall good agreement among the reviewers and TEP members with the performance management definitions, the method to determine personal priorities, and the decision that personal priorities can be any number from the three sections for a total of at least three.

TABLE 8. REVIEWER AND TEP MEMBER AGREEMENT WITH SURVEY STATEMENTS ABOUT CRITICAL DATA ELEMENTS

Survey Item Number	Survey Statement	Reviewers*: Strongly Disagree & Disagree Freq (%)	Reviewers*: Strongly Agree & Agree Freq (%)	TEP*: Strongly Disagree & Disagree Freq (%)	TEP*: Strongly Agree & Agree Freq (%)
1	The definition of the numerator is easy to understand.	5 (10.9)	41 (89.1)	1 (8.3)	11 (91.7)
2	The definition of the denominator is easy to understand.	2 (4.4)	44 (95.7)	1 (8.3)	11 (91.7)
3A	The performance measure reporting period is defined as 12 months.	3 (6.5)	43 (93.5)	0 (0.0)	12 (100)
3B	This performance measure may be reported by the state or contracted [assessment] entity.	3 (6.5)	43 (93.5)	1 (8.3)	11 (91.7)

Survey Item Number	Survey Statement	Reviewers*: Strongly Disagree & Disagree Freq (%)	Reviewers*: Strongly Agree & Agree Freq (%)	TEP*: Strongly Disagree & Disagree Freq (%)	TEP*: Strongly Agree & Agree Freq (%)
3C	This performance measure is to be reported after each FASI assessment for individuals seen during the 12-month reporting period.	4 (8.7)	42 (91.3)	5 (41.7)	7 (58.3)
3D	Documented functional needs will be based on receiving a 5 or below, or 88.	6 (13.0)	40 (87.0)	0 (0.0)	12 (100.0)
3E	A reviewer will assess a FASI to identify 3 personal priorities.	6 (13.0)	40 (87.0)	3 (25.0)	9 (75.0)
3F	Personal priorities can be any number from the three sections for a total of at least 3.	10 (21.7)	36 (78.3)	2 (16.7)	10 (83.3)

*Total N for reviewer respondents to each question is 46 (100%). Total N for TEP respondents to each question is 12 (54.5%).

Systematic Assessment of Face Validity

The reviewers and TEP members were asked a series of questions soliciting their opinion regarding the effectiveness of the performance measure as a measure of quality and whether it indicated a measure of person-centered supports and services. Each group is described separately.

Reviewer results. One hundred percent of the reviewers completed the feedback form. The feedback form used a four-level Likert scale that included the anchors "strongly disagree," "disagree," "agree," and "strongly agree." The data are presented as a dichotomized list that combined "strongly disagree" with "disagree" and combined "strongly agree" with "agree."

Reviewers were asked a series of questions regarding whether the performance measure could be used to determine quality and person-centered services in HCBS.

The results demonstrated that strong agreement was found on all high-quality questions regarding the performance measure's ability to determine aspects of high-quality HCBS care. There was particularly strong agreement on the identification of personal priorities as a measure of person centeredness and on whether the care addresses the individual's needs. Less agreement was demonstrated when the reviewer was asked about whether the services were of high quality if personal priorities were identified. This latter point is well taken, because this measure identifies whether the individual was asked about his/her personal priority and not whether the services provided were based on those priorities.

TEP results. A total of 55% of the TEP members completed the feedback form. The feedback form used the same Likert scale and rating merging methods. TEP members and reviewers were asked the same questions. Table 9 summarizes the varying responses from the TEP for the quality and person-centered supports and services questions. The TEP demonstrated high agreement on the questions that described the importance of identifying personal priorities in delivering services and supports important to the individual, the individual's needs, and aspects of person-centered supports and services. Moderate agreement was found on the question regarding whether performance on this measure provides important information for assessing whether HCBS recipients are receiving person-centered services and whether identifying personal priorities is an important step to high-quality services. Interestingly, there was moderate to low agreement on whether performance on the measure provides important information about whether HCBS recipients are receiving high-quality care. The TEP comments may provide insight into this last response. A significant number of comments discussed the important link between identifying personal priorities and service planning, and they

stated that this performance measure does not address this link. For example, one TEP member commented "… because knowing whether personal priorities have been captured does not necessarily speak to the services that may be provided in response to those priorities" and another stated "…there's a missing connection between the priorities and actions of the provider." It is understandable that the developer team received this feedback because this performance measure is designed to be a first step in increasing awareness of assessors to elicit personal priorities rather than to align the priorities with goals and service plans.

TABLE 9. REVIEWER AND TEP MEMBER AGREEMENT WITH SURVEY STATEMENTS ABOUT QUALITY AND PERSON-CENTERED SERVICES

Survey Item Number	Survey Statement	Reviewers*: Strongly Disagree & Disagree Freq (%)	Reviewers*: Strongly Agree & Agree Freq (%)	TEP*: Strongly Disagree & Disagree Freq (%)	TEP*: Strongly Agree & Agree Freq (%)
5A	Identifying personal priorities is an important step to creating person-centered services because it addresses the individual's needs.	6 (13.0)	40 (87.0)	2 (16.7)	10 (83.3)
5B	Identifying personal priorities is an important step to creating person-centered services because the assessor can create goals addressing the individual's needs	13 (28.3)	33 (71.7)	5 (41.7)	7 (58.3)
5C	Performance on this measure provides important information for assessing whether groups of CB-LTSS recipients are receiving person-centered services.	11 (23.9)	35 (76.1)	4 (33.3)	8 (66.7)
5D	Identifying personal priorities is an important step to creating person-centered services because the [assessment] entity can deliver services and supports important to the individual.	8 (17.4)	38 (82.6)	1 (8.3)	11 (91.7)
5E	Identifying personal priorities is an important step towards high quality services because the assessor can create a plan to address the individual's needs.	10 (21.7)	36 (78.3)	4 (33.3)	8 (67.7)
5F	Performance on this measure provides important information for assessing whether groups of CB-LTSS recipients are receiving high quality services.	14 (30.4)	32 (69.6)	7 (58.3)	5 (41.7)

*Total N for reviewer respondents to each question is 46 (100%). Total N for TEP respondents to each question is 12 (54.5%).

2b1.4. What is your interpretation of the results in terms of demonstrating validity? (i.e., *what do the results mean and what are the norms for the test conducted?*)

The face validity of the performance measure was supported by the high positive levels of endorsement among the reviewers and TEP members on the performance measure definitions, the importance of identifying personal priorities as a component of person-centered supports and services, and their

consideration that this is a positive first step toward a measure to support quality improvement leading to quality care in HCBS.

2b2. EXCLUSIONS ANALYSIS

NA ☐ no exclusions — *skip to section 2b3*

2b2.1. Describe the method of testing exclusions and what it tests (*describe the steps—do not just name a method; what was tested, e.g., whether exclusions affect overall performance scores; what statistical analysis was used*)

Individuals who did not have a FASI-identified need were excluded from the performance measure, ensuring that only individuals with functional needs in self-care, mobility, and IADLs were included in its testing. Individuals with functional needs in one of these three areas include the majority of HCBS recipients. However, FASI evaluates only functional needs; there may be other reasons an individual is receiving HCBS services (e.g., cognitive, behavioral, or emotional needs) that may not be manifested as a functional need.

2b2.2. What were the statistical results from testing exclusions? (*include overall number and percentage of individuals excluded, frequency distribution of exclusions across measured entities, and impact on performance measure scores*)

Nine individuals out of the total sample of 684 did not have a FASI-identified need (Table 10). Although this is to be expected, it is reassuring that only a small group of individuals did not have a functional need. These were individuals with intellectual/developmental disabilities, brain injury, or serious mental illness who may be receiving services because of cognitive, emotional, or behavioral needs. FASI is only one component of a comprehensive, person-centered assessment for individuals receiving HCBS.

TABLE 10. NUMBER OF UNIQUE INDIVIDUALS AND NUMBER IDENTIFIED AS NOT HAVING A FASI-BASED NEED

Measure Component	Individuals in Programs Serving Those Who Are Frail Elderly (row %)	Individuals in Programs Serving Those With a Physical Disability (row %)	Individuals in Programs Serving Those With an Intellectual or Developmental Disability (row %)	Individuals in Programs Serving Those With a Brain Injury (row %)	Individuals in Programs Serving Those With Serious Mental Illness (row %)	Total
Total unique individuals	122 (17.8)	120 (17.5)	231 (33.8)	126 (18.4)	85 (12.4)	684 (100)
Individual does not have a FASI identified need	0 (0.0)	0 (0.0)	4 (44.4)	2 (22.2)	3 (33.3)	9 (100)

2b2.3. What is your interpretation of the results in terms of demonstrating that exclusions are needed to prevent unfair distortion of performance results? (*i.e., the value outweighs the burden of increased data collection and analysis.* ***Note**: **If patient preference is an exclusion**, the measure must be specified so that the effect on the performance score is transparent, e.g., scores with and without exclusion*)

Individuals with serious mental illness, developmental/intellectual disabilities, or brain injury may not have functional disabilities that limit their participation in everyday activities. Thus, it is reasonable that these individuals, while needing HCBS for other reasons (such as behavioral needs), may not have FASI-identified needs and therefore need not report personal priorities. Not having function-based personal priorities does

not equate with poor quality of services for these individuals. It is important to note that FASI data elements capture only one aspect (i.e., function) of a comprehensive, person-centered assessment.

_____

2b3. RISK ADJUSTMENT/STRATIFICATION FOR OUTCOME OR RESOURCE USE MEASURES
If not an intermediate or health outcome, or PRO-PM, or resource use measure, skip to section 2b4.

2b3.1. What method of controlling for differences in case mix is used?

☐ **No risk adjustment or stratification**

☐ **Statistical risk model with risk factors**

☐ **Stratification by risk categories**

☐ **Other,**

2b3.1.1 If using a statistical risk model, provide detailed risk model specifications, including the risk model method, risk factors, coefficients, equations, codes with descriptors, and definitions.

2b3.2. If an outcome or resource use component measure is not risk adjusted or stratified, provide rationale and analyses to demonstrate that controlling for differences in patient characteristics (case mix) is not needed to achieve fair comparisons across measured entities.

2b3.3a. Describe the conceptual/clinical and statistical methods and criteria used to select patient factors (clinical factors or social risk factors) used in the statistical risk model or for stratification by risk (*e.g., potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of p<0.10; correlation of x or higher; patient factors should be present at the start of care*) **Also discuss any "ordering" of risk factor inclusion**; for example, are social risk factors added after all clinical factors?

2b3.3b. How was the conceptual model of how social risk impacts this outcome developed? Please check all that apply:

☐ **Published literature**

☐ **Internal data analysis**

☐ **Other (please describe)**

2b3.4a. What were the statistical results of the analyses used to select risk factors?

2b3.4b. Describe the analyses and interpretation resulting in the decision to select social risk factors *(e.g. prevalence of the factor across measured entities, empirical association with the outcome, contribution of unique variation in the outcome, assessment of between-unit effects and within-unit effects.)* **Also describe the impact of adjusting for social risk (or not) on providers at high or low extremes of risk.**

2b3.5. Describe the method of testing/analysis used to develop and validate the adequacy of the statistical model or stratification approach (*describe the steps—do not just name a method; what statistical analysis was used*)

Provide the statistical results from testing the approach to controlling for differences in patient characteristics (case mix) below.
If stratified, skip to 2b3.9

2b3.6. Statistical Risk Model Discrimination Statistics (*e.g., c-statistic, R-squared*)**:**

2b3.7. Statistical Risk Model Calibration Statistics (*e.g., Hosmer-Lemeshow statistic*):

2b3.8. Statistical Risk Model Calibration – Risk decile plots or calibration curves:

2b3.9. Results of Risk Stratification Analysis:

2b3.10. What is your interpretation of the results in terms of demonstrating adequacy of controlling for differences in patient characteristics (case mix)? (i.*e., what do the results mean and what are the norms for the test conducted*)

2b3.11. Optional Additional Testing for Risk Adjustment (***not required****, but would provide additional support of adequacy of risk model, e.g., testing of risk model in another data set; sensitivity analysis for missing data; other methods that were assessed*)

_____

2b4. IDENTIFICATION OF STATISTICALLY SIGNIFICANT & MEANINGFUL DIFFERENCES IN PERFORMANCE

2b4.1. Describe the method for determining if statistically significant and clinically/practically meaningful differences in performance measure scores among the measured entities can be identified (*describe the steps—do not just name a method; what statistical analysis was used? Do not just repeat the information provided related to performance gap in 1b)*

Because this measure is not routinely implemented in HCBS programs, there is not sufficient experience to identify what counts as a meaningful difference in the score across program types. However, chi-square results indicated a statistically significant difference in the performance measure scores ($c2=13.60$, $p<0.01$). Table 11 shows that the highest performance measure score is from the brain injury and intellectual/developmental disabilities program types (50.8% and 49.3%, respectively), whereas the lowest performance measure scores are from frail elderly and physical disability program types (33.6% and 35.8%, respectively).

TABLE 11. IDENTIFYING PERSONAL PRIORITIES FOR FASI NEEDS: SCORE BY PROGRAM TYPE

Measure Score	Individuals in Programs Serving Those Who Are Frail Elderly	Individuals in Programs Serving Those With a Physical Disability	Individuals in Programs Serving Those With an Intellectual or Developmental Disability	Individuals in Programs Serving Those With a Brain Injury	Individuals in Programs Serving Those With Serious Mental Illness	Total
Performance measure score, %	33.6	35.8	49.3	50.8	45.1	43.9

2b4.2. What were the statistical results from testing the ability to identify statistically significant and/or clinically/practically meaningful differences in performance measure scores across measured entities? (e.g., *number and percentage of entities with scores that were statistically significantly different from mean or some benchmark, different from expected; how was meaningful difference defined*)

2b4.3. What is your interpretation of the results in terms of demonstrating the ability to identify statistically significant and/or clinically/practically meaningful differences in performance across measured entities? (i.*e., what do the results mean in terms of statistical and meaningful differences?*)

2b5. COMPARABILITY OF PERFORMANCE SCORES WHEN MORE THAN ONE SET OF SPECIFICATIONS

If only one set of specifications, this section can be skipped.

Not applicable

Note*: This item is directed to measures that are risk-adjusted (with or without social risk factors)* ***OR*** *to measures with more than one set of specifications/instructions (e.g., one set of specifications for how to identify and compute the measure from medical record abstraction and a different set of specifications for claims or eMeasures). It does not apply to measures that use more than one source of data in one set of specifications/instructions (e.g., claims data to identify the denominator and medical record abstraction for the numerator).* ***Comparability is not required when comparing performance scores with and without social risk factors in the risk adjustment model. However, if comparability is not demonstrated for measures with more than one set of specifications/instructions, the different specifications (e.g., for medical records vs. claims) should be submitted as separate measures.***

2b5.1. Describe the method of testing conducted to compare performance scores for the same entities across the different data sources/specifications (*describe the steps—do not just name a method; what statistical analysis was used*)

2b5.2. What were the statistical results from testing comparability of performance scores for the same entities when using different data sources/specifications? (*e.g., correlation, rank order*)

2b5.3. What is your interpretation of the results in terms of the differences in performance measure scores for the same entities across the different data sources/specifications? (i.*e., what do the results mean and what are the norms for the test conducted?*)

2b6. MISSING DATA ANALYSIS AND MINIMIZING BIAS

2b6.1. Describe the method of testing conducted to identify the extent and distribution of missing data (or nonresponse) and demonstrate that performance results are not biased due to systematic missing data (or differences between responders and nonresponders) and how the specified handling of missing data minimizes bias (*describe the steps—do not just name a method; what statistical analysis was used*)

In theory, using the FASI field test data ensured that missing data were not an issue in terms of the critical data elements. However, data abstracted onto the measure test forms needed to be merged with the FASI field test data to determine HCBS program type and demographics. The developer team found 36 measure test abstraction forms that could not be paired with FASI field test forms (Table 12). Without being able to match the measure test data to the FASI field test data, the team was unable to determine their program type, which is the unit of analysis. In addition, four abstraction forms were missing data indicating whether an individual had a functional need.

TABLE 12. DESCRIPTION OF DATA BY PROGRAM TYPE

Measure Component Characteristic	Individuals in Programs Serving Those who Are Frail Elderly (row %)	Individuals in Programs Serving Those with a Physical Disability (row %)	Individuals in Programs Serving Those with an Intellectual or Developmental Disability (row %)	Individuals in Programs Serving Those with a Brain Injury (row %)	Individuals in Programs Serving Those with Serious Mental Illness (row %)	Total
Measure testing forms received	229 (18.1)	237 (18.7)	387 (30.5)	225 (17.8)	153 (12.1)	1,267* (100)
Usable forms	229 (18.6)	237 (19.3)	387 (31.4)	225 (18.3)	153 (12.4)	1,231 (100)
Unique individuals	122 (17.7)	123 (17.8)	232 (33.7)	126 (18.3)	85 (12.6)	688 (100)
Individuals missing FASI need	0 (0.0)	3 (75.0)	1 (25.0)	0 (0.0)	0 (0.0)	4 (100)
Final number of unique individuals	122 (17.8)	120 (17.5)	231 (33.8)	126 (18.4)	85 (12.4)	684 (100)

*Included in this total is 36 abstraction forms (2.8 percent) that could not be paired with FASI field test data.

2b6.2. What is the overall frequency of missing data, the distribution of missing data across providers, and the results from testing related to missing data? (*e.g., results of sensitivity analysis of the effect of various rules for missing data/nonresponse; **if no empirical sensitivity analysis**, identify the approaches for handling missing data that were considered and pros and cons of each*)

Missing data were minimal for this performance measure. The 36 forms that could not be aligned with FASI field test records were a result of incorrect form and assessor identifiers and not a result of data missing from the fields on the abstraction form related to identifying the critical data elements.

2b6.3. What is your interpretation of the results in terms of demonstrating that performance results are not biased due to systematic missing data (or differences between responders and nonresponders) and how the specified handling of missing data minimizes bias**?** (i.*e., what do the results mean in terms of supporting the selected approach for missing data and what are the norms for the test conducted; **if no empirical analysis**, provide rationale for the selected approach for missing data*)

Performance results were not biased because of missing data in the critical data elements.

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*) Update this field for **maintenance of endorsement**.

Some data elements are in defined fields in electronic sources

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

The data entry process will depend on the resources of the state entity. Some HCBS programs may use the electronic version of the FASI in their health records, whereas others may rely on paper versions.

The FASI set recently was field tested in HCBS programs and found to be a reliable and valid assessment of function. CMS will make the FASI readily available to all HCBS providers through the Data Element Library (DEL). All data elements come from defined fields in the FASI. If provider organizations implement the FASI into their electronic health records (EHRs), then all data elements will be in defined fields in an electronic record. If the paper form is uploaded to the EHR or if the HCBS programs use paper forms, the data can be abstracted for the defined fields on a data abstraction form.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

The reviewers, Technical Expert Panel (TEP) members, and researchers identified the following difficulties in data collection for measure testing:

? Understanding the FASI tool and measure instructions. Reviewer and TEP member feedback suggested that measurement guidelines were clearly specified, and the sources and documents were readily available (see Section 4a2.2.2); however, some reviewers reported that certain aspects of the FASI and measure instructions were difficult to understand, including the association between functional needs and priorities with service planning, acronyms used, and uses of performance measures.

? Eliciting information from individuals being served. Reviewer and TEP members expressed concern about whether individuals served were actively involved in identifying personal priorities. Reviewers felt that

those assessing individuals in the field needed more training on eliciting personal priorities and shared decision-making practices.

? Administrative burden (accessibility of information, time to complete measure). Although there were some conflicting viewpoints on the time and accessibility of the resources needed to complete the measure, sufficient positive comments were received to warrant consideration of the measure.

Several recommendations for measure implementation solutions were obtained during testing and through reviewer and TEP member feedback. The recommendations included the following:

? Training. TEP members and reviewers affirmed the need to identify personal priorities as a quality measure but felt that further training on methods to encourage discussions with individuals being served is necessary. Therefore, it is recommended that a training program be instituted with widespread measure implementation. During measure testing, reviewer training included a 1.5-hour Microsoft® PowerPoint presentation with time for questions and discussion. The content included (1) FASI set description and purpose, (2) performance measure foundational principles, (3) detailed description of the measure with examples, and (4) instructions on how to complete the data abstraction form. Weekly roundtables were conducted with the researchers to discuss different aspects of the measure and to answer any specific reviewer questions. A robust training program is recommended during measure implementation. Training should include (1) an online, accessible presentation (asynchronous or synchronous) based on the measure testing training and (2) a module on best practices to effectively elicit and record personal priorities for all individuals receiving HCBS.

? Time to gather data. In general, reviewers agreed that the resources are readily available to collect the data elements for the measure. Nevertheless, a streamlined version of the data abstraction form may be helpful when the measure is used outside of the testing process; see Appendix X for an example. Additionally, if the completed FASI assessment was in an electronic system, it could extract the information needed for this measure, thereby reducing the burden of collecting data for this performance measure.

? Sampling. Use of standard sampling techniques is recommended to allow for scientifically sound analysis and maintenance of data integrity while decreasing the time needed for the analysis. Possible methods include stratified sampling by population, sampling only newly eligible individuals served by HCBS, and random sampling.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified *(e.g., value/code set, risk model, programming code, algorithm)*.

Not applicable.

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
Public Reporting Quality Improvement (external benchmarking to organizations) Quality Improvement (Internal to the specific organization)	*

*cell intentionally left blank

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

Not applicable (no current uses indicated above).

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (*e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?*)

CMS intends to share information about the availability and potential utility of this measure for public reporting through numerous communication venues. The measure may support states in their efforts to meet Medicaid's section 1915(c) Home and Community Based Services Waiver Program Assurances, particularly the Service Plan Assurance, which requires that participants have a service plan that is appropriate to their need and that they receive the services/supports specified in the plan. States must establish performance measures, and remediation and quality improvement strategies in their waiver application. Once approved by CMS, a state must demonstrate that they are monitoring their programs by submitting evidence reports to CMS using the approved performance measures. CMS has also established Sub Assurances, which are how the Assurances are operationalized. The first Sub Assurance is that service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means. This PM could be used to help address this first Sub Assurance. For more information on the waiver assurances, see https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf

In addition, the FASI data elements are included in the CMS Data Elements Library, which may increase the likelihood of uptake by stakeholders seeking information about functional assessment data elements that can be used across settings.

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (*Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.*)

The measure in this submission is derived from the HCBS FASI set, which is available publicly through the CMS Data Element Library. Because the FASI set was developed for voluntary use in Medicaid HCBS, it is expected that states are likely to use the measures derived from the assessment tool for their internal assessment of HCBS program quality and related quality and improvement projects, as well as for public reporting at the state level. These measures will likely be included in CMS's HCBS Recommended Measure set (current draft available for public comment) for voluntary adoption by states' HCBS programs.

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

This process measure was tested in 10 organizations in five different states (Colorado, Connecticut, Georgia, Kentucky, and Minnesota) located in geographically diverse regions of the country. These organizations participated in the 2017 FASI field test and agreed to continue their participation by testing this performance measure. These organizations serve different populations including individuals who are older adults and those with physical disabilities, intellectual/developmental disabilities, acquired brain injury, or mental health or substance use disorders. Individuals included in the testing and analysis were eligible to receive services under Medicaid HCBS programs within the five states. HCBS programs enable individuals who would meet institutional level of care requirements to live in the least restrictive environment of their choosing in the community.

Measure testing focused on the reliability and face validity of the measure and did not include a method to give the participating organizations the results of the testing, their performance on the measure, or interpretative guidelines. In the future, CMS plans to share information about the availability and potential utility of the measure for reporting through numerous communication venues. Communication of the performance data, results, and interpretative guidelines will be addressed in the implementation plan.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

Measure testing focused on the reliability and face validity of the measure and did not include a method to give the participating organizations the results of the testing. The results of the testing were submitted to CMS to review and use to develop future activity. The measure was tested as including an annual (12 month) reporting period to coincide with the reporting requirements in Medicaid's section 1915(c) Home and Community Based Services Waiver Program Assurances and Sub Assurances. CMS currently is not planning to mandate its use. CMS will use various communication vehicles to provide performance measure results, reporting instructions, and educational material needed to calculate the measures.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

During performance measure testing, the reviewers that abstracted the FASI data completed a feedback form. After reviewing at least 10 forms, or at the end of data collection, reviewers completed a one-time feedback form on a secured, online platform (SurveyMonkey®). The feedback form was designed to allow reviewers the opportunity to share opinions and experiences in completing the performance measures and to provide a critique on the usability, appropriateness of content as a performance measure, and specifications of the measure (i.e., validity). In addition, a TEP consisting of 22 subject matter experts and stakeholders was convened. They reviewed the performance measures and preliminary results and provided feedback. Following the TEP, members also completed the online feedback form. The results of the feedback are summarized in the next two sections of the application.

4a2.2.2. Summarize the feedback obtained from those being measured.

In the feedback survey, the reviewers were asked a series of questions regarding the feasibility of implementing the measure, the clarity of the rules and measure description, and whether the measure would assist in measuring quality of services and supports. One hundred percent of the reviewers completed the feedback form. Table 6 summarizes the questions and results addressing the feasibility and usability of the measure. A more detailed analysis of the feedback is provided in the validity section (Section 2b1.) in the measure testing form portion of the application.

Table 6. Reviewer Agreement With Survey Statements About Usability and Feasibility

Survey Statement: Usability/Feasibility Total N (%) Strongly Disagree & Disagree (%)* Strongly Agree & Agree (%)*

The documents and sources to implement this PM for groups of CB-LTSS recipients are readily available. 46 (100) 2 (4.4) 44 (95.7)

The measurement guidelines clearly specify the documents or sources needed to implement this PM. 46 (100) 4 (8.7) 42 (91.3)

The time necessary to collect the information [on] each CB-LTSS recipient included in the PM is reasonable (does not cause undue burden for the [assessment] entity or state). 46 (100) 6 (13.0) 40 (87.0)

This PM will assist the [assessment] entity or state with continuous improvement under its CB-LTSS quality management system. 46 (100) 10 (21.7) 36 (78.3)

*The column sums the frequency of the Likert scale responses "strongly disagree" and "disagree" into one category and "strongly agree" and "agree" into the second category.

A significant majority of the reviewers believed that the documents and sources needed for the measure are readily available and clearly specified, and that the time necessary to complete the measure is reasonable. Qualitative comments supported these findings. Representative examples included the following: "Rules are very clear and understandable."; "It would be beneficial to report on this performance measure at least quarterly for trend analysis."; and "The rules are very user friendly and easy to understand."

The reviewers also were queried on the performance measure as a quality measure (see the testing protocol sections). Overall, a majority agreed with the statement, "This performance measure will assist the [assessment] entity or state with continuous improvement under its HCBS quality management system." In reviewing the qualitative comments, however, five comments questioned the need for requiring a specific number of priorities (e.g., "People should be asked about priorities, but not required to have three"). In addition, three comments suggested that the opinion of the individual served is important to quality services but may be elicited by means other than personal priorities (e.g., "Developing personal priorities I think is important however it doesn´t mean the person is getting a person-centered service plan, or high-quality services….what we need to ensure is that the person has a voice in their plan which includes the [item] important to and for [them] and ensures there are supports to assist that person live the life they want."; "[I] do not agree that a client that may identify personal priorities has anything to do with the quality of the services being delivered. They may identify their priority as wanting to go swimming. That has nothing to do with the quality of care they may or may not receive through a personal care provider agency.")

4a2.2.3. Summarize the feedback obtained from other users

Feedback was solicited from the TEP members using the same feedback form provided to the reviewers. The TEP consisted of 22 members that represented provider organizations, state Medicaid agencies, advocacy groups, self-advocates, and potential users of the performance measure. Twelve of the 22 TEP members provided feedback, including 8 potential FASI performance measure users, 2 advocacy group representatives, and 2 self-advocates. TEP members reviewed the performance measures and the preliminary results of performance measure testing before completing the feedback form. The level of agreement for the usability and feasibility statements are summarized in Table 7.

Table 7. Technical Expert Panel (TEP) Agreement With Survey Statements About Usability and Feasibility

Survey Statement: Usability/Feasibility Total N (%) Strongly Disagree & Disagree (%)* Strongly Agree

& Agree (%)*

The documents and sources to implement this PM for groups of CB-LTSS recipients are readily available. 12 (52.2) 4 (33.3) 8 (66.7)

The measurement guidelines clearly specify the documents or sources needed to implement this PM. 12 (52.2) 0 (0.0) 12 (100.0)

The time necessary to collect the information [on] each CB-LTSS recipient included in the PM is reasonable (does not cause undue burden for the [assessment] entity or state). 12 (52.2) 4 (33.3) 8 (66.7)

This PM will assist the [assessment] entity or state with continuous improvement under its CB-LTSS quality management system. 12 (52.2) 3 (25.0) 9 (75.0)

*The column sums the frequency of the Likert scale responses "strongly disagree" and "disagree" into one category and "strongly agree" and "agree" into the second category

In general, a majority of the TEP respondents agreed with the feasibility and usability statements; however, there was less agreement when compared with the reviewers' results. The greatest differences in percent agreement between the TEP and reviewer respondents were regarding statements on the availability of documents and resources to implement the performance measure and statements that time expectations are reasonable. These differences may be due to the relatively lower number of TEP respondents and their lack of experience in using the performance measure in the field. There was agreement, however, that the guidelines to complete the performance measure were clearly specified. TEP members agreed that the use of the performance measure will assist the assessment entity or state with a continuous quality improvement system for HCBS.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

Reviewer and TEP feedback were used to modify the original performance measure proposed. The original performance measure defined the numerator to include those individuals who recorded at least three personal priorities in the self-care, mobility, and IADL sections of the FASI form. Reviewers and TEP members suggested that provider organizations offering services to individuals with only one or two needs were unlikely to identify three personal priorities, resulting in potential bias. Therefore, the numerator was modified. The modified performance measure defines the numerator as requiring at least as many personal priorities as identified needs (up to a combined total of three). Thus, if an individual has one need identified on all three sections of the FASI form, then only one personal priority is required to meet the numerator's guidelines. If an individual has three or more needs identified from the FASI assessment, then to be included in the numerator, three personal priorities need to be identified on the FASI form.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

The proposed performance measure was developed to be a first step in closing the gap that currently exists between assessment and the person-centered service planning process. Eliciting and recording personal priorities with every individual assessed for HCBS is an essential early step to a person-centered approach to

service delivery. Three short-term outcomes are expected to be associated with the implementation of practices aligned with the performance measure: the individual receiving services will be more engaged in his or her own priority setting and service planning; case managers and assessors will be more responsive to the individual's priorities in service planning; and assessors will receive additional training to effectively elicit and record person-centric information. The attainment of the short-term outcomes may lead to a longer-term, high-quality outcome; HCBS providers may demonstrate greater shared decision-making and improved person-centered service plans.

The performance measure was not measured over time; therefore, changes as a result of its implementation were not measured. Data collected during performance measure testing indicated, however, that improvement is needed. Each HCBS program type had a relatively low score on the revised performance measure, with an average score of 56% and a range from 34% for individuals who were older adults to 52% for individuals with an acquired brain injury (see table in 1b.2). The average score for the programs was 44% with a range of 9.7% to 67.5%. In addition, reviewer and TEP member feedback demonstrated that the performance measure definition was clear, the resources were readily available, and identifying personal priorities is an important step to providing high-quality services. However, there was discrepancy on the reviewer and TEP member feedback on whether the performance measure provides important information for assessing whether HCBS recipients are receiving high-quality services.

Participating organizations can use the results of this measure in quality improvement programs and to develop training on best methods to elicit and accurately record personal priorities. Organizations that serve different populations may tailor the training toward improving assessor competencies for specific populations that demonstrate lower performance measure scores. Finally, designing service plans based on the personal priorities may lead to person-centered service plans.

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

The developer team was positively surprised about the magnitude of reviewer agreement regarding the importance of this measure—it focuses attention on person-centered practice and has potential use in quality improvement. This finding was further supported by feedback from the open-ended comments. The developer team experienced technical difficulties with the electronic abstraction form during implementation that presented some challenges during the data collection process. In addition, although the training on both FASI and measure data collection was well received and other indicators about the process were positive (e.g., feedback from the weekly roundtables with reviewers during data collection, the reviewer feedback forms, and the interrater reliability scores), the team received comments that additional user training may be needed. Specifically, comments suggested that assessors should be trained in methods to engage HCBS participants being assessed to elicit information on personal priorities.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

Unexpected benefits are not yet well understood because this measure has not been implemented. However, the immediate benefit is that the reviewers have increased awareness that HCBS recipients with documented functional needs should have their personal priorities better documented. Furthermore, reviewers commented that the priorities should be person-centered and should be written collaboratively by both the assessor and the individual receiving services. Thus, the practice of identifying personal priorities has increased awareness of person-centered practices.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria **and** there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

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

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

Yes

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

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. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

No appendix Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): Centers for Medicare & Medicaid Services

Co.2 Point of Contact: Helen, Dollar-Maples, Helen.Dollar-Maples@cms.hhs.gov, 410-786-7214-

Co.3 Measure Developer if different from Measure Steward: The Lewin Group

Co.4 Point of Contact: Colleen, McKiernan, Colleen.McKiernan@lewin.com, 703-269-5595-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

The research team involved in the development of the measures includes the following:

Centers for Medicare & Medicaid Services

Kerry Lida, Ph.D.

Other Investigators

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Additional research assistance was provided by Karen Schlumpf, MHP, EdDc, George Washington University.

The current developers for NQF 3593 include:

The Lewin Group (Lewin)

The National Committee for Quality Assurance (NCQA)

Qlarant

George Washington University (GW) School of Medicine and Health Sciences

Marymount University

DMA Health Strategies

The TEP members involved in the development of the measures are listed below. TEP members attended meetings in February 2018 and/or July 2018. They provided stakeholder feedback regarding measure concepts and measure specifications, including aspects such as value for quality improvement and potential implementation feasibility.

- Brian Bennett, Louisiana TEFT Grantee
- Mary Lou Bourne, National Association of State Directors of Developmental Disabilities Services
- Joe Caldwell, National Council on Aging
- Marcus Canaday, West Virginia Medicaid
- Tim Cortez, Colorado TEFT Grantee
- Danielle Darby, Revitalizing Community Membership of Washington
- Camille Dobson, National Association of States United for Aging and Disabilities
- Pam Erkel, Minnesota TEFT Grantee
- Chester Finn, self-advocate, New York Office for People with Developmental Disabilities
- Nancy Flinn, Courage Kenny Rehabilitation Institute
- Wendy Fox-Grage, AARP Public Policy Institute
- Dolores Frantz, Pennsylvania Developmental Disabilities Agency
- Michelle Goody, Massachusetts Medicaid
- Kendra Hanley, Health Services Advisory Group
- Celeste Januszewski, University of Illinois at Chicago
- Angela Kimball, National Alliance on Mental Illness
- Rachel LaCroix, Florida Agency for Health Care Administration
- Steve Lutzky, HCBS Solutions
- Michael Monson, Centene Corporation
- Teri Morgan, Virginia Medicaid
- Lorraine Nawara, Maryland TEFT Grantee
- Bonnie Neighbour, Peer Specialist
- Jim O'Neill, self-advocate
- Jake Reuter, North Dakota Medicaid
- Julie Robison, Connecticut TEFT Grantee
- Jennifer VanderNoot, New Hampshire TEFT Grantee
- Dave Zacks, self-advocate

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2018

Ad.3 Month and Year of most recent revision: 03, 2018

Ad.4 What is your frequency for review/update of this measure? Annual review/update

Ad.5 When is the next scheduled review/update for this measure? 04, 2021

Ad.6 Copyright statement:

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: