Meeting to Review Measures for the 2028 HCBS Quality Measure Set
April 8, 2025, 11:00 AM–4:00 PM ET
DAY 1 TRANSCRIPT

Patricia Rowan:

Good morning, everyone. My name is Tricia Rowan, and I am pleased to welcome you to the first day of our meeting to review measures for the 2028 home and community-based services or HCBS quality measure set. We'll spend the next several minutes going over the day's objectives. Next slide.

Before we get started, I want to briefly acknowledge my colleagues here at Mathematica who are part of the HCBS quality measure set review team. They include Asmaa, Kanch, Rosemary, Deb, Denesha, Kathleen, and Rick. Thank you to this wonderful team. And I'll turn it over. Now we'll go to the next slide to discuss project milestones.

All right. We have several objectives for our voting meeting this week. First, the work group will review the measures that were suggested for removal from or addition to the HCBS quality measure set and we'll vote to recommend updates to the measure set. There will also be an opportunity to discuss gap areas. And finally, we'll provide multiple opportunities for work group members and members of the public to ask questions and make comments. I would like to pause for a moment here and note that we are committed to a robust, rigorous, and transparent meeting process, even despite the virtual format.

That said, we acknowledge that folks may have technical difficulties or challenges with the virtual meeting and we hope everyone will be patient with us as we do our best to adhere to the agenda and fulfill the meeting objectives. The use of webcam for video will be enabled for our presenters and work group members to use if you would like, but not for members of the public. If we encounter any issues with bandwidth or webinar quality, we may disable the use of video. I also want to remind work group members of a few ground rules for participation.

So first, we acknowledge that everyone brings a point of view based on your organizational or individual perspective. As a work group member, however, you're charged with recommending updates to the quality measure set as stewards of the Medicaid HCBS program as a whole and not from your own individual or personal organizational perspectives. Please keep this in mind during the discussion and voting. Second, the meeting today is focused on discussing the measures that were suggested for addition to or removal from the quality measure set. We will not be discussing CMS policies. And CMS is joining us today in listen-only mode.

In addition, we know that spending several hours a day in a virtual meeting can be challenging, so we do ask that you be punctual in returning from breaks so that we can have everyone present for discussion and voting. We also want to remind public attendees that we will have designated opportunities for public comment and ask that you save your comments until we reach those public comment periods. We will not be accepting public comment through the Q&A feature, so we will encourage you to submit your comments orally, to raise your hand and say them out loud. All right. Next slide. Now we will introduce the work group members and share any disclosures of interest. Next slide.

To ensure the integrity of the review process, we asked all work group members to submit a form that discloses any interest, relationships, or circumstances over the past four years that could give rise to a potential conflict of interest or the appearance of a conflict related to the current HCBS quality measures, set measures, or any new measures that are being discussed by the work group. Members who redeem to have an interest in a measure that was suggested for removal or addition will be recused from voting on that measure. During the introduction and roll call, members are asked to disclose any interests related to the existing or new measures that will be discussed by the work group. Next slide.

As we go through the roll call, we ask that work group members raise their hand when their name is called. That's in the webinar platform. Again, kind of the bottom right-hand corner, you'll see a little hand icon. You'll hear a tone once we've unmuted you. And please ensure that you're not also double-muted on your headset or phone. When we unmute you, you can say hello, share your disclosures, or indicate whether you have nothing to disclose. When you're done, please mute yourself in the platform and lower your hand. We're going to make all of the work group members panelists, so when you would like to speak later during the meeting, you should be able to unmute yourself when we call on you. Next slide.

All right. So on these next two slides, we've listed the work group members in alphabetical order by their last name. So when I call your name, again, please use the raise hand feature so we can unmute you. And if you are muted locally on your headset or phone, please remember to unmute your line. If you have any technical issues, please use the Q&A function for assistance. So we are going to start -- Laney is unable to join us today. So we will start with ShaRhonda.

ShaRhonda Sly:

Good morning. My name is ShaRhonda Sly and I work for the Ohio Department of Medicaid. I have nothing to disclose.

Patricia Rowan:

Thank you, ShaRhonda. Joseph Caldwell. We unmute Joe. Rick, are you able to --

Rick:

I don't see Joseph joining us just yet.

Patricia Rowan:

Joe has his hand raised.

Rick:

Got you.

Patricia Rowan:

Joe Caldwell?

Rick:

Go ahead, Joe.

Patricia Rowan:

Joe, you might be locally muted. There you go.

Joseph Caldwell:

There it goes. Hi, everyone. I'm Joe Caldwell. I'm with Brandeis University and I do have a disclosure of interest I'd like to name. For the measures that were submitted by the University of Minnesota, the RTC on outcome measurement, we were part of that pilot testing of the measures in Massachusetts. So for those measures, I'm going to recuse myself from voting on those measures.

Patricia Rowan:

Thanks, Joe. Next, we have Eric Carlson. Rick, can we unmute Eric? Go ahead, Eric. You'll have to unmute yourself locally.

Eric Carlson:

Eric Carlson from Justice in Aging. Nothing to disclose.

Patricia Rowan:

Thanks, Eric. Lorin is also unable to join us today so we will go next to Carolyn Foster. Carolyn, can you raise your hand? There we go. Rick, can we -- all right, Carolyn. You should be able to unmute now.

Carolyn Foster:

Okay. Sorry about that. I was having some trouble with the Webex platform when I was logging on, but I just caught the last person and I think I'm just going to say I have nothing to disclose. Was there anything else?

Patricia Rowan:

Nope. Just wanted to make sure you were here, that your sound sounds good, and your disclosure. So we appreciate that. Thank you. All right. Next, we have Tara. Go ahead, Tara. You should be able to unmute. Try unmuting again. There we go.

Tara Giberga:

There we go. Third time is a charm.

Patricia Rowan:

Yep.

Tara Giberga:

Hey, everyone. This is Tara Giberga. I am with the Pennsylvania Department of Human Services, Office of Developmental Programs, the Quality Management Division director. And I have nothing to disclose.

Patricia Rowan:

Thank you, Tara. Next, we have Dennis. Let's see. Do we see Dennis in -- do not see Dennis attending. Dennis, if you're here and you're a calling user, send us a message in the Q&A. But otherwise, we will move on to Sarah. All right, Sarah. Go ahead and unmute.

Sarah Hoerle:

Hi. This is Sarah Hoerle. I'm from the Colorado Department of Healthcare Policy and Financing. And I have nothing to disclose.

Patricia Rowan:

Thank you, Sarah. Next, we have Heleena. Go ahead. Heleena.

Heleena Hufnagel:

Hi. Good morning, everyone. My name is Heleena Hufnagel, and I am with Washington Healthcare Authority. And I have nothing to disclose. Thank you.

Patricia Rowan:

Thank you. Next, we have Misty Jenkins. Do we have Misty here? Misty, if you're on the line, can you raise your hand in the Webex feature? If not, send us a message in Q&A and we'll help. Okay, let's go to Raina. Go ahead, Raina.

Raina Josberger:

Hi, good morning. My name is Raina Josberger. I work for the New York State Department of Health. And I did want to report that I sit on two other quality measurement groups. I sit on the partnership for quality measurement, the post-acute care recommendation group with Patel, as well as NCQA's map on the LTSF measures.

Patricia Rowan:

Thank you for sharing that, Raina. That didn't rise to the level of needing to recuse yourself from any votes, but we do appreciate –

Raina Josberger:

Great.

Patricia Rowan:

-- you sharing the information.

Raina Josberger:

Great. Thanks.

Patricia Rowan:

All right. Let's go to the next slide. Do we have Marci? Go ahead, Marci.

Marci Kramer:

Good morning. This is Marci Kramer. I work for AmeriHealth Caritas Community Health Choices. And I don't have anything to disclose.

Patricia Rowan:

Great. Thank you for being here. Next, we have Cathy. We see Cathy's hand. Go ahead, Cathy. Cathy, you might need to unmute yourself locally.

Cathy Lerza:

I guess, sorry.

Patricia Rowan:

It's okay.

Cathy Lerza:

I'm Cathy Lerza. I'm the assistant director of the Kentucky Division of Developmental and Intellectual Disabilities. I have nothing to disclose.

Patricia Rowan:

Wonderful. Thank you for being here. Next, we have Eric. Eric, can you raise your hand and we'll unmute you? There we go. Go ahead, Eric. You should be able to unmute now.

Eric Levey:

Can you hear me?

Patricia Rowan:

Yes, we can.

Eric Levey:

I'm Eric Levey. I'm the chief medical officer of Health Services for Children with Special Needs. We're a health plan, a Medicaid plan in DC. I put that in the disclosure, but I didn't have anything else to disclose.

Patricia Rowan:

Great. We appreciate that. All right. Next, we have Morgan. Let's unmute Morgan. Go ahead, Morgan. You should be able to unmute yourself now.

Morgan Loughmiller:

Hi. My name is Morgan Loughmiller. I work at the Kansas Department for Aging and Disability Services. And I have nothing to disclose.

Patricia Rowan:

Great. Next, we have Joseph Macbeth. Go ahead, Joseph.

Joseph Macbeth:

Hi. This is Joe Macbeth. And I am with the National Alliance for Direct Support Professionals. And I have nothing to disclose.

Patricia Rowan:

Wonderful. We have -- next, we have Deborah. Go ahead. Deborah, are you able to say hi?

Deborah Paone:

Yes. Hi. This is Deborah Paone. I'm with the Special Needs Plan Alliance. And I have nothing to disclose.

Patricia Rowan:

Wonderful. Thanks for being here. Next, we have Delan Pillay. Go ahead, Delan.

Delandran Pillay:

Good morning, everyone. My name is Delan Pillay from the California Department of Healthcare Services. And I have nothing to disclose at this time. Thank you.

Patricia Rowan:

Thank you. Next, we have Jason Rachel. Go ahead, Jason.

Jason Rachel:

Good day, everyone. Jason Rachel with the Virginia Department of Medical Assistant Services. And I have nothing to disclose.

Patricia Rowan:

Wonderful. Next, we have Dawn Rudolph. All right. Go ahead, Dawn. You should be able to unmute now.

Dawn Rudolf:

Hi. This is Dawn Rudolph from the Wyoming Institute for Disabilities at the University of Wyoming. I have nothing to disclose.

Patricia Rowan:

Great. Next, we have Damon. Go ahead, Damon. You should be able to unmute now.

Damon Terzaghi:

Hi. My name is Damon Terzaghi. And I am with the National Association for Home Care and Hospice, which has recently been renamed the National Alliance for Care at Home. And within the past four years, I was employed by ADvancing States, which is one of the measure stewards for the NCI-AD-related measures. And that employment agreement terminated in December of 2022.

Patricia Rowan:

Thanks, Damon. We appreciate the disclosure. We did not determine that that was a reason for you to recuse yourself from voting on those measures, though. Thank you. Next, we have Renata. Go ahead, Renata. Might need to unmute yourself.

Renata Ticha:

Okay. Hi, Renata Ticha from the University of Minnesota's Institute on Community Integration. I have been on the development team of the research and training center on HCBS outcome measurement. So I am not going to be voting on the RTC/OM measures.

Patricia Rowan:

Thank you. Next, we have Brent. Go ahead, Brent. You should be able to unmute. Try again. Try unmuting again. There we go.

Brett Watkins:

There we go. Good morning. Brent Watkins from the Oregon Department of Human Services with the Office of Developmental Disability Services. I have nothing to disclose. Thank you.

Patricia Rowan:

Thank you. And next, we have Amanda. Go ahead, Amanda.

Amanda Yanez:

Hi, I'm Amanda Yanez. I'm the director of Quality Accountability and Innovation Policy for the Division of TennCare Long-Term Services and Supports. And I have no conflicts to disclose.

Patricia Rowan:

Great. Let me circle back and see if either Dennis Heaphy or Misty Jenkins have joined us. I am not seeing either of them. We'll keep an eye out to see if they join during the day, but appreciate everybody hanging with us during the roll call, making sure everybody sounds good. And I will go on to the next slide. All right.

So let me just take a moment to provide a brief overview of the HCBS quality measure set. Next slide. CMS released the first HCBS quality measure set in 2022 for voluntary use by states. The HCBS quality measure set is a set of nationally standardized quality measures for Medicaid-covered HCBS that promotes common and consistent use of the measures within and across states, allows states and CMS to have comparative quality data on HCBS programs, and drives improvement of care and outcomes for people who receive HCBS. Implementing an effective quality measure reporting program includes periodically reassessing the measures since many factors such as changes in regulatory guidelines, state experiences with reporting, or performance rates can warrant modifying the measure set. Next slide.

Earlier this year, CMS published the 2024 HCBS quality measure set for Medicaid-funded HCBS. They also released a CMCS informational bulletin, or CIB, requiring that states with money follows the person demonstration grants report on a subset of the measures starting in the fall of 2026. The HCBS quality measure set draws from four experience of care surveys that are listed here on the slide. They're the HCBS cap survey, the NCI-IDD survey, the NCI-AD survey, and the personal outcome measure or POM. States can select from these different experience of care surveys when they implement the measure set as long as they are surveying all major HCBS population groups. Next slide.

I want to go over a little bit how we're going to organize our day, but first, I want to describe how we're going to organize the discussion, and we'll do some practice voting. Next slide. All right. So this work group process is designed to help identify gaps in the existing measure set and to suggest updates to strengthen and refine the measure set for state reporting in 2028. If the work group -- the work group must first determine whether a measure is feasible for state reporting, and if so, whether that measure strikes an appropriate balance between the desirability and viability of the measure from the perspective of state-level quality measurement and improvement. Next slide.

We asked work group members to consider criteria and three areas when they were assessing measures for inclusion in the HCBS quality measure set. We went over these criteria during our previous work group meetings and they're available on the slides and on our website. So I'm not going to spend too much time going over them again today. But those areas -- the first area is related to minimum technical feasibility requirements. Measures that were suggested for addition to the HCBS measure set must meet the minimum technical feasibility criteria in order to be considered by the work group.

So our team at Mathematica reviewed all of the suggested measures to make sure they met those criteria, and that's how we determine which measures will be discussed today. The second area of criteria is related to the actionability and strategic priority of the measure. And finally, we had some other considerations for suggesting a measure for addition, which included whether the outcome being measured is prevalent enough to reduce reliable and meaningful state-level results, consideration of the data collection burden of the measure and possible alignment of the measure specifications with other CMS programs.

The criteria for suggesting measures for removal from the measure set are generally, for the most part, the inverse of the criteria for suggesting measures for addition. So I'm not going to walk through them in too much detail today. But as I said, detailed information on the criteria for addition and removal are available on the slides. These slides are all on our website if you want to follow along. And our team will put the link to our website in the chat. They were also reviewed during previous work group meetings. Next slide.

So on this slide and the next, we have listed the criteria that work group members consider when suggesting a measure for removal. Since I summarized them previously, I'm not going to read this information, but again, the slides are available on our website and we just put the link to the website in the chat. Next slide. The remaining criteria for suggesting a measure for removal are continued here on this slide. Next slide.

And on this slide and the next two, we've listed the criteria that work group members consider when discussing and suggesting a measure for addition. So this slide has the minimum technical feasibility criteria and again, all measures that will be considered by the work group today had to meet these minimum criteria. Next slide. The actionability and strategic priority criteria for addition are here, and next slide. And finally, these are the remaining criteria for addition with the other considerations included. Next slide.

All right. So now let me move on to provide an overview of the voting process. So each measure that we will be discussing today and tomorrow will be voted on in its currently specified form. What that means is

that, you know, how it stands today without any conditions, or exceptions, or expectations of changes. If a measure is being considered for removal from the HCBS measure set, a yes vote means that I do recommend removing this measure from the HCBS quality measure set. And if the measure is being considered for addition, a yes vote means I recommend adding this measure to the HCBS quality measure set.

Measures will be recommended for removal or addition if two-thirds of the eligible work group members vote yes on the specific measure. Voting will take place by domain after work group discussion and public comment. And voting is for work group members only. Other attendees of today's meeting are not eligible to vote on the measures but are eligible to share their thoughts during the public comment period. Generally, we will take vote -- do a vote first on the measures that are suggested for removal and then move on to the measures that were suggested for addition. So work group members should let us know in the Q&A function in Webex if you will be absent for some of the voting. And our team can submit votes on your behalf. Let me go to the next slide.

And I want to pause here briefly to see if there are any questions from work group members about the criteria or the voting logistics before we do a practice vote. So work group members, if you do have any questions, you should be able to unmute yourself, but please still use the raise hand feature which will just help us kind of call on you and keep the discussion orderly. No questions. All right. Well, I'm not seeing any hands raised so why don't we move on to doing a practice vote. Test it out. All right. So just as a reminder for attendees, like I said, voting is for work group members only. So work group members, at this time, we would like to ask you to navigate to the Slido voting page. We sent out the link in the email that we sent to you with the voting guide a couple of days ago. And I think, at this point, we're going to have -- our team is going to share the screen with the Slido and there's also a QR code you can use.

So why don't we -- Denesha, why don't we bring up the Slido and start the practice vote. All right, great. So yes, if folks have to -- if work group members still need to navigate to Slido, you can use the QR code here or you can join at slido.com and enter that little code that's on the screen. Again, only work group members are able to vote. And you will need to register with your email address and name. And it needs to be the same email address where you get information from us. That's how we signed you up. You'll be prompted to enter your email address and you will get a verification code sent to your email.

So be sure to use that same email address where you receive communication from the Mathematica team. Once you log in, you can remain on this page for the duration of the meeting and new voting questions will appear as we make them available. So if you don't see a question live or if it hasn't changed to the next question, you should just refresh your page and it should pop up. If you need any help, we did send out a voting guide, but you can send us a message through the Q&A feature in Webex.

And the third page of the voting guide we sent out last week has like an FAQ section that addresses most of the problems that have come up in the past, but we won't assume we caught them all. So during voting on measures, if, for any reason, you're unable to submit your vote, please send us a message through the Q&A in Webex or to our email address if you're not able to access Webex. Your votes will only be visible to the Mathematica team. Once you have emailed or sent your votes for our team, we do ask that you stop trying to submit it on your own just to avoid the possibility of kind of your vote being double-counted.

And I also would just want to share that Mathematica will do a careful review of all of the voting results at the end of each day of this meeting to make sure that each eligible work group member's vote was counted and only counted once. So with all of that, let's go do a practice vote. So you can see the question here on the slide. It's what is your favorite season and the options should appear for fall, winter, spring, and summer. I think we've got maybe 22 or 23 folks on the line and I see 22 votes already so I will keep my fingers crossed, but you guys are already star students on this voting technology.

So if anybody is having any problems getting onto the Slido, just let us know. Send us a note in the Q&A. All right. Why don't we go back to the slides and we'll keep going through the content as folks are continuing the practice vote. If you do -- I guess we should have shared the results. I'm sorry I missed that. Denesha, if you want to pull it back up again, I'm sorry about that. Okay. So we close the vote and it looks like fall is the winner, followed by spring, 50% of the votes for fall, another 40% for spring. I think I agree with that. I live in South Florida though so we don't really get fall. So I'm very envious of all of you who get nice fall weather. All right, great. We'll go to the next one. I think actually the next one, 27. Great. So now that we've practiced the voting process, let's take a minute to go over how we are organizing the measure discussion. Next slide.

So today and tomorrow, the work group will discuss 39 measures, including 15 that were suggested for removal and 24 that were suggested for addition. This is a lot of measures to talk about in two days. So we do ask that the work group members be cognizant of time when making your questions or when making your comments. To facilitate the discussion, Mathematica has organized the measure suggestions into several domains based on the topic addressed. These domains build on the current consensus-based entity domains, which are informed by the National Quality Forum 2016 HCBS quality framework. As I mentioned before, measures will be voted on in their specified form and voting will take place after discussion of all the measures within that domain. Next slide.

So this slide, this table on this slide lists the nine domains that we'll be discussing today and tomorrow. The table includes the number of measures that are currently in the quality measure set within each of the domains as well as the number of measures suggested for removal and addition within that domain. I do want to note that this domain framework is simply intended to help us organize the work group discussion. CMS has not indicated a goal or a desire to have measures in all of these domains. So again, this framework is not necessarily endorsed by CMS. It's really just a mechanism for organizing the conversation today and tomorrow since we have so much to get through. All right, next slide.

Now, I am going to hand it over to my colleague Asmaa, and she will review measures in the first domain, which is related to choice and control.

Asmaa Al-baroudi:

Thanks, Tricia. Good morning, everyone. There were nine measures suggested for addition to the HCBS quality measure set in this domain and none were suggested for removal. In the next few slides, I'll share some very high-level information about these measures, but for the sake of time, we are not going to read all of the details. The slides for this meeting and the measure information sheet packets with full information about each measure being considered are available on our website. Next slide.

The first three measures suggested for addition in this domain come from the NCI-AD Adult Consumer Survey for people with physical disabilities and/or older adults who receive at least one survey other than case management. This survey instrument is stewarded by ADvancing and HSRI. The first measure is the NCI-AD Percentage of People in Group Settings Who Are Able to Choose Their Roommate measure. Next slide.

The next measure suggested for addition in this domain is the NCI-AD Percentage of People in Group Settings Who Are Able to Furnish and Decorate Their Room However They Want To measure. Next slide, please.

The third NCI-AD measures suggested for addition in this domain is the NCI- AD Percentage of People in Group Settings Who Are Able to Lock the Door to Their Room measure. Next slide. The next four measures suggested for addition in this domain come from the NCI-IDD; in-person survey for people who receive at least one service in addition to case management from their state development disability survey system. This survey instrument is stewarded by the National Association of State Directors of Developmental Disability Services and HSRI. The first measure is the NCI-IDD; the Percentage of People who Report That There Are Rules About Having Friends or Visitors at Home measure. Next slide.

The next measure suggested for addition in this domain is the NCI-IDD, the percentage of people reported to be using a self-directed services option measure. Next slide, please. The next measure suggested for addition in this domain is the NCI-IDD the Percentage of People who Report Staff Do Things the Way They Want Them Done measure. Next slide.

The final NCI-IDD measure suggested for addition in this domain is the NCI-IDD the Percentage of People Who Report That They Know Whom to Talk to if They Want to Change Services measure. Next slide, please.

The next two measures suggested for addition in this domain come from the research and training center on HCBS outcome measurement or RTC/OM survey instrument. This would be a new experience of care survey option that states could select from on the HCBS quality measure set. The population surveyed is adults 18 and older who receive HCBS or HCBS-like services, which include both Medicaid and non-Medicaid services. This survey instrument was developed and is stewarded by the Institute on Community Integration at the University of Minnesota. The first measure is the RTC/OM: Personal Choices and Goals Self-Determination Index measure. Next slide, please.

The next measure suggested for addition in this domain is the RTC/OM: Services and Supports Self-Determination Index measure. Next slide. We'll now invite discussion from the work group members about the nine measures suggested for addition in the choice and control domain. You may raise your hand if you wish to speak. We will call your name and unmute you when it is your turn. Please remember to say your name before making your comment and indicate which measure you are referring to if your comment is specific to a measure or group of measures. Now I will turn it over to Tricia to facilitate the work group discussion, public comment, and votes.

Patricia Rowan:

Thanks, Asmaa. We are doing well on time, which is great. So we do have a little extra time to talk about these measures. We'll start with work group discussion on the measures. So if folks have any comments or questions on any of the nine measures that Asmaa just introduced within this domain, feel free to raise your hand and we'll bring you off mute, and we can get the discussion started. I'm not seeing any hands raised. There, I see Brent. Brent, thanks for breaking the ice. Go ahead and you can unmute yourself. Go ahead.

Brent Watkins:

Yeah, thank you. So, looking over the additions, one concern I had was related to the NCI-IDD, the percentage of people reported to be using a self-directed support option. The concern I have is really around the definition of self-directed, and being a state that uses national core indicators, and working with other states over the years as we meet, I think there has been -- some states interpret that differently, right?

So my big concern would be that depending -- how consistent that is across each state and are we really measuring the same thing. In other words, how Oregon may develop or how we may define self-directed in our work may be different than a state, even Washington, which is next door to us or another state. So I think that's my one concern with that particular measure has to do with there's such a broad interpretation of what self-directed is and is it something that would be consistent across all of the states.

Patricia Rowan:

Thank you, Brent, for that comment. I don't know -- I know we do have representatives from the measure steward for NCI-AD on the line. I don't know if Steph or Rosa is here. If you all want to raise -- I see Dorothy. Rick, could we briefly unmute Dorothy if Dorothy could answer that question about the definition of self-direction?

Rick:

Stand by, please. Let's see.

Patricia Rowan:

Dorothy has her hand raised.

Rick:

Okay.

Patricia Rowan:

Dorothy --

Rick:

Dorothy, you're unmuted. Looks like you -- let's try that again. There we go.

Dorothy:

Got it. Sorry. Sorry, I re-muted myself. Hi, Brent. This is Dorothy. Yeah. We've talked a lot about this with Oregon and other states regarding the definition of self-directed supports option. The survey tool -- so these data come from the background information section. So these are not asking the person themself what -- whether they believe they're self-directing their supports or whether they are participating in a self-directed supports option. This does come from the background information, which allows states to sort of apply a more standardized definition and instruct surveyors what kind of coding to look for to ensure that they are including the accurate information regarding self-direction.

And we are not talking about self-determination here or the value of being able to make decisions for oneself. We are talking about more formal self-directed supports options which allow people more leeway in choosing who their supports are, potentially, services and supports to -- goods and services to purchase, maybe budget authority, et cetera. And I will add that in the survey tool itself, there is a more specific definition for those who are filling out that background information. And I'll open it up to other NCI team members to add.

Patricia Rowan:

Thanks, Dorothy. I see Rosa. Can we go ahead? Go ahead, Rosa. You should be able to speak now.

Rosa:

Great. I just wanted to say I don't think that we have anything to add, Dorothy. That was very comprehensive. Thank you.

Patricia Rowan:

Great, thanks. All right. I see ShaRhonda has her hand raised. Let's go next to ShaRhonda.

ShaRhonda Sly:

Thank you. Just a few thoughts and my observations about the additions of the RTC/OM survey. There are a few concerns that I would have with those, provider-administered. If it's provider-administered, it's hard to equate that with how the other survey measures are completed with the more independent entity structure for evaluating. So it'd be kind of hard to do an apples-to-apples comparison when you're looking across programs. I see a potential burden on providers' time and funds that could directly impact the burden on the state, especially when it comes to provider rates, especially as we're looking towards implementing access rule requirements and payment adequacy. I could see some direct impact in the future on that. And that's the last of my comments. Thank you.

Patricia Rowan:

Thanks, ShaRhonda. Deborah, are you able to unmute?

Deborah Paone:

Yes, thank you. My comment, I think, builds off of Brent and the previous speaker using -- you know, having background information about whether the person is using self-directed support options depends on so many factors, you know, across states, whether the state allows, under what circumstances. And I don't believe this is really a quality measure of the provider, of the service provider. It's more of a

demographic or a characteristic of the sample. So it didn't rise to the level of, to me, a quality of care or quality measure related to the service provider. Thank you.

Patricia Rowan:

Thanks. And just clarifying, Deborah, your comment was about the self-directed supports measure, right?

Deborah Paone:

Yes. The one we're talking about, the percentage of people reported to be using self-directed supports options.

Patricia Rowan:

Great. Thank you. Damon. I see Damon has his hand raised.

Damon Terzaghi:

The one clarification question I had, I saw when reviewing the prior measure set and the other measures for inclusion, there's the self-direction amongst MLTSS members measure. Is there anything comparable outside of the IDDD group beyond that MLTSS measure? Because one concern I have is, though I think it's really important to have more information about the utilization of self-direction nationally, only capturing it for part of the population might be a pretty significant limitation.

Patricia Rowan:

So you are right, Damon, that the only measure being considered and voted on this year during this review process related to self-direction is this one from the NCI-IDD instrument. There may be others, other measures out there, but they were not suggested for addition or removal this year. Let's see. I see Eric's hand. Eric?

Eric Levey:

Yeah. Hi. So the first three are all related to being in a room in a residential setting. And I'm just wondering -- so these questions would only apply to people getting residential services and I don't know -- if you look at all the waivers, what percent are receiving in-home supports versus residential? And does it matter that we're not really asking similar questions or questions that would apply to people who are getting in-home supports, not in a -- you know, in an institutional facility type residential setting?

Patricia Rowan:

Yeah. Thanks. I think that's a good point. I appreciate it.

Eric Levey:

And the one other question I had and it got to it a little bit in the exclusions for these is when you're asking -- when you're surveying directly of the client, because it says it doesn't allow for proxies, how do you judge when the response is really not valid, meaning the person's cognitive abilities are really not good enough to even answer the question?

Patricia Rowan:

I see Steph Giordano has her hand raised. Rick, can we unmute Steph? Steph from HSR, I can respond on behalf of the measure steward. Go ahead, Steph.

Steph Giordano:

Thanks so much and thanks for the question. So I'll answer first, Eric, your first part of the question, which is about the percentage of people in the group setting. So the proportion of our sample for these items are relevant. And I will say, we somewhat share your concern here. So these questions are of the, I think, 20,000 or so participants. These are only relevant to just under a quarter of respondents. Certainly consider these important measures, but ones that are very much related to HCBS settings rules.

And so they really don't capture some of the broader pieces of choice and control for the entire population that is surveyed through NCI-AD. So again, to your point, about a quarter of respondents are able to answer these questions or these are applicable to about a quarter of respondents. We do have measures in place for both the AD and IDD surveys to ensure that surveyors are checking for cognition, essentially, before starting surveys. So we have -- we train all of our NCI surveyors and part of that training includes what we call proxy determination.

So determining whether the participant, person receiving services is able to answer questions on their own, or may need help, or may need somebody to answer on their behalf. And so that's something that's done at the beginning of the survey and throughout when it seems that the participants may not be able to respond to select questions. I would have to check again on these items for the AD survey, but I do not believe that a proxy can answer on the person's behalf for these questions. So if the person is unable to respond on their own, a proxy may not be able to respond on their behalf. Thanks.

Eric Levey:

Thank you.

Patricia Rowan:

Thank you, Steph. Let's see. I see Raina has her hand raised. Raina? Raina, you should be able to go ahead. You look unmuted to me, but we're not hearing you.

Raina Josberger:

Can you hear me? Can you hear me now?

Patricia Rowan:

Yeah. Now we can hear you.

Raina Josberger:

Okay, great. Sorry, it's the double-mute. I was also going to comment, similar to Eric, my concern on the three AD measures and being very limited to that group setting, which I know states can opt out of. So I'm just concerned about putting measures in there be very restricted to a certain population and not applicable across.

Patricia Rowan:

Thanks, Raina. I see Carolyn has her hand raised. Go ahead, Carolyn.

Carolyn Foster:

Thanks. I want to give the caveat that because I'm looking at this from a pediatric view and none of these -- our measures are actually from pediatric patients. So you can take my input with a grain of salt. But I wanted to highlight a prior speaker's point about the self-directed supports option. While I actually think self-directed supports are really important, depending on the state, for some families it's not really the best option, especially in pediatrics.

So I do worry a little bit about the percentage of -- depending on how I am reading the numerator and denominator to be understood could actually not necessarily reflect the desires of what people need and want even when the programs are available and do fit the need for some patients. So I just wanted to highlight agreement there. And then I realize we're -- the point of the discussion is primarily to be focusing on whether to approve particular measures, but you'll probably hear me referring to the same concerns that others have raised, where I think there's a large gap here in measures that reflect the larger population.

And then importantly, without the ability to have -- you know, I'm very concerned about the issue that the higher-level patients with IDD, or worse IDD, or in my situation, kids who by definition typically need a proxy. In some ways, they're most at risk for removal of control, right? They're the ones who are most at risk of not being able to express their needs. And so measures that don't capture their perspective or at risk of missing them, I just worry about the most -- potentially some of the most vulnerable patients' input not getting captured.

Patricia Rowan:

Thanks so much, Carolyn. I see Tara has her hand raised. Let's go next to Tara.

Tara Giberga:

All right. Yeah. I had a couple questions -- comments actually. The first one is related. I guess I got a little more into the weeds as far as the technical aspects and the ability for things to be interpreted differently, which makes it difficult to compare. So looking at NCI-AD percentage of people in group settings who are able to choose their roommate, you know, my mind went to there's several factors that could impact this measure and thus not make it a good choice for comparison. So for example, how an individual interprets the question, the availability of group settings and space within group settings, and one person's choice might conflict with others. For example, I choose you to be my roommate, but you don't want me to be your roommate. What if I don't want a roommate?

So all of those factors kind of came to mind as far as being able to use this as a good comparison measure. The other comment I had was related to the percentage of people who report staff do things the way they want them done, which is Number 6 on the screen. Again, I'm not sure that I agree this is a good measure for comparison. I have some concerns about how things are defined, or interpreted, or could be interpreted by the respondents, which represents issues with consistency within and across states. And then the last comment I have regarding this group of measures is related to RTC services and

supports self-determination index, which is the last one, Number 9 on the screen. In general, I have concerns about implementation. I think there are some good measures here. I just think implementation could be very painful and problematic.

But I have concerns about one of the combination scores that's included in the self-determination index, specifically who decides who your staff members are. With this being included in a composite score, again, because of staffing shortages that have been a challenge for years. For many states and the associated limitations to staff that are available, it seems unlikely that this particular survey question, at the provider level, allows for a state to have any real impact on performance improvement. So for this reason, I'm not sure that it's a good measure to use to compare state progress. And that was the last comment I had regarding this set of measures.

Patricia Rowan:

Thanks so much, Tara. We appreciate that. Let's see. I see Marci has her hand raised. Marci, you should be able to unmute.

Marci Kramer:

Morning. I have -- on the percentage of people who report there are rules about having friends or visitors at home, Number 4, I'm not sure that gives us helpful information because those rules may not allow reasonable times for visitors. So is it actually limiting access to visitors or are the times, you know, reasonable so that they can have the visitors that they want? So that's the only concern I have about that measure.

Patricia Rowan:

Thanks, Marci. I see Eric Carlson has his hand raised. Eric, you should be able to unmute. Go ahead.

Eric Carlson:

Thank you. I've got a handful of comments. I'm just going to start with the house rules and then go down real quickly. My comment on the house rules follows the previous comment. There may be -- what are these house rules? You can imagine one that's relatively benign and some others that are entirely the opposite. So I don't see it as that helpful, just a bare bones question of whether there are rules or not, you know, as the policy of the state is that there shouldn't be any rules whatsoever.

I'm not sure about that because again, there's -- it could be big differences in the sort of rules that might be imposed. Moving down to self-directed supports, my question there is whether this information might just be available from the Medicaid program administration itself. It's unclear to me why you would survey participants to get this information that I'm presuming would just be available through program administration. The surveying on whether people, participants believe the staff do the things they want where they want them done.

This kind of answer would be based on dozens, hundreds of interactions over the course of a year. I'm just not sure how actionable it is at the end of the day if you look at that percentage as a state or as a provider and are deciding on what action needs to be to be taken to address it. I'm not sure it's specific enough to be actionable in that way. And then skipping one and going to the RTC proposed measures, and this

would be my comment on -- I know there's plenty of them that we're going to be considering. I don't think I'll comment on the rest of them. Just this comment applies to all of them.

The same kind of comment that I'm not sure how actionable it is to look at a composite score. It's pulled from three questions and in some later instances, I forget, seven questions, 15 questions, a lot of inputs, and then getting a composite score. And looking at that, again, as a state and provider saying, what does this tell us to do? Whether they're -- if the number is 2.7, or 3.9, or whatever it might be, how is it actionable? What kind of message does it give? I'm not sure that it provides useful information in that way.

Patricia Rowan:

Thanks, Eric. I really appreciate your comments. I see Cathy also has her hand raised. Cathy, you should be able to unmute yourself. Go ahead.

Cathy Lerza:

Thank you. There have been a number of comments regarding measures not being, you know, covering the full population, and that's valid. I think it would be helpful to include when we're looking at these to include what federal regulation the measure fulfills and the population to which it applies. That would give us a lot more to go on. And then I also just wanted to comment that the wording of the measures certainly can't give us the degree of information needed to know exactly how to get it, what it all measures. So some of those concerns are just based on you can't tell it from the wording of a measure. And so it just requires more delving into and so, you know, the people that are accustomed to those measures will know more about what it really entails than anyone just looking at it for the first time.

Patricia Rowan:

Yeah, that's a fair point for sure. Thanks, Cathy. Deborah, are you able to come off mute? I see your hand raised.

Deborah Paone:

Yes. Thank you. I wanted to just affirm and agree with both Eric and Tara, who spoke. My concerns, I'm speaking now to the measures that relate to both the 21-item composite, so let me get the right name here, the personal choices and goals, self-determination index and the support self-determination index. Some of the same challenges they raised both about the methodological, the composite measures, what kind of information is actually actionable and the 21 items on the Self-Determination Index.

You know, all of it is good, but there are so many and there's I appreciate the work that has gone into that and the algorithm about, you know, the person's participant exercise of control and what they would prefer and how important it is. But it has so many variables impacting the results that I feel it would be very challenging to utilize this for action. So I think it may be not appropriate for a quality measure when one is trying to compare provider behavior or even across states. Thank you.

Patricia Rowan:

Thanks Deborah. Is anyone from the University of Minnesota on the line who would like to answer any of the operational questions about the RTC/OM measures? If so, please raise your hand. We're happy to give you a chance to respond. Or if there is anyone –

Renata Ticha:

This is Renata, I cannot respond, but two of my colleagues, Brian Abery and Alec Nyce are on the call, so they should feel free to respond.

Patricia Rowan:

Oh, yes. I see Brian raised his hand. Brian, go ahead. You should be able to unmute. Oh, you might have muted. Sorry. Try again. Unmuting. There we -- There we go. Try that.

Brian Abery:

Okay. I think I'm unmuted now.

Patricia Rowan:

We can hear you. Yep.

Brian Abery:

Okay. There were a couple of reasons behind the development of the measures as they currently exist. Number one, what we have found and what our colleagues at the University of Kansas, Mike Wehmeyer and Carrie Sjogren have found over the years is that self-determination tends to be pretty consistent across different kind of areas of life, so to speak.

So that in a residential setting especially where we have done most of our work, we find that looking at self-determination on an item by item basis or specific decision by decision basis, really doesn't provide any additional information. What we have found is very big differences between the levels of self-determination people are able to exercise when it comes to personal choices and goals in their life and services and supports. And that's why we broke it into two specific measures.

The other thing that I think is different about these measures and the reason why we have a Self-Determination Index is because current measures for the most part, only focused on the degree of control an individual has. And we have found through, again, 30 plus years of research both in our field and in other fields, that most people don't want to make all the decisions in their life by themselves. Sometimes they want to make them independently, sometime in conjunction with others.

Sometimes they want to voluntarily give up decision making kind of authority to another person who is trusted. And the Self-Determination Index takes that into account. Plus the fact that if we really want to look at the control somebody has over their life, we need to take into consideration the areas in which they find is important in life and want to have control over. And what we find is that the current measures that are out there fail to do that. Alec, would you like to speak a little bit about the index and how the index was developed?

Patricia Rowan:

Go ahead, Alec. You should be off mute now. Go ahead.

Alec Nyce:

Thank you. Can everybody hear me?

Patricia Rowan:

We can.

Alec Nyce:

Excellent. Thank you, Brian. The Self-Determination Index was developed as a discrepancy between what people's expected or desired level of control is, and their current level of practice control and that is weighted by the level of importance that the certain domain such as whether or not they have decisions over how they spend their personal money.

That is how that score is calculated. And we decided to use a composite score as this aligns with the gold standard of developing psychometric measures in the standards of psychological and educational measurement, which is published by the APA, the National Council on Measurement in Education, and other educational organizations. And this is why we developed the measure as a composite measure because this aligns with current best practices and any sort of composite measure development. And we find that one of the big benefits of this is that all measures of -- all items have some amount of measurement error associated with them.

And so, when we have a composite level measure, this allows us to quantify the amount of measurement error within a particular measure, and also allows for individualization across people for how they respond to the collection of items. And we're able to determine people that are lower on self-determination versus higher in self-determination. And it really allows for the identification of performance gaps on self-determination for individuals and allows providers to across time also track how individuals are doing on self-determination and whether or not certain policies, certain practices, and whether individuals can improve in self-determination over time.

Patricia Rowan:

Thank you, Alec and Brian, we appreciate that. Let's see. I -- Carolyn Foster, I saw you had a hand raised earlier, was there anything you wanted to add or other questions you had?

Carolyn Foster:

Thanks. I was listening, trying to listen carefully to the measure experts, so thanks for sharing that. I was trying to understand, because I'm sympathetic to the prior comments around the personal choice and goals may be very far removed from what states can be actioned on, have action on. And wondered, I just wanted to clarify I was trying to look in the technical documents. I assume the services and supports can be separated from the personal choices and goals.

That's why we're voting on them separately. I ask that because I do think the services and supports are a little more directly within control of what someone may have access to or oversee. I wondered if the --

just want to confirm that. It still seems also very focused on inpatients, and not people living in the community. So I think it's the same, I just want to make a comment, it's the same sort of challenge I think we have are the first three where a lot of the available measures are primarily focused on people living in institutions.

Patricia Rowan:

Thanks, Carolyn. Brian has his hand raised. Let's let Brian respond to Carolyn's question. Rick, if you can unmute. Yep, go ahead, Brian.

Brian Abery:

Yes. The two are able to be looked at separately. That was the intent. None of the individuals who took part in either the piloting or the actual field study were in institutions. They were all individuals who were receiving home and community-based services within the community.

Carolyn Foster:

Oh, thanks. Thanks for clarifying that. That's helpful.

Brian Abery:

Yes, some of those individuals lived on their own. Some of those individuals lived in a kind of small community residential settings, but none of them lived in institutional settings.

Carolyn Foster:

Thanks.

Patricia Rowan:

Thanks Brian. Renata, I see your hand raised. Go ahead.

Renata Ticha:

Yeah, so I think I was allowed to respond. So actually it's just following up on Brian's response that we actually discussed with our project officer when we were developing the measures, whether we could also have a sub-sample of more congregate settings, and they told us we could not. And so, all of the measures were tested and developed specifically for HCBS community-based settings. That's one thing I'm going to say. And also, I'm just going to make a remark that we specifically follow the NQF domains and subdomains as revised by our stakeholder input. And so, the measures can be mapped onto the specific NQF domains.

Patricia Rowan:

Great. Thanks Renata. Damon, I see you have your hand up.

Damon Terzaghi:

Just a quick clarification question because I didn't see it in the specification center on beforehand. Are the RTC measures proprietary and is there a fee involved in utilizing them or are they available publicly?

Patricia Rowan:

Rick, can you unmute Brian?

Brian Abery:

Yes, they are not proprietary. They are meant to be essentially given out and used publicly. We want to make sure of course that individuals have the necessary training to administer, analyze, and interpret the data. But again our research and training centers full kind of six years of work was meant to develop measures that could be used at the provider level that we could essentially give away for free.

Damon Terzaghi:

Thank you. I appreciate that. And then I had one other very quick comment, which is, we kind of moved away from this discussion, but the earlier one about individuals in group settings and some of the concern about the limited scope of the population incorporated in that. I understand that, but when we think about some of the regulatory framework that these measures are operating under and the specific applicability to the HCBS settings rule and some of the criteria that are established for residential settings, I think that those NCI-AD measures are pretty important to ascertain compliance.

Patricia Rowan:

Thanks, Damon. Amanda.

Amanda Yanez:

Hi. Nothing specific to the measures that hasn't already been said. That's why I've been quiet so far. But I did want to kind of just touch base on my thoughts on what Damon just said, because I do understand that perhaps the purpose of including those is that they align with the HCBS settings requirements and the final rule. However, I feel like most states are already collecting data on that and doing measurements for that just as far as the compliance piece and if we want to get to real quality versus compliance, some of those other pieces as far as members having access and information about the services and are in safe environments are more prevalent questions from a quality perspective, just my view.

Patricia Rowan:

Thanks, Amanda. Are there comments or questions from work group members on the measures within the choice and control domain? Eric, if you don't mind coming off mute and sharing your comment. Just for the public attendees, since not everybody sees the chat.

Eric Carlson:

Thanks. I just wanted to communicate my agreement with the point that it's appropriate to have some measures that are specific to the congregate residential settings. I understand that that's a subset of the population, but that's a non-trivial, important subset of the population. And those measures are focused on measuring compliance with the studies role to a certain extent. And I don't know if there is likely in a state another method of measuring what the reality is in those settings. So I support those measures that are focusing on that subpopulation.

Patricia Rowan:

Thanks Eric. Any other questions or comments from the work group on these measures? All right, well, we are actually doing really well on time, so, you know, if you have other questions or anything, now it's a good time to ask them. Otherwise, we'll move into a public comment period on these measures. All right. I do not see any other hands raised from the work group members. So oh, Raina, go ahead.

Raina Josberger:

Hi, sorry. I just wanted to follow up on that last comment around the group setting AD measures. I -- and it's more for the measure steward for the NCI-AD group. Those measures, even if they were not chosen to be part of an HCBS measures they would still be included in the standard reporting, right? Be available to states as standard measures?

Patricia Rowan:

Rosa. Can we take Rosa off of mute? Go ahead Rosa, do you want to respond to that one?

Rosa:

Yeah, and I did want to respond from earlier. Those are not available by proxy. I did double check. So Steph was correct when she said that she thought that, but yes, those are part of the full survey. They're not opt out questions.

Raina Josberger:

Okay, great. Thanks Rosa.

Rosa:

Thanks Raina.

Patricia Rowan:

So states that do the survey would still receive that information even if it's not included in the HCBS Quality Measure Set?

Raina Josberger:

Right. Right. Yeah. Thank you.

Patricia Rowan:

Great. All right, let's see. Deb, can we move on to slide 41. At this point we would like to provide an opportunity for public comment on the measures within the choice and control domain. So similar to how we've been doing it. If members of the public would like to raise their hand in Webex and make a comment on any of these measures, we will be able to bring you off mute. Once you're done making your comment, please lower your hand. And when you do come off mute, please introduce yourself and share your organizational affiliation as well as the specific measure you are commenting on. So I see Camille Dobson has her hand raised. Rick, can we unmute Camille? Go ahead, Camille.

Camille Dobson:

Yeah. Hi, good morning. This is Camille Dobson. I'm the Deputy Executive Director of Advancing States. We are the membership association for the state agencies that deliver home and community-based services for older adults and people with physical disabilities. And I speak today not as the measure steward, but as our role as supporting states in delivering high quality and effective home and community-based services. And I wanted to provide just a little bit of context and also some comments of reiterating I think some of the statements that were made around the potential additions, the one, two, and three to the NCI-AD portion of the quality measure set.

The measure set was originally developed in collaboration between CMS and the states in order to maximize the usability of quality measures. Not just for public reporting and quality measurement, but also to help states meet their compliance requirements under the 1915(c) waiver assurances. And so, the measure set was put together with dual purposes in mind. And if you read the SMD that released the quality measure set in 2022, you will see that they are actually arranged by waiver assurance to show where they would be widely applicable.

So we are focused on really outcome-based, quality-based measures that would help show the effectiveness and the quality of HCBS services. And NCI-AD, those three that were suggested are really focused on the HCBS settings rule compliance, which is important, but has applicability and availability for the states to use as a way to measure how they're doing in terms of the HCBS settings rule, but doesn't add much in general to assessing the overall quality of the HCBS system in the state. Thank you.

Patricia Rowan:

Thanks, Camille. I see Rosa has her hand raised. Can we unmute Rosa? Go ahead.

Rosa:

That was a mistake. I just forgot to put it down. Thanks though.

Patricia Rowan:

No problem. And Sarah, are there any other meeting attendees, members of the public who would like to make comments about any of the measures within the choice and control domain? Any other questions or comments from work group members before -- oh, I see Andrew Greer has a hand raised. Rick, can we unmute Andrew? Go ahead. Andrew.

Andrew Greer:

Can you hear me?

Patricia Rowan:

We can, yes. Please introduce yourself if you don't mind.

Andrew Greer:

Hi, Andrew Greer, I'm the Senior Policy Analyst at the Virginia Department of Medical Assistance Services. I've got a question I guess in trying to understand the intent of how states can use the NCI-IDD measure the Percentage of People Reported to Be Using a Self-Directed Supports Option. Looking at it from as the

commenter from advancing states brought up, looking at it from like a 1915(c) perspective, is it intended to say that if the percentage of individuals who are using self-directed supports is low, that that means the state is out of compliance in some sort of way?

Patricia Rowan:

Thanks for that question, Andrew. Rosa, do you want to take that one or someone from, or maybe that's Dorothy actually. Yeah. Can we unmute Dorothy, Rick? Go ahead Dorothy.

Dorothy:

I'm sorry. I actually don't have an answer for that because it's true there is such variability in the self-directed programs that it is -- I'm not sure that that measure is appropriate to be used as a quality measure. But I would like whoever -- if there is the person who proposed this to be used as part of the Quality Measure Set, I would appreciate them to weigh in.

Patricia Rowan:

Thanks Dorothy. I see Camille has a hand raised again or actually Deborah. Okay. We'll go to Camille first and I'll go to Deborah.

Camille Dobson:

Yeah. Hi Tricia. I just was responding to Andrew's question. It is not –

Patricia Rowan:

Yeah, go for it.

Camille Dobson:

It is the percentage of people who are self-directing, report as self-directing is not a piece of data that CMS collects in any of their 1915(c) waiver assurances. States may offer it potentially if they want to, but it's not something that CMS looks at since it's a program characteristic. And states have the option of offering self-direction or not. So not something we would see from that perspective.

Patricia Rowan:

Thanks, Camille. I appreciate your response. Deborah, go ahead.

Deborah Paone:

Well, I didn't know if you needed me to say that again, but that's what I had said in the beginning. This doesn't appear to raise to the level of a quality measure, because there's such variability of states using self-directed supports and how they do and what they cover. So I think it's a great piece of information, but it doesn't rise to that level.

Patricia Rowan:

Thanks Deborah. Any other comments from members of the public? I see Matt has a hand raised, go ahead, Matt.

Matt Crandall:

Yes. Oops. Can everyone hear me?

Patricia Rowan:

Yes, we can hear you.

Matt Crandall:

Awesome. Thank you. Just a comment on the RTC/OM measures. And this has kind of already been stated before, but I just want to add and confirm that I agree with this. When we're looking at those performance measures or potentially adding them to the HCBS Measure Set, one of the questions I always ask when we collect data is, okay then what? What do we do with the data? I think that the questions are valuable, but I'm not sure about the states being a vehicle or an avenue to collect that and require us to report on it. Because as a state, you know, what is our actionable items with that data? What can we do?

I mean, sure we have like supportive employment, companion services that kind of address somewhat of those, but like for instance, looking at experiences, seeking employment, in the definition it talks about promotion opportunities and those sorts of things. And we want to give the participants the skills to be able to go after those. But we also aren't in control of those either. And so if a participant is feeling frustrated about being promoted, you know, as a state we can't exactly force employees for more individuals. And I know that's kind of a rough example, but just want to throw that out there. Something for us to consider is consider adding these.

Patricia Rowan:

Matt, we appreciate your perspective. I see Rosa has a hand raised. Rick, can we unmute again? Sorry, we might be double muting.

Rosa:

The double muting is so dangerous. Yeah. Oh, thanks for just clarifying who Matt was. I wasn't sure who Matt was who was speaking, so I just appreciate you clarifying that afterwards.

Patricia Rowan:

Let's see. Matt, can you raise your hand again? I know you said Wyoming.

Matt Crandall:

Yeah, so my name is Matt Crandall. I am the Policy and Communications Unit Manager here for the state of Wyoming for our HCBS section.

Patricia Rowan:

Thanks. We appreciate that, Matt. I see a hand raised from Renata. Renata, do you want to go ahead?

Renata Ticha:

Yes, thank you. I just wanted to respond to Matt's comment. While you are correct that our measures were developed for providers as our target population well, target population, the people they serve,

obviously. One of the intents behind the measures are that the data from providers in each state can be aggregated and shared with the state specifically for the quality of the different domains under NQF.

Patricia Rowan:

Thanks, Renata. All right, before we move into voting on these measures, are there any final comments from work group members or members of the public on these measures? All right, I am not seeing any hands raised. So let's move into the voting process. Denesha is going to bring up the Slido, and while we are changing the screen, I just want to reiterate that only work group members on the official work group roster are eligible to vote. We appreciate everyone's interest and engagement, but only the 25 folks who were listed on the roster at the beginning of the slides are eligible to submit votes. We encourage other members who are attending the meeting to share your perspective during the public comment period like many folks just did. So thank you.

Denesha, do you want to bring up the Slido? Here we go. And work group members, while we're doing that, if you want to kind of navigate over to your Slido, we are going to walk through each of the votes. So as I mentioned before, we'll vote on each individual measure separately. So notes, here we go. All right. The first vote that we'll be taking is, should the NCI-AD Percentage of People in Group Settings Who Are Able to Choose Their Roommate measure be added to the HCBS Quality Measure Set? The options are, yes, I recommend adding the measure or no, I do not recommend adding the measure. Voting is now open, and if the question does not appear on your voting page, please refresh your browser.

Patricia Rowan:

And Deborah, I see that you're still here. I assume you're going to submit your own votes, but feel free to come off mute if you need me to do it.

Deborah Paone:

No, I'm here so I'm doing it.

Patricia Rowan:

Perfect, perfect. All right. I think we are expecting 23 votes because we have, I have not seen Misty or Dennis join yet, so we are expecting 23 votes, and I think that's what we've got. So let's close the voting and share the results. All right. So 52% of the work group voted yes to recommend adding the measure to the HCBS Quality Measure Set. That does not meet our threshold for recommendation. As a reminder, two thirds of the work group must vote in favor in order for it to meet the threshold for recommendation. So the NCI-AD Percentage of People in Group Settings Who Are Able to Choose Their Roommate measure is not recommended by the work group for addition to the HCBS Quality Measure Set.

Let's move on to the next vote. The next vote is for should the NCI-AD Percentage of People in Group Settings Who Are Able to Furnish and Decorate Their Room However They Want To measure be added to the HCBS Quality Measure Set? And the options, again, are yes, I recommend adding this measure to the HCBS Quality Measure Set and no, I do not recommend adding this measure. Voting is open. All right, we are expecting 23 votes and we have 23. Let's close the voting and share the results.

All right, 61% of the work group voted yes, I recommend adding the measure to the Quality Measure Set. That does not meet our threshold for recommendation. So the NCI-AD Percentage of People in Group Settings Who Are Able to Furnish and Decorate Their Room However They Want To measure, is not recommended for addition to the HCBS Quality Measure Set. Let's move on to the third vote.

A third vote is, should the NCI-AD Percentage of People in Group Settings Who Are Able to Lock the Door to Their Room measure be added to the Quality Measure Set? Again, the options are yes, I recommend adding the measure or no, I do not recommend adding the measure. Okay, we're expecting 23 votes, we've got 22. Our team is just going to take a look at what we've got. I think Carolyn might be missing your measure. There we go.

Carolyn Foster:

Oh, okay. Sorry. No pressure.

Patricia Rowan:

All right, let's lock the voting and share the results. All right, 65%, we're getting closer, but that does not quite meet our two thirds 66% threshold for being recommended. So the NCI-AD percentage of people in group settings who are able to lock their room measure is not recommended by the work group. All right, let's go to the next one. All right, now we're moving on to the NCI-IDD measure Percentage of People who Report That There Are Rules About Having Friends or Visitors at Home. Again, the options are yes, I recommend adding this measure or no, I do not recommend adding this measure and voting should be open. All right, we're expecting 23 votes and we see 23. So we will close the voting and share the results.

For this one, 30% of work group members voted yes. That does not meet our threshold for recommendations. So the NCI-IDD Percentage of People who Report That There Are Rules About Having Friends or Visitors at Home measure is not recommended by the work group for addition to the HCBS Quality Measure Set. Moving on. Y'all are like rock stars at this. I'm so impressed. The next measure is, should the NCI-IDD Percentage of People Reported to Be Using a Self-Directed Supports Option measure be added to the HCBS Quality Measure Set? The options are, yes, I recommend adding this measure or no, I do not recommend adding this measure. And voting should be open now.

All right, we hit our 23 votes that we are expecting, so we will lock the voting and share the results. For this one 13% of work group members voted yes, that does not meet our threshold for recommendation. So the NCI-IDD percentage of people reported to be using self-directed supports option measure is not recommended by the work group for addition to the HCBS Quality Measure Set. Moving on, the next one. The next question is, should the NCI-IDD Percentage of People who Report Staff Do Things the Way They Want Them Done measures should be added to the HCBS Quality Measure Set?

Again, the options are yes, I recommend adding the measure or no, I do not recommend adding the measure, and voting is now open. All right, we can go ahead and lock the vote. Share the results. All right, 52% of the work group voted yes, that does not meet our threshold for recommendations. So the NCI-IDD Percentage of People who Report Staff Do Things the Way They Want Them Done measure is not recommended by the work group for addition to the HCBS Quality Measure Set. Next slide.

The next one is, should the NCI-IDD Percentage of People Who Report That They Know Whom to Talk to if They Want to Change Services whether or not it should be added to the measure set? The options again are yes, I recommend adding or no, I do not recommend adding, and voting is open. All right, we're at 23 votes and we will lock and share the results. This one, 87% of the work group voted yes, that does meet our threshold for recommendation.

So the NCI-IDD Percentage of People Who Report That They Know Whom to Talk to if They Want to Change Services measure is recommended by the work group for addition to the HCBS Quality Measure Set. All right, moving on to the next two measures. The next question is, should the RTC/OM: Personal Choices and Goals Self-Determination Index measure be added to the HCBS Quality Measure Set? Again, the options are yes, I recommend adding or no, I do not recommend adding.

For this one, we're expecting 21 votes because Joe and Renata have recused themselves for voting on these measures. All right, we are at 21. So let's lock the vote. 29% of the work group voted yes, that does not meet our threshold for recommendation. So the RTC/OM: Personal Choices and Goals Self-Determination Index measure is not recommended by the work group for addition. And now we'll move on to the final vote in this domain. Should the RTC/OM: Services and Supports Self-Determination Index measure be added to the HCBS Quality Measure Set? Options here are, yes, I recommend adding or no, I do not recommend adding. Again, here for this one, we're expecting 21 votes.

All right, we can lock the voting and share the results. For this one, 33% of work group members voted yes. That does not meet our threshold for recommendation. So the RTC/OM: Services and Supports Self-Determination Index measure is not recommended by the work group for addition to the HCBS Quality Measure Set. All right, good job everybody for using the technology. I have been doing these sorts of meetings for several years now and I don't think we've ever had such smooth voting for the first time out of the gate. So really appreciate work group members you being prepared and working with our team to submit those votes. Thanks so much.

Let's go back to the slides. And we can, I think now skip to slide 52. So we are at the point in our agenda where we are going to take our first break. We're a little bit ahead of schedule, so our first break was supposed to be until 1:30 Eastern. We generally do like to stay on our agenda with the breaks because we know that some folks join at certain times during the day to discuss specific measures or measure stewards, for example, join at certain times in the day. So I think what I'm going to do is let's keep the break as it was advertised and return at 1:30 Eastern Time. That gives you a little bit longer of a break if you want to eat some lunch, or go for a walk, or anything like that. Also gives our team a little bit of time to just regroup and make any adjustments we need to, to the technology.

So if any members of the work group are having any issues with any of the technology, we will be here. Send us a note in the Q&A or just come off mute. Otherwise, you can stay connected to the meeting and we'll just resume at 1:30 Eastern Time. Now that's in about 45 minutes, so thanks everybody. We'll talk again soon.

Deb Haimowitz:

To be cognizant of time, we'll be moving on to our next domain. So onto our next Domain: Consumer Leadership and Development. There was one measure suggested for addition to the HCBS Quality

Measure Set in this domain and none suggested for removal. The measure suggested for addition in this domain is also an RTC/OM measure.

This one is RTC/OM: System Supports Meaningful Consumer Involvement which evaluates the extent to which the organization providing HCBS and or the HCBS system as a whole provides opportunities for leadership and supports the HCBS recipient to be involved in the design and improvement of HCBS. We will now invite discussion from the work group members about the measure suggested for addition in the consumer leadership and development domain. You may raise your hand if you wish to speak. We will call your name and unmute you when it is your turn. Please remember to say your name before making your comment. And I'll now turn it over to Tricia to facilitate the work group discussion.

Patricia Rowan:

Thanks, Deb. Why don't we go back to the previous slide with the details on this measure and we'll take any comments or suggestions questions from the work group on this measure. Go ahead and use the raise hand feature again. I see Tara.

Tara Giberga:

Good afternoon. Hope everyone enjoyed their lunch. I have mixed comments about this measure. I really like it. But, you know, as we spoke about earlier, this morning regarding some of the other measures with the RTC/OM, I have some concerns about the challenges to implement it and the actionability of it, but again, I really do like the measure. It's a 10-item composite score. But also, some of the additional challenges I see are related to -- I'm a little concerned about the limited testing, the field study only included three states.

But on the flip side, again, I really like the measure because I do think the measure set does not currently include anything related to meaningful consumer involvement and effective service delivery in HCBS should be prioritized with meaningful involvement of recipients to improve the service. I 100% agree with that. It's that the whole backbone of quality is defined by the people receiving or using the goods and services. And so mixed comments there regarding this measure.

Patricia Rowan:

Thanks Tara. Damon.

Damon Terzaghi:

The one question I had was in the kind of technical information we were sent beforehand. It appears that this is largely assessed at the provider level, but there's kind of a comment about it could be assessed at a statewide level with appropriate technical assistance. I'm just curious how that would apply given kind of how the questions really do seem to be provider-focused or at least focused on the provider of services. You know, as with the previous commenter, I really like the measure and I really support the idea of assessing and improving consumer involvement in the control of services. I'm just kind of wondering from a systemic standpoint, if we're looking at including this in the Quality Measure Set, how it would be applied to the broader state system.

Patricia Rowan:

Damon, I think that's a great question. I don't know if we still have Brian or Alec from the University of Minnesota, if either of you want to respond with your thoughts on how data would get from the providers that administer the instrument and be aggregated for state level reporting in the HCBS Quality Measure Set. Or also, I know Renata, if you'd like to comment on that as well, you can go ahead and come off mute. Go ahead.

Renata Ticha:

Yes. Yeah, thank you for the question. And as I think we mentioned when we discussed the previous domain of measures, we were specifically tasked to develop these measures for provider levels, because that's where was the biggest gap as seen by the funder. That said, we designed the scoring of all of our measures to be able to be aggregated and compared across providers within a state. And so the aggregate scores would be the ones used at the state level to report on the level of consumer involvement in system supports. I'm not sure if my colleagues Brian or Alec want to add anything.

Patricia Rowan:

Yeah, Brian or Alec, if you're still here and want to add anything, feel free to raise your hand and we'll bring you off mute. Okay. I see Alec. Rick, go ahead and unmute. Go ahead Alec.

Alec Nyce:

Thank you. I just wanted to say that I think Renata explained it very well. These are definitely scores that were originally developed for the provider, but these can easily be adapted to reporting at the state level as well. Is just depends on how states would like to use the measure and aggregate the scores, but I think Renata summed it up very well.

Patricia Rowan:

Thanks, Alec. Other comments or questions on this measure? All right, well this is the only measure in this domain that we are discussing. So at this point we can move in and invite any public comment on the measure for discussion in the consumer leadership and development domain. So if there are any other members of the public who would like to make a comment or ask a question about the RTC/OM System Supports Meaningful Consumer Involvement measure we can go ahead and do that now. I am not seeing any hands raised for public comment. Any other comments or questions from work group members? Otherwise, we will move on and vote on this measure.

All right, why don't we move on to voting. I'll have Denesha bring up the Slido and work group members you should be able to log back in to Slido the same way you had before to submit votes. All right, so we just have one measure to vote on in this domain. It is the RTC/OM System Supports Meaningful Consumer Involvement measure whether it should be added? The options are yes, I recommend adding or no, I do not. Voting is open. Deborah, I saw you had your hand up. Did you have a question or did you want to add a comment about this measure?

Deborah Paone:

Sorry. No I just had difficulty working the Slido, but sorry, it's working now. Thank you.

Patricia Rowan:

Is it working? Okay, good. Glad to hear it. So for this measure, we are expecting 21 votes. Again, Joe and Renata are recused from voting on the RTC/OM measures. So I think we are at 21. We can go ahead and lock the voting and share the results. So 43% of the work group voted yes, which does not meet our threshold for recommendation. So the RTC/OM System Supports Meaningful Consumer Involvement measure is not recommended by the work group for addition. We are going to move on to our next domain. Measures in the System Performance and Accountability domain. So we'll go to slide 59. And I am going to hand it to my colleague, Kanch to take us through these next few measures.

Kanchana Bhat:

Thanks Tricia. So now we're going to talk about our next domain, the System Performance and Accountability domain. There was one measure suggested for removal and one measure suggested for addition to the HCBS Quality Measure Set for this domain. Since this is our first domain with a measure suggested for removal, we'll begin by discussing the measure suggested for removal, and then we'll move on to the measure suggested for addition. Next slide.

The measure suggested for removal from this domain is the Fee For Service LTSS/Managed LTSS-7 Minimizing Facility Length of Stay measure. This is an administrative measure stewarded by CMS, which calculates the proportion of admissions to facility among LTSS participants, 18 and older that result in successful discharge to the community within 100 days of admission. There are both fee for service and managed care specifications for this measure. Next slide.

We're now going to invite discussion from the work group members about the measures suggested for removal in the System and Performance and Accountability domain. You may raise your hand if you wish to speak. We'll call on your name and unmute you so you can speak up. And please remember to say your name before making your comment and indicate which measure you're referring to if your comment is specific to the measure. And I'm going to ask Tricia to facilitate the discussion.

Patricia Rowan:

Yeah, thanks, Kanchana. Thanks for going back to the previous slide. So this is the minimizing facility length of stay measure. We'll start with work group discussion on this measure.

Patricia Rowan:

Dawn.

Dawn Rudolph:

Hi, it's Dawn Rudolph. I have a question about this one, being the LTSS-7 measure. In one of the responses, the person who suggested the measure be removed indicated that it wouldn't leave a gap because the LTSS-8 measure would address similarly, but as I look at the LTSS-8 measure, that measure specifies nursing facilities and ICF-ID facilities, where this LTSS-7 does not specify or limit the facility. And I think my specific question is whether by not limiting the facility it opens the opportunity for the state to measure length of stays at other facilities like psychiatric hospitals. And I wouldn't want that to not be measured if that is currently being collected by this measure.

Patricia Rowan:

Is Mary Botticelli from CMS on the line? Mary, are you able to answer that question about the types of facilities that are included in this measure? Rick, can we unmute Mary?

Patricia Rowan:

Mary, go ahead.

Mary Botticelli:

I'm Mary Botticelli from CMS and I -- and indistinct: related to the LTSS measures. So the first thing that I wanted to say is that MLTSS-7 and MLTSS-8 do look at different features, right, in terms of facilities. And so for the definition of facilities -- sorry, I'm paging through my document so I can make sure that I note what's exactly in the specifications. There are LTSS technical specifications that identify this. They're provided in nursing facilities ICFs and IDDs, hospitals and hospitals and nursing facilities, furnishing inpatient psychiatric hospital services for individuals under 21 and institutes for mental disease, IMDs. And then facilities for individuals 65 and older. Did that answer your question, Dawn?

Dawn Rudolph:

So all of those facilities that you just named are included in this LTSS-7?

Mary Botticelli:

Right. Yeah.

Dawn Rudolph:

Okay. So it is broader than the LTSS-8 that was mentioned by somebody who had recommended it for removal?

Mary Botticelli:

Right.

Dawn Rudolph:

I like the broadness of it. Thank you for clarifying.

Mary Botticelli:

Sure.

Patricia Rowan:

Thank you, Dawn. And thank you, Mary. Eric Levey, I see you have your hand up.

Eric Levey:

Yeah, I was just going to ask the speaker from CMS what's been the experience with the measure so far? Does it -- you know, are people happy with it? Has it shown trends? Have people been able to use it to assess quality and think about improvement?

Mary Botticelli:

So currently, all the measures on the HCBS Quality Measure Set are voluntary. And so there are, you know, there are some states that we can assume are using the LTSS, Long-Term Services and Supports or Fee For Service LTSS and MLTSS measure and as well as the measure number six and eight, which I'll use administrative data. But we don't collect that information at this point because the measure set is voluntary. In last year, the Medicaid access rule was, I'm sure you all know was passed as legislation. And so the HCBS Measure Set was part of that and states, you know, will be required to report on the measures in the HCBS Measure Set. All states beginning in 2028 based on the measures that are in the measure set.

As well, the money follows the person demonstration program states have a term, you know, term to start reporting earlier on the HCBS Measure Set at the end of starting in September of 2026. And so these measures are, you know, are currently on the measure set. We're looking at them now as to whether to continue them on the measure set. Because they are claims measures, CMS has actually been working to prepare them for being able to be collected by CMS on behalf of the states. So the reporting, you know, for the measures in the HCBS measure set are at the state level by CMS directly for the states, if the state chooses to have CMS report them.

Eric Levey:

Thank you.

Patricia Rowan:

I see Cathy has her hand raised. Cathy?

Cathy Lerza:

Yeah, and I had my hand raised before that person from CMS was speaking. But what I wanted to bring up is that currently this measure is one of the ones that is stated that must be reported for money follows the person's states. And the reporting is next year, but for this year's data.

Patricia Rowan:

That's right, using calendar year 2025 data and reporting in 2026.

Cathy Lerza:

And so if this is removed, what happens with that requirement?

Patricia Rowan:

These -- I mean, ultimately that's a CMS call, but these recommendations are voting to make recommendations for the 2028 quality measure set. ShaRhonda has her hand raised. ShaRhonda, did you want to mention anything about this measure? Go ahead.

ShaRhonda Sly:

Thank you. Is CMS able to address the concern that people have noted about the lack of influence for those that are dually eligible and the short-term nursing facility stays that are typically covered by Medicare, like, and how that intersects with this measure requirement?

Patricia Rowan:

Mary, is that something you're able to respond to?

Mary Botticelli:

So LTSS, you know, it looks for a higher proportion of discharges to the community for two or more months, basically, within three months of admission. And so it looks actually at the length of stay when the participant is in the facility. And so -- and you're right, ShaRhonda, you know, there are Medicaid recipients who are dual-eligible. And so the difference between this one and fee-for-service LTSS-8 is that it looks for, you know, scores to be higher, which would equate to better performance from the states.

Because there's a higher proportion of successful transitions to the community for 60 or more days for two months -- around two months or more. So you know, this is specifically looking for, you know, on the managed care side, for the MLTSS measures, you'd be looking at the managed care plan and, you know, the participants in there who receive LTSS. And then for fee-for-service, it would be the state, you know, fee-for-service LTSS system. So were you referencing the difficulty with obtaining the information on the dual-eligible members?

ShaRhonda Sly:

So the concern that was noted is that individuals who are dually eligible by Medicaid and Medicare, short-term facility stays of up to 100 days following an acute hospitalization are covered and coordinated by Medicare, not Medicaid. So I think the concern is that states -- since this is a quality measure that we have set thresholds for, that circumstances out of the influence of the state or the managed care plan's ability to decrease that length of stay are -- could potentially pull what looks like compliance numbers down for something that there is no level of influence over. Does that make sense?

Mary Botticelli:

Right, yeah. Yeah. And so the LTSS measure focuses on discharges within 100 days because the emissions, you know, lasting longer than 100 days, that's generally when folks are moving into more long-term care. And especially, you know, participants who are dually eligible for Medicare and Medicaid, they -- you know, they potentially could lose their community housing, along with other folks, you know, who aren't duals, making it more difficult for them to return to the community. That's why the -- you know, that's how the measure is specified.

Patricia Rowan:

Thank you. Carolyn?

Carolyn Foster:

Hi, thanks so much. I just wanted to clarify, I think a former speaker had -- when they were talking about the differences between the measure that's already in existence versus this one for removal, made a distinction, and I want to make sure I understood. Because they mentioned that it would allow for inclusion of facilities that are doing mental health for patients under 21. And when I read the technical measure difference, it looked like they were both 18 and older. And that's important because I would want to make a potentially different decision if I understood those technical requirements differently. Because

there's so rarely measures that actually get at the length of stay, especially for mental health for kids, that I was hoping you could just confirm that I heard correctly.

Mary Botticelli:

So the -- you mean the definition of facility?

Carolyn Foster:

Well, yeah, but the measure is only applying to patients 18 and older. So it's only those kids from 19, 20, 21. That's really the only group that's being captured, right? It's not –

Mary Botticelli:

Right, yes. Yeah.

Carolyn Foster:

Okay. I just -- I'm going to keep saying this, but I just want to continue to call out the immense deficit. And the fact that there's really, from what I can tell, looking at a lot of the technical requirements of these, no real reason that we can't look at lower ages. I understand that's not an issue here, but I just want to call that out.

Mary Botticelli:

Thank you, Carolyn.

Patricia Rowan:

Joe?

Joe Caldwell:

Yeah, I just wanted to say I think this is an important measure, an important concept. And I think it is very different than the MLTSS-8 and Fee-for-Service-8. That has to do with kind of, you know, long-term stays and rebalancing, and getting people out of nursing homes and other institutions. Whereas this one, you know, really is targeting the short-term stay and making sure people, you know, don't turn into, you know, a long-term institutional placement. And I think there's definitely a role that HCBS systems and states should play in achieving this. So I think it's a good measure. And so I'm against removal.

Patricia Rowan:

Thank you, Joe. Jason?

Jason Rachel:

So my perspective real quick, just to circle back on the comment that was originally made in our documentation around duals and not having the Medicaid agency or HCBS not having, kind of, control over that. And I don't -- I think my read of this measure is that that's not what it's -- it's not measuring the number of transitions from facilities of under 100 days. It's saying when there is a transition of a state between 60 and 100 days, that there's a successful discharge defined as remaining in the community for 60 days. And that, in my mind, is 100% the control of the HCBS Medicaid program in developing both the

bridge to transition, and then commencing those waiver services, or those HCBS services quickly and effectively that meets that member's needs.

So that they can, again, as this measure reads, successfully reside in the community for 60 days. Because in a lot of these short-term stays, dual or otherwise, they're going to need HCBS services after that short-term rehab stay. And again, I feel that that -- I would just want to be, as my read of it, that that is in control of the Medicaid agency and the HCBS system as a whole. Again, to develop processes, be it either through the fee-for-service system or the managed care system, that can establish and commence services quickly. And that those are meeting the needs of that individual, especially during that critical time of, you know, recently being discharged from short-term rehab stay. So I just wanted to note that. So thank you very much.

Patricia Rowan:

Thanks, Jason. Mary, did you want to respond to that?

Mary Botticelli:

I didn't have anything more to say.

Patricia Rowan:

Okay.

Mary Botticelli:

Related to that. Thank you.

Patricia Rowan:

Yep. Damon?

Damon Terzaghi:

Yeah, I raised my hand during the discussion of dual eligibles as well. And I would just agree with what Joe and Jason were discussing, that you really do need to have that robust community-based services system in place, as well as access to services and supports to facilitate transition. So regardless of if an individual is a dual eligible or not, there's a really important role that this measure plays in assessing the participant experience. And I guess I would just be concerned if we start, kind of, saying, oh, because that person is on Medicare, it's not the state's responsibility. Because that kind of minimizes the individual based upon administrative bureaucratic constraints. And I don't think that's what these quality measures are intended to do. Particularly with this one where there is a very defined and specific role of the state home and community-based services system in supporting it.

Patricia Rowan:

Thanks, Damon. Eric Carlson.

Eric Carlson:

Thanks. I just have a question looking at the technical specifications, the item about continuous enrollment period. People in this measure, participants receiving Medicaid LTSS on the facility admission

date. So does that include people who just start receiving Medicaid funded LTSS when they have their first day of nursing facility care? Or is it limited to people who are existing LTSS participants in the community prior to the admission to the facility?

Patricia Rowan:

Mary, do you want to respond to that?

Mary Botticelli:

Yes. Yeah, so the continuous enrollment element relates to how long the person, you know, needs to be -- participate in LTSS in the managed care plan or in the state's fee-for-service delivery system. And so for MLTSS-7, I'm trying to look to see if there -- it was specifically specified in there what the continuous enrollment criteria is, or you were referring to the continuous enrollment criteria that is, you know, included for all of the measures.

Patricia Rowan:

In the measure information sheet, it says participants receiving Medicaid LTSS on the facility admission date through 160 days following the facility admission date. And I think the question was, would someone who becomes eligible for Medicaid services on the day of the admission be included in the denominator, or do they have to have been established? But Eric, tell me if I got your question wrong.

Eric Carlson:

No, that sounds exactly right.

Mary Botticelli:

Right, so it would need to be, you know, the participant receiving LTSS through its fee-for-service or managed care plan on the facility admission date. Which means that they could, you know, they could already, you know, be receiving LTSS through the managed care plan or the fee-for-service delivery system prior to being admitted to the facility. This is talking about the period that they need to be enrolled in that, is 160 days following when they're admitted. So you know, there might be someone who was admitted prior to, you know, coming in today, right, on the 4th of April. It doesn't mean that they have to be enrolled in LTSS by the managed care plan, or by the state on the day of admission. Did that answer your question?

Eric Carlson:

No. Let me just give you the example again. Person is not receiving LTSS, living at home, no supports, then enters a nursing facility, and starting on that first day gets Medicaid-funded, nursing facility care. Is that person included in the denominator? They have not previously been receiving HCBS, their LTSS. Their Medicaid-funded LTSS starts on the first day in the nursing facility. Are they included?

Mary Botticelli:

If they have 160 days of continuous enrollment following when they're admitted, they would be included.

Eric Carlson:

No, see it's not -- you don't have to. Oh, I'm sorry. So it has to be -- yeah, okay, so I understand. You say -- So yes, as long as they continue with LTSS for 160 days?

Mary Botticelli:

Right. Yes.

Eric Carlson:

Thank you.

Patricia Rowan:

Thanks, Eric and Mary. Last comment from Brent.

Brent Watkins:

Yeah, thank you. Just a comment about some of the timelines and certainly around the responsibility and some of the presumptions around the role of the state agency. Particularly as it relates to reasons why people may -- why those admissions may last longer than 100 days or particularly 60 days of readmission into the community. Recognizing that sometimes those -- there are factors outside the control of the state agency.

People maybe have medical conditions that may warrant readmission within those 60 days because they have fragile health, for instance. Reasons why it may be difficult to find community placement, especially today with some of the challenges in finding vacancies and providers that can provide that level of care. I'm just curious how this measure addresses some of those things that may be extenuating circumstances and how a state would report on that, that may not be what I think is presumed in terms of the reason why this measure exists.

Patricia Rowan:

I definitely appreciate your comment. I see Raina has her hand up. And just given the time, I'm going to move on to Raina's comment and then we'll, if there's any other questions or responses from Mary, we'll do that. Go ahead, Raina.

Raina Josberger:

Thank you. Yeah, I did have a question, again, following up on the continuous enrollment question that was discussed earlier. Because just following the example that was given, if somebody is not on Medicaid, they enter a nursing facility. Typically they will not get Medicaid, you know, that first day. It's a very long process to get institutional Medicaid. So I just wanted clarification from CMS if I could. So anybody who gets Medicaid some point after day one would be excluded from this measure? Is that correct?

Mary Botticelli:

So Raina, you know, the measure talks about continuous enrollment 160 days after -- basically after admission, right? And so -- For that question it would be best -- because I know that we have other questions that you've posed to us about the LTSS measures. If you could send that question to the HCBS quality mailbox, that would be great. Thanks.

Raina Josberger:

Okay. Yeah. I know at least in my state, institutional Medicaid is a much longer process than regular Medicaid eligibility. But thank you.

Mary Botticelli:

Yeah, thank you.

Patricia Rowan:

All right. I do want to make sure -- we're a little bit behind schedule, and I want to make sure we are able to get to the additions. And then if we have a little of time, if we make up a little time, I'll go to Eric and Tara. So why don't we go to slide 62. Or 61, maybe it is. Yeah, 62. And I'll hand it back to you, Kanch.

Kanchana Bhat:

Thanks, Tricia. So the measure suggested for addition in this domain, the system performance and accountability domain, comes from the Health Plan CAHPS survey. And it's a measure of health plan satisfaction. This measure is stewarded by the Agency for Healthcare Research and Quality and is also used on the Medicaid and CHIP Child and Adult Core Sets. Next slide.

So we're going to turn to a workgroup discussion now. And we invite workgroup members to raise your hand if you'd like to speak about the addition to the system and performance and accountability domain. And I'll turn it over to Tricia again to facilitate the discussion.

Patricia Rowan:

Thanks. So yeah, any comments or questions on potentially adding the Health Plan CAHPS, Health Plan Satisfaction Survey? Deborah?

Deborah Paone:

Yes, well, I'm just wondering, and forgive me for not having gone back and reviewed the CAHPS survey. But I'm just wondering with regard to this utilization of the measure, would it be applicable for managed care plans that cover HCBS for the specific geographic area and for that individual? And where the individual is eligible for the full range of HCBS?

In other words, you know, some people are fully duly eligible and other people are partially. And so they have different ranges of services. And also in some states, the person has a managed care plan for Medicare and then a managed care plan for Medicaid, and they're not the same plan. So I'm just wondering about, kind of, the potential for confusion by the person who's responding. Or is there some way to protect that in terms of the sample or other parameters? Thank you.

Patricia Rowan:

Yeah, thank you, Deborah, for that question. Unfortunately, no one from AHRQ was able to participate today. So I do think that would be a policy question that CMS or AHRQ would need to work out if the measure was added to the quality measure set. Unfortunately, I can't answer your question. I'm sorry. I see Tara?

Tara Giberga:

Yes, Tara. My concern about this measure, the numerator is the percentage of respondents who provided a response of 10 to the question. But the question we're asking is to rate from zero to 10. So I just find myself wondering why we would limit -- you know, why this measure would limit to responses only out of 10. You know, an eight might be good, a nine might be good kind of thing. So I just don't agree that this is actually a meaningful measure for outcomes if they're only looking to include that rating of 10.

Patricia Rowan:

Thanks, Tara. Raina?

Raina Josberger:

Yeah, I had a similar comment, and I was just trying to quickly Google it. I thought the adult core set used eight, nine, 10 as reporting that as the numerator, but I can't confirm.

Patricia Rowan:

I can confirm that the adult core set uses nine and 10.

Raina Josberger:

Nine and 10, okay. And was there a reason, then, that this was proposed to be different than the child and adult?

Patricia Rowan:

I cannot comment on that.

Raina Josberger:

Okay. Okay. Deborah?

Deborah Paone:

Well, just building on the last two commenters, methodologically, then, it really hasn't -- we don't know the distribution of 10 only across regions. And that seems like a strange thing to just cut it off. So perhaps testing needs to happen or some more thoughtfulness around eight, nine, and 10 or nine and 10. I don't know. I'm just offering up thinking, building on the other commenters.

Patricia Rowan:

Yeah, I appreciate the comment, Deborah. Thank you. I'll start with Eric Carlson and then go to Eric Levey.

Eric Carlson:

Quick question or comment. Is this focused on HCBS much at all? It just -- it seems to be dealing with a health plan that may include HCBS, but the question isn't focused on HCBS. Is there any indication here that -- would it be possible for this answer to be related to the health plan, even though the services that the person had a problem with didn't have much at all to do with community-based services?

Patricia Rowan:

You're absolutely right, Eric. This is just a general question about satisfaction with the health plan, which, you know, may or may not cover HCBS services. So I think you're raising a good concern. Eric Levey?

Eric Levey:

Yeah, I agree with the last comment. I think this question is already in the core measure set for children and adults for health plans. So they're all reviewing it anyway. The question is, does it relate or measure quality for home and community-based services? And I think the answer is no. And also I think you said that you want a measure set that can be applied to any state program that includes home and community-based services, and many programs, it's fee-for-service or it's the managed -- they don't use a managed LTSS model. They may have a waiver that's separate from the health plans. So it doesn't seem like it would apply to a lot of HCBS services.

Patricia Rowan:

Yeah, good point, Eric. Thank you. All right. I am not seeing any other hands raised on this one. So we're going to move into the public comment period for both of these measures, both for addition and removal. So team, could we actually go back to slide 59 that has both of these measures listed? We'll take comments from members of the public on this one. And I did see a comment from Jamie Kennedy in the Q&A. Jamie, we would ask that you come off mute and share that verbally, just so it can be included in the meeting record. Let's start with Dale. And Dale, if you don't mind, please introduce yourself and your organizational affiliation.

Dale Schaller:

Dale Schaller. I am an independent consultant with some subject matter expertise and patient experience. And I am calling in as a member of the public and not representing AHRQ or the CAHPS Consortium. But I just kind of wanted to build on some of the earlier questions or concerns and note that the health plan rating question is really an integral part of the CAHPS Health Plan survey, which is designed to assess enrollee experiences with a specific health plan. And the results, you know, are used for accountability, as mentioned, as part of the core set for adult and kids. It requires a probability sample of about 300 enrollees. NCQA actually asks for 411 to get an accurate assessment of performance. The plan survey itself asks the respondent at the very beginning of the survey to confirm that this is their health plan that they're responding to. So it's not a standalone, sort of, measure at all. And so I guess my question with that sort of background is, how would this be administered in the context of asking HCBS beneficiaries this question? Is the idea to, where does the question get embedded?

I mean, because it really is part of an overall survey instrument, which is already being administered by almost all states for Medicaid and CHIP. Not to mention Medicare enrollees and commercial enrollees. And so it's kind of my source of my question and concern, because I don't think we're going to get an accurate assessment of health plan performance in any case. Unless it's part of a sample that's drawn for health plan beneficiaries of a specific health plan. And just quickly, I think the comments on how to score it are really very good. The nine, 10 is a rating recommendation from the CAHPS Consortium. NCQA uses a combination of eight, nine and 10 as a top box score. I'll stop there.

Patricia Rowan:

Thanks, Dale. I see Camille Dobson has her hand raised. Can we unmute Camille?

Camille Dobson:

Sorry. Double muted. Sorry. Camille Dobson again from ADvancing States. I had just two comments. Back to Eric's question, I think it's really important to understand, while this is -- the survey is administered to every health plan, has to do the CAHPS survey for part of their NCQA accreditation and HEDIS reporting, etc. I think it's important to see -- to determine whether it will be applied only to those health plans in Medicaid that are delivering an LTSS benefit. Or else it really doesn't have a lot of relevance to the HCBS measure set.

I think that's a critical part to clarify, and I'm not sure that that's definitely not in the measure specs, I don't think. And I'm not sure whether the work group can put those kinds of constraints on the way it's used. Secondly, the measure set is very carefully constructed to have both a fee-for-service and a managed care measure for every aspect of the -- measures of the measure set. And this would -- essentially, adopting this would put it a little out of whack. There would be a measure on the measure set that a fee-for-service system couldn't use. Thank you.

Patricia Rowan:

Thanks, Camille, and I do just want to respond to your first point, that it would be a CMS policy decision on which plans would need to -- you know, would be reporting. So I think then the work group would be voting on it as it's specified, which does not include that information. So you are, you're right there. Other public comments on this measure before we move into voting? I see Naomi. Naomi, can you introduce yourself, and Rick will unmute Naomi. Go ahead.

Naomi:

Hi. I'm from the Oregon Department of Human Services, Aging and People with Disabilities. I'm a policy analyst there, and I just wanted to give a quick comment on the LTSS/MLTSS-7, minimizing the facility length of stay. You know, we just really have concerns about the availability of providers and the capacity. Because the people that take longer to discharge tend to have really complex issues. And we also are concerned that if we're rushing to get them out, to make sure we're meeting this measure, that we may be incentivizing inappropriate discharges that are not what the people, the individuals we're serving, really want. And so, we just have some concerns about that given the current state of our provider capacity.

Patricia Rowan:

Thank you, Naomi.

Naomi:

Yup.

Patricia Rowan:

All right. We are going to move into voting on these measures. Erica -- or actually, that might have been just leftover hand up. Okay. Denesha, let's pull up the voting. All right. So like I mentioned at the beginning, we'll start by voting on the removals and then vote on the additions. The first one vote is,

should the fee-for-service LTSS/MLTSS-7 Minimizing Facility Length of Stay measure be removed from the Quality Measure Set?

And the options are, yes, I recommend removing this measure, or no, I do not recommend removing this measure. Voting is open. I think for this one we expect 23 votes. We're at 23, so let's go ahead and close the vote and share the results. For this one, 35% of the workgroup voted yes, that does not meet the threshold for recommendation. So the fee-for-service LTSS/MLTSS-7 Minimizing Facility Length of Stay Measure is not recommended for removal by the workgroup. Next vote. And then this is our vote for additions. Should the Health Plan CAHPS Health Plan Satisfaction measure be added to the HCBS Quality Measure Set?

The options are, yes, I recommend adding this measure, or no, I do not recommend adding this measure. And voting should be open. All right. We have the 23 votes we're expecting, so we will share the results. 9% of the workgroup voted yes, that does not meet the threshold for recommendation. So the Health Plan CAHPS Health Plan Satisfaction measure is not recommended by the workgroup for addition. All right. Thanks, everybody, for your engagement on those two domains. We have come to the point of our second break, but we're a little over schedule. So we're going to take like, an eight-minute break or nine-minute break. We'll resume at 2:35 Eastern Time. So hopefully enough to get a coffee or some chocolate, and we'll resume in about nine minutes. Thanks, everybody.

Denesha Lafontant:

Welcome back from the break, everyone. We're going to move into our next domain, service delivery and effectiveness. So there are two measures suggested for removal and one measure suggested for addition to the HCBS quality measure set in this domain. Next slide, please.

The first measure suggested for removal is the HCBS CAHPS Survey. It is the Staff Listen And Communicate Well measure, which evaluates the quality of communication between a participant and the staff providing HCBS. Next slide.

The second measure suggested for removal is from the NCI-AD Survey. It is the Percentage of People Who Had Adequate Follow-Up After Being Discharged from a Hospital or Rehabilitation/Nursing Facility measure. Next slide.

We will now invite discussion from the workgroup members about the two measures suggested for removal in the service delivery and effectiveness domain. You may raise your hand if you wish to speak. We will call your name and unmute yourself when it is your turn. Please remember to say your name before making your comment and indicate which measure you are referring to, if it is -- if your comment is specific to a measure or group of measures. I'll turn it over to Tricia to facilitate the discussion.

Patricia Rowan:

Thanks, Denesha. Yeah. So like the last time, we will start with a discussion of the measures suggested for removal. And we'll start with any comments or questions from workgroup members. Amanda, go ahead.

Amanda Yanez:

Hi, this is Amanda Yanez. I agree with the HCBS CAHPS measure removal, but as far as the NCI-AD removal, I think that's a really key component of HCBS services in ensuring that people are stable and healthy and safe in the community and feel like that should not be removed from the measure set. It's also something that's very actionable for states to follow up on and improve quality.

Patricia Rowan:

Thank you, Amanda. Yeah, Eric, go ahead.

Eric Levey:

Yeah. So I looked at the comments and the reasons for removal, and it really comes down to question, sort of, 29 and I guess 42, because they say, how often were the explanations about your services that gave you a -- were hard to understand because of an accent or the way the person spoke English? And I think, you know, it's probably not the best way to ask that question, but the other questions are all fairly good. I don't know if we could make a recommendation back to AHRQ that they consider updating those questions and how they're asked. But it seems a shame to throw out the whole measure when it's really just the way the two questions are asked.

Patricia Rowan:

Thanks, Eric. We can definitely share the workgroup comments with CMS and they can pass them along to AHRQ. But we would vote today on the measure as it currently exists. So I just wanted to clarify that. Joe Caldwell.

Joe Caldwell:

Yeah, I think my comments kind of echo Eric's. Like, I think they did raise really good points about those two questions around the accent of the workers, and -- but I'm kind of conflicted. Do we throw the whole thing out? Because I like it overall as a measure. And I do know, like, these measures do have to be re-specified every so often. And so, yeah, I mean, it's kind of beyond the scope of what we're voting on today, but I think they should consider some changes to this measure in the future, regardless of how we vote today.

Patricia Rowan:

Thanks, Joe. Tara?

Tara Giberga:

Similar to the last two commenters, I also kind of paid attention to the wording of question 29 and 42. The way it is worded, it negatively characterizes accents as a problem. There's kind of assumption that maybe the person receiving services or the caregiver don't actually speak the same language. Like, it's just -- it's very problematic. But the overall questions that go into the measure I have some concerns about. And I found myself asking as I was reviewing is, does this really measure what they think it does? And I don't think it does. I think there are some fundamental problems with the way this measure is being gathered with all of the questions included. I just don't think it's really getting at what they think it's

measuring. So just -- that was the comment for that one. The comment for the NCI percentage of people who have adequate follow-up after being discharged.

This one, I had concerns surrounding how the word adequate would be defined in the gathering of this information in this measure. I'm not sure how that would be determined. And also just that contact -- So like, it's the -- did you receive a follow-up after being discharged? Well, contact, you could say, yes, I did, but was that an adequate? That could -- you know, contact does not equate to an adequate follow-up. So I think there's some challenges to how this measure could be defined for it to be a solid quality measure set inclusion. Thanks, Tara. Sarah?

Sarah Hoerle:

Yeah. Sarah from Colorado. I, you know, kind of wanted -- I wanted to comment on the NCI-AD measure. I think that removing it would be a -- I don't think we should remove it. It's something that we use when someone is discharged from a hospital. There are certain times when obviously folks need to be contacted in order to decrease, kind of, that readmission to hospital nursing facility rate. I think that it's a measure that we use. And so it would be -- you know, we would continue to use it. But I think that it's an -- actually, it's a really important measure for states to have and to ensure that, you know, when folks are being -- you know, leaving a hospital, leaving a nursing facility, that they are having follow-up from case management from, you know, kind of those conclusions with their doctors and making sure that they have the right services and supports in place.

Patricia Rowan:

Thanks, Sarah. I see that Steph Giordano from HSRI, has her hand raised. Rick, can we unmute Steph? Steph, did you want to respond to any of those questions?

Stephanie Giordano:

I think it was Tara's comment just around what does adequate mean for the NCI-AD measure here. And I just wanted to just read off what the actual question is, which is after leaving the hospital or, excuse me, rehab nursing facility, did anyone follow up with you to make sure you had the services and supports you needed? And this is certainly based off of the person's perception on whether they had what we're calling in the measure adequate follow-up. But the actual question itself is whether there was follow-up to make sure the person had services and supports needed.

Patricia Rowan:

Thank you, Steph. I see Brent has a hand raised. Brent?

Brent Watkins:

Yeah, thank you. So related to the NCI-AD question around discharge as well, in talking to our -- the folks on our aging side, I think they had some similar concerns about the vagueness of the question, particularly around the whole, how do we define adequate? Who's doing the follow-up? What is follow-up? It just seems like it has a lot of vagueness in it. And it is a question or an answer based on perception as well. And I wonder, while that's important for us as a state to address, as a measure that we're reporting to CMS, I have some concerns about that.

Patricia Rowan:

Thanks, Brent. Sarah?

Sarah Hoerle:

Yeah, I just wanted to comment on that last one. I think it's important, at least, you know, if people's perceptions are that they're not being followed up with by anyone after they leave the hospital, I think that's really important for the state to know. And that that would be a gap that the state should be addressing. And I think that's something that -- why it's really important for us not to remove that.

Patricia Rowan:

Thanks, Sarah. Other comments on these two measures suggested for removal? All right. Well, we also had one measure suggested for addition. So I will hand it back to Denesha to talk us through that one.

Denesha Lafontant:

Thanks, Tricia. So the measures suggested for addition in this domain is from the NCI-AD Survey. It is the Percentage of People Who Know Whom to Contact if They Have a Complaint About Their Services measures.

Patricia Rowan:

All right. Thanks, Denesha.

Denesha Lafontant:

Sorry.

Patricia Rowan:

No, that's okay. We can get back into the discussion on that measure. Let's go back to the previous slide with the detail, and we'll take any workgroup comments on this measure for addition. ShaRhonda?

ShaRhonda Sly:

I'd just like to point out that that would be equivalent to the NCI-IDD measure that was voted to add for percentage of people who know to report who to talk to if they want changes.

Patricia Rowan:

Thanks, ShaRhonda. Cathy?

Cathy Lerza:

This measure would also move toward what's required regarding a grievance system in the access rule.

Patricia Rowan:

Thanks, Cathy. Tara?

Tara Giberga:

I -- this one feels like, as far as inclusion in a quality measure set, this feels a tad bit more compliance-driven than outcome-driven. And I don't know if it's really a meaningful measure to assess and compare state progress, improving HCBS service delivery and outcomes.

Patricia Rowan:

Thanks, Tara. Amanda?

Amanda Yanez:

Amanda Yanez, I agree with Tara's assessment of this. It is much more of a compliance measure. And if we were looking for something that was quality-based, whether or not my complaints or services get addressed quickly, or efficiently, or effectively would be what I would be looking for.

Patricia Rowan:

Thanks, Amanda. Other thoughts or comments on this measure? Sarah?

Sarah Hoerle:

Yeah, I just wanted to agree with the individual who spoke to that this would really help with the grievance portion of the access rule. I think that it would be a good step in the right direction in, kind of, promoting that.

Patricia Rowan:

Thanks, Sarah. All right. I am not seeing any other hands raised for this measure. So at this point, we can move into public comment on the measures in this domain. And, team, if we can go back to slide 69 that has all three measures listed, we will take public comment on any of the measures in the service delivery and effectiveness domain. Just if you are going to make a comment, just let us know which measure you're speaking about specifically. Oh, I see Marci Kramer from the work group has a hand raised. Marcy, did you want to go ahead before we move into public comment? Go ahead.

Marci Kramer:

Yes. So sorry, I missed it. For the HCBS CAHPS Staff, Listen and Communicate Well. One of the things that we've encountered with feedback is that you may have more than one staff that you are rating. And you may have some staff that work really well and communicate well, and you may have some staff that do not. So having one question to capture all of that may be a little difficult to convey the communication and listening for all services when the results are mixed for the different staff and services that you have. So just wanted to add that to the conversation.

Patricia Rowan:

Thanks, Marci. I appreciate that. All right, turning to public comment on these measures, I see Caitlin Crabb has a hand raised. Rick, can we unmute Caitlin? And Caitlin, please introduce yourself and indicate which measure you are commenting on. Yeah, we can hear you.

Caitlin Crabb:

Oh, okay, great. Hi, my name is Caitlin Crabb. I am from Illinois. I work at the University of Illinois, Chicago. And my comment was about the percentage of people who know who to contact if they have a complaint. I guess the only thing I wanted to add is in my experience, and this is, you know, specifically with people with intellectual disabilities, many people don't even know who their case manager is. Their state-level case manager. And I know that probably varies by, you know, how often people see them, which varies by state, etc. But I think that's a really important piece that should be measured. And I don't know that if it's measured in another way. You know, people just knowing who they can go to if they have a complaint about their services or if they want to change something. I think that's really important to capture somewhere and to report back to states. So that was my comment.

Patricia Rowan:

Thank you, Caitlin. I do just want to clarify that this measure is specifically from the NCI-AD survey, which is for people -- older adults and people with physical disabilities. Not from the IDD survey, which surveys people with intellectual and developmental disabilities. So I appreciate your comment. I just wanted to clarify that. Other public comments on these measures? I see hands raised from Naomi and Mary and Marci. I assume those are all from your previous comments. If so, can you just put your hand down the same way you raised it, just so -- help me keep track of people. Thanks. I see Camille has a hand raised.

Camille Dobson:

Good afternoon. Camille Dobson from ADvancing States. I wanted to support Sarah's comment about ways to triangulate the experience of the Grievance and Appeal System. CMS has a very clear requirement that states educate beneficiaries about the existence of a grievance and appeal system, and this could serve as a, sort of, a measurement tool, rough as it is, to see if those education and outreach activities are working. And secondly, case management is the core of a good HCBS program in any measure that states can take actionable action on regarding the performance and the quality of case managers. Back to, I think, the previous speaker's point about not knowing who their case manager is, they're usually the first point of contact. And this would be another opportunity for quality improvement processes. Thank you.

Patricia Rowan:

Thanks, Camille. I see, Caitlin, you have your hand up still. Was that -- did you want to add anything else to your previous comment?

Caitlin Crabb:

Yeah, this is Caitlin again. I just wanted to clarify, I know that this is from the NCI-AD, but I -- extrapolating experience from IDD, I would imagine that other populations might also have this issue of not knowing who their case manager is or who to talk to about a complaint, just because there are so many people involved in the HCBS service world. It's easy to get confused, especially if they're not in contact with them that often. So I just wanted to clarify that it could apply to other populations as well, so.

Patricia Rowan:

Thank you. All right. Any other comments on these measures before we move on to voting? Mary, did you have a comment? I think your hand might just be raised from before. Right, can we unmute Mary just to

make sure? Go ahead, Mary. Okay, I think, yeah, that was -- I think her hand was just raised from before. I see Joe Caldwell has his hand up. Joe, go ahead.

Joe Caldwell:

Yeah. Just one more comment on the NCI-AD and knowing who to contact with a complaint. I just went and looked it up because I was curious. And, you know, it's about 88% was the average in the last go around. But there was a lot of variation. So I think this is a good measure. You know, it ranged from the 80s up to, like, almost 100%. So anyway, again, I support that. I think it's a good measure.

Patricia Rowan:

Thanks, Joe. I see Dale Schaller has a hand up for public comment. Rick, can we unmute Dale? Go ahead, Dale.

Dale Schaller:

Yeah, thanks. And again, I'm just -- this is a personal comment. I find myself in agreement with the concerns about those two questions and the Staff Listen and Communicate Well composite on HCBS CAHPS. Here's my concern, is voting the measure off the list, off the survey, could be premature in that, while this -- my understanding is that the survey went through the new consensus based entity that Partnership for Quality Measurement endorsement process last year. This was not removed. I mean, this passed.

There were a couple of standalone measures that did get taken out of the survey. But if the vote is for what gets included in 2028, there is a chance that, if these concerns are passed along to AHRQ as the steward for HCBS CAHPS survey, some of these could be addressed. Because there is another process currently underway, looking at ways of improving the survey. Not specifically on this issue, but I think this issue could be added to the list. So no promises, just kind of a conjecture, but I wanted to throw that into the mix, in case that might have some influence on all your workgroup votes.

Patricia Rowan:

Thank you, Dale. That's a really good point. Appreciate it.

Dale Schaller:

Thank you.

Patricia Rowan:

All right, let's move into voting on the measures in this domain. So we will have Denesha bring the Slido back up. All right. And similarly, we will start by voting on the removals first. So the first vote is should the HCBS CAHPS Staff Listen and Communicate Well measure be removed from the HCBS Quality Measure Set? The options are yes, I recommend removing this measure or no, I do not recommend removing the measure. Voting is now open.

Cathy Lerza:

I inadvertently got knocked off of it. I need the code so that I can get back in.

Patricia Rowan:

Cathy, can you see the Webex? Do you see the code with the hashtag that says 2028HCBSQMS? That should be the code to get you back in. Let us know if that does not work. All right, looks like we have the votes we're expecting. So let's lock it down and share the results. Oh, 57% of the workgroup voted yes that does not meet our threshold for recommendations. So the HCBS CAHPS Staff Listen and Communicate Well measure is not recommended for removal by the workgroup. Next vote.

Next one is, should the NCI-AD Percentage of People Who Had Adequate Follow-Up After Being Discharged from a Hospital or Rehabilitation/Nursing Facility measure be removed from the HCBS Quality Measure Set? The options are yes, I recommend removal, or no, I do not recommend removing this measure. Right. Looks like we have our 23 votes. Share the results. So 43% of the workgroup voted yes, which does not meet our threshold, so this measure is not recommended for removal from the HCBS Quality Measure Set. Our next vote in this domain is the measure suggested for addition. So the question is, should the NCI-AD Percentage of People Who Know Whom to Contact if They Have a Complaint About Their Services measure be added to the HCBS Quality Measure Set? The options are, yes, I recommend adding or no, I do not recommend adding the measure. All right, looks like we have our votes.

Let's share the results. 83% of the workgroup voted yes that does reach our threshold for recommendation. So the NCI-AD Percentage of People Who Know Whom to Contact if They Have a Complaint About Their Services measure is recommended by the workgroup for addition to the HCBS Quality Measure Set. Great. Thanks, everyone. We are nearing the end of the day. We have one more domain to discuss. We're a little ahead of schedule, which I think is a good thing. So I'm going to hand it to my colleague, Asmaa, to take us through the three measures that were suggested for removal in this domain.

Asmaa Al-baroudi:

Great. Thank you, Tricia. Our last domain for discussion today is the person-centered planning and coordination domain. There were three measures suggested for removal in this domain and none suggested for addition. Next slide, please.

The first measure suggested for removal is the fee-for-service LTSS/MLTSS- Comprehensive Assessment and Update measure. This is an administrative measure that uses case management data to measure the percentage of LTSS participants, 18 and older who have documentation of a comprehensive assessment, the documentation of both core and supplemental elements. Next slide.

This slide includes the denominator and numerator statements for the measure, which we won't read in detail. Next slide, please. The second measure suggested for removal is the fee-for-service LTSS/MLTSS-2 Comprehensive Person-Centered Plan and Update measure. This is an administrative measure that uses case management data to measure the percentage of LTSS participants 18 and older who have documentation of a comprehensive person-centered plan with documentation of both core and supplemental elements. Next slide.

This slide includes the denominator and numerator statements for the measure, which we won't read in detail. Next slide, please. The final measure suggested for removal is the fee-for-service LTSS/MLTSS-3 Shared Person-Centered Plan with Primary Care Provider measure. This is an administrative measure that

uses case management data to measure the percentage of LTSS participants 18 and older who have a person-centered plan transmitted to their primary care provider or another documented medical care provider. Next slide. This slide also includes the denominator and numerator statements for the measure, which we won't read in detail. Next slide, please.

We'll now invite discussion from the workgroup members about the measures suggested for removal from the person-centered planning and coordination domain. You may raise your hand if you wish to speak. We'll call your name and unmute you when it's your turn. Please remember to say your name before making your comment and indicate which measure you are referring to if your comment is specific to a measure or group of measures. Now, I'll turn it over to Tricia to facilitate the workgroup discussion.

Patricia Rowan:

Thanks, Asmaa. All right, we'll take comments on these three measures that were suggested for removal. ShaRhonda?

ShaRhonda Sly:

Thank you. So my comments are specific to MLTSS-1 and MLTSS-2. I am a proponent for keeping both 1 and 2 measures standard. This is really the first opportunity that we have to ensure that like that there are floor expectations really for what is collected about the person in order to really build a true person-centered service plan as well as the contents of a person-centered service plan. It allows for true apples-to-apples comparison across populations. And the requirements for both 1 and 2 really are fundamental to Medicaid responsibilities and INC programs regardless of who the target population is that a program serves.

Patricia Rowan:

Thanks, ShaRhonda. Sarah?

Sarah Hoerle:

Yeah. This one's actually specific to MLTSS-1. I actually would like to remove this measure. I think it's very, very compliance-based. It does -- it is measuring service plans. But, you know, for the 10 core elements, let's say, you know, we don't have a, you know, mini cognitive screening and so, therefore, you miss this measure for 1, you know, 1 out of the 10. I think that again, it's a -- and it's very data-heavy. It will just, I think put quite a bit of burden on the states to collect all of this information with not a lot of bang for your buck.

Patricia Rowan:

Thank you, Sarah. Morgan?

Morgan Loughmiller:

Hi, this is Morgan. I am going to discuss MLTSS-1 and 2. I agree with Sarah. I think these are extremely burdensome for the state to collect and I am in support of removing those two measures.

Patricia Rowan:

Thanks, Morgan. Tara?

Tara Giberga:

I'm going to also support what Morgan and Sarah said. I think these measures LT -- ML -- specifically fee-for-service LTSS-1 and LTSS-2 are extremely burdensome for states to even consider collecting. I think they are very much compliance-driven, which again, is not in the spirit of the Quality Measure Set. We're moving more towards outcomes. This is a lot of data-driven compliance data being collected that is the juice is not worth the squeeze. And let's see, for the LTSS-3 I was in agreement with the submitters that, again, I think this is a compliance task as well. And it doesn't truly measure the quality of HCBS service delivery.

The submitter actually indicated that there's no similar requirements for primary care physicians to communicate to HCBS programs. So this could be problematic in measuring just because the HCBS programs can be held accountable. But the burden of complying with the requirement is not solely on the HCBS provider, so. And that's all I have for comments on these.

Patricia Rowan:

Thanks, Tara. Brent?

Brent Watkins:

I just wanted to support a lot of the comments that have been made. And in addition to being burdensome, you know, when I first saw the core elements and the supplemental elements specifically related to person-centeredness as it relates to quality it is compliance-based, but it felt regressive to me in terms of what we're trying to do for people with disabilities or for any of the populations that we're looking at supporting here. You know, instead of looking at progressing the way we look at person-centered practices, compliance is exactly the opposite of that.

Patricia Rowan:

Thanks, Brent. Eric Carlson?

Eric Carlson:

Thanks. Regarding compliance, I don't know if I'm necessarily opposed to measures that look for compliance or non-compliance. But in this case, these seem like the type of measures that in recent years have generated super high percentage compliance scores that have allowed states to say, "Look, look how great we're doing 99% or 97%," that sort of thing. I'd be interested in other people's experience as well because I certainly don't have any encyclopedic knowledge of what states have reported. But I think I've seen some of that and it seems like that kind of requirement that maybe doesn't help much in part because there's almost perfect compliance that doesn't really help move things forward.

Patricia Rowan:

Thanks, Eric. Tara?

Tara Giberga:

Just real quick, Eric, I wanted to say I agree with you. We see the same thing here in our state. Compliance with similar measures are very high. So again, how would this move quality outcomes forward?

Patricia Rowan:

Brent?

Brent Watkins:

I want to just maybe clarify and agree with that. So I'm not opposed to compliance in measures specifically, but for the last number of years until recently I had run the quality assurance division for our agency. And we found exactly that, that when we focus on compliance, we get people doing minimum standard just to be able to say that they're complying and it doesn't really have any relationship to quality. And so we've actually found ourselves trying to I won't say move away from compliance, but make sure that we recognize those things that we have to do for compliance that are rule-based, but really as it relates to the person's experience and making sure that the support that they receive from all parts of the system are focused on quality.

We've had to move away from that because anytime you measure -- you're measuring compliance, that's what you're going to get and you're going to get the minimum standard. And I think that would be my concern with this is exactly what people have stated as we -- if it's focused on the compliance, again, there's a place for compliance, but when that's the focus, that's what you're going to get people -- it's going to drive their behavior and I don't think it's the behavior we want to drive.

Patricia Rowan:

Thanks, Brent. Other comments or questions on these measures? I see Mary Botticelli from CMS has her hand up and CMS -- these are CMS measures. Mary, did you want to respond or add anything here? Maybe not. Okay. All right. I don't see any other hands raised from the workgroup members. So at this point, we'll move into a public comment period on these measures. Again, would ask that if you're a member of the public commenting on these measures, please introduce yourself and your organizational affiliation and indicate which measure you're commenting on if it's specific to a measure. So I see Laura Vegas has her hand raised. Can we unmute Laura? Go ahead, Laura. Rick, can we unmute Laura?

Rick:

Looks like she -- did she -- Laura, did you drop? Oh. Oh, there go. Sorry.

Patricia Rowan:

Go ahead, Laura. Laura, we are not hearing you. I don't know if you're also muted on your phone or your headset. Okay, I'm going to move on to Dylan Johnson. Can we unmute Dylan? Go ahead.

Dylan Johnson:

Afternoon. Can you all hear me?

Patricia Rowan:

Yes.

Dylan Johnson:

Okay. Awesome. So, good afternoon. My name is Dylan Johnson. I'm the Quality Improvement Coordinator for the Wyoming HCBS. And I guess I am going to have to disagree with some of our other

states. We are in favor of keeping LTSS measures 1 and 2. We find that this is a good measure of the core element of helping out a participant, their measure -- their person-centered plan, and their comprehensive assessment. And that we also -- I personally find that there are other measures as well with the NCI that help back up these to help show if they are moving in a good way.

Patricia Rowan:

Thanks, Dylan. We really appreciate your perspective. Let's unmute Camille. Go ahead, Camille.

Camille Dobson:

Hi, good afternoon. Camille Dobson. I will tell you that of all of the conversation around the MFP recording -- reporting requirements and the access rule MLTSS-1 and 2 has caused the most dread, consternation, and anxiety for our states, particularly that are delivering the services and fee-for-service. These were originally constituted and built back in 2013 and 2014 for MLTSS plans, which I think explains the very heavily medical-type questions that are built into the assessment and the planning process. And they were built really to provide some assurance that MLTSS plans were doing the core functions that need to be done when they're delivering an LTSS package.

Sadly, applying those same approaches to a fee-for-service system is really like matching apples and rocks. The state's assessment process is usually for eligibility. It does not collect the kind of information that's required to pass the core elements and even some of the supplemental elements. And the person-centered planning process happens in many states in a very diffuse system that relies on many, many case management agencies with systems that aren't equipped today to collect any of that information in a meaningful way.

So I would support Sarah and our other state members who have talked about the extreme administrative burden and the cost burden to the states, the fee-for-service states in particular to figure out a system to collect these measures. And then I would say, because Laura couldn't get off speaker, I would say that the conversation with our colleagues at NASDDDS around the IDD system, echoing Brent to some degree, the IDD system's process of person-centered planning has moved way beyond some of these things. And we hear regularly from their members that it's taking them backwards to more deficit-based assessment processes as opposed to strength-based processes. Thank you.

Patricia Rowan:

Thank you, Camille. Let's see if we can get Laura's audio working this time. Laura, do you want to try again?

Laura Vegas:

Yes, can you guys hear me?

Patricia Rowan:

Yes, we can hear you now. Go ahead.

Laura Vegas:

So sorry. Yeah, this is Laura Vegas with NASDDDS, the National Association of State DD Directors. And as Camille said, we represent the IDD service delivery systems across the United States. And by and large for LTSS-1 and 2, we've heard a lot of concern from our membership not because they don't believe in comprehensive assessments, and not because they don't believe in robust person-centered planning, but the core and supplemental elements contained in each of these measures are not what states are currently doing to make sure the assessment is comprehensive and to make sure the person-centered plan is robust. And for some of the core elements in the comprehensive assessment measure some of those aren't even normed for people with intellectual and developmental disabilities.

So it would -- it's quite a mismatch. And states would have to basically set up entirely new systems for how they do assessments and how they do person-centered planning. And as Brent mentioned some of these elements feel like they're moving us away from true person-centered planning and true person-centered assessment. And we feel like we've made great advances in our service delivery system over the last 10 to 15 years. And we have real concerns that these measures being required and mandatory will really have a more of a negative impact on our system than a positive impact. Thanks for the opportunity to comment and for your patience.

Patricia Rowan:

Thanks, Laura. I see Mary's hand up. I think that's still from before. Rick, can we just unmute Mary briefly to see if Mary, if there was anything you wanted to add? All right, we can mute Mary again. Naomi, let's unmute Naomi.

Naomi Sacks:

Hi. Thank you. Yeah, I couldn't agree more with Brent and Camille, and Sarah. For us in Oregon, I work, again, I'll just quickly state, I work for the Office of Aging and People with Physical Disabilities in Oregon, the Oregon Department of Human Services. I really just could not agree more because the measures are in there really turn us back to a medical focus.

We don't have -- we're entirely fee-for-service except for our PACE program and the burden in order to be able to even begin to -- you know, I mean, it's complete system overhaul to be able to capture these things that we don't now capture. So we're looking at systems, we're looking at training, we're looking at a whole different focus of our assessments, which we've been trying to continually work towards being more person-centered and more outcome-focused. And it just feels like a huge mountain to climb. And I know that we're -- you know, other states feel likewise.

So really hoping that we can all have the perspective of looking nationally. I think we absolutely support that there are elements in these in person-centered planning that we should be capturing and should be measures that are truly outcome-focused. And we'd just like to see these removed and to have some work started anew to propose additions in the future that really get to the most important things that we want to incentivize and focus on in terms of person-centered planning and coordination. Thanks.

Patricia Rowan:

Thank you, Naomi. Other comments from members of the public on these measures suggested for removal? All right, I see. Oh, Pam Lester. Let's unmute Pam. Go ahead, Pam.

Pamela Lester:

Oh, thank you for giving me the opportunity to talk about these measures. I am the Quality Manager for Iowa Medicaid. And one of the things that I think are important with these measures is we do require LTSS distinction through NCQA and we have done a crosswalk and the elements align with the core and optional elements within MLTSS-1 and 2. And we are also looking at our assessments as we are like other states where our assessment is really more determining level of care or needs-based qualifications and doesn't get to the comprehensiveness that's required in these measures.

I do feel strongly that these measures do create a comprehensive look at these measures and to be patient-centered, you must have a comprehensive look at that measure, including their medical, because medical may be what is a barrier to them and their outcomes. So feel very strongly that these measures should continue to stay in the measure set. Thank you.

Patricia Rowan:

Thanks, Pamela. I see Cathy on the workgroup has her hand raised. Cathy, do you want to go ahead?

Cathy Lerza:

I just thought that I should mention something about the third one. We haven't really talked about that one. I believe that it is really more based on the population served, whether or not it's important to share it with the primary care provider. There are some LTSS recipients who are not medically complex, really don't have -- so their services are not related to medical, and so it doesn't really seem to me important to provide it to a primary care physician.

Patricia Rowan:

Thank you, Cathy. Carolyn?

Carolyn Foster:

I had that same concern, Cathy, but when I read the technical documents, I think it actually says that it could be another designee. Maybe I read it wrong, but I was assuaged by that. It doesn't mean these all the other overarching comments but have already been discussed don't impact my vote, but I just wanted to clarify that for myself.

Cathy Lerza:

Thank you.

Patricia Rowan:

Sarah?

Sarah Hoerle:

Yeah. I just wanted to actually agree with Cathy, we hadn't talked about LTSS-3. And you know, I agree that, again, I think it's another compliance-based measure. And you know, if your system doesn't automatically send the person-centered plan to your primary care provider, then that, you know, is something that states will have to spend money on and change. And if they're, you know, people are not medically complex or maybe they don't want their primary care provider to have their person-centered plan. I just think that it's not -- I think -- I just, I agree that it should be removed.

Patricia Rowan:

Thanks, Sarah. Other comments on these measures from the workgroup or members of the public before we move into voting? All right. I am not seeing any more hands raised, so why don't we move on to voting on these measures? I'll have Denesha bring up the Slido.

All right. The first measure that we'll be voting on is, should the fee-for-service LTSS/MLTSS-1 measure Comprehensive Assessment and Update be removed from the HCBS Quality Measure Set? The options are yes, I recommend removing, or no, I do not recommend removing this measure. The voting should be open. Our team is just checking to see whose votes we're still waiting on and just give us a minute here. Looks like Marci Kramer. Marci, we don't have your vote yet.

Marci Kramer:

Yeah, I got kicked out of Slido, so I'm trying again, so bear with me.

Patricia Rowan:

Okay.

Marci Kramer:

If you want me to send it to you, I can do that too.

Patricia Rowan:

No. Take your -- go ahead and try to get back in. You should be able to use either the QR code that's on the screen here or go to slido.com and enter the code 2028HCBSQMS on there. Let us know if it doesn't work. All right, I think we got you, Marci. All right, we did have somebody step away and unable to vote. So our denominator is 22 for this one, we're expecting 22 votes, so we can go ahead and share the results. Oh, 82% of the workgroup voted yes, that does meet our threshold for recommendation.

So the fee-for-service LTSS/MLTSS-1 Comprehensive Assessment and Update measure is recommended by the workgroup for removal from the HCBS measure set. Next vote. This is also a removal. Should the fee-for-service LTSS/ MLTSS-2 Comprehensive Person-Centered Plan and Update measure be removed from the HCBS Quality Measure Set? The options are yes, I recommend removing, or no, I do not recommend removing. This should be live. Okay. We're just taking a look at who -- which votes we've received. I think we're waiting on one person, so just give us a minute. Carolyn Foster, looks like we haven't gotten your vote. Are you able to get into the Slido?

Carolyn Foster:

Yep, I just got in. Thanks.

Patricia Rowan:

Awesome. Thanks. We got it. We'll go ahead and share the results. All right, so for this one, 86% of the workgroup voted yes. That does meet our threshold for recommendations. So the fee-for-service LTSS/MLTSS-2 Comprehensive Person-Centered Plan and Update measure is recommended by the workgroup for removal from the HCBS Quality Measure Set. And our final vote of the day is, should the fee-for-service LTSS/MLTSS-3 shared person-centered plan with primary care provider measure be removed from the Quality Measure Set? The options are yes, I recommend removing, or no, I do not recommend removing this measure from the HCBS Quality Measure Set. All right. And I think with that we can share the results. 91% of the workgroup voted yes, that does need our threshold for recommendation.

So the fee-for-service LTSS/MLTSS-3 shared person-centered plan with primary care provider measure is recommended for removal from the HCBS Quality Measure Set. All right, that is our last vote of the day. So let's pull up the slides again and we are nearing the end of our time together and I just want to briefly preview what's on the agenda for tomorrow's meeting. Let's go to the next slide.

All right. So tomorrow we have five remaining domains of measure suggestions to work through, which are listed here on the slide. We will also be facilitating a conversation among the workgroup members to identify gap areas in the HCBS Quality Measure Set. And we will also provide a final opportunity for public comment and discuss the next steps in the review process. Next slide.

So we did want to preview our plan for the workgroup discussion of gap areas just to help folks, you know, think about it a little bit this evening. So the way that we will go through this discussion of gap areas is we will ask each workgroup member to briefly mention one gap area that they think should be a priority for the HCBS Quality Measure Set. You can also plus one a gap area that's been mentioned by another workgroup member.

And just note, we plan to call on all workgroup members in the order listed on the roster. So we can kind of keep that in mind as we go through the discussion. There will also be an opportunity for public comment on the gap areas. And this gap discussion will come toward the end of the day after we have voted on all of the measures and we sort of have a sense of what has been recommended to be added or removed. And you know, the discussion should really focus on workgroup member perceptions of what measure -- what opportunities there might be for either measure development or measure updates. And that information will help inform the call for measures for the next review cycle. Next slide.

Before we adjourn for the day, I would like to give our Co-Chair ShaRhonda an opportunity to share any final reflections on the day or opportunities for tomorrow before we adjourn. So ShaRhonda?

ShaRhonda Sly:

Thank you. I'd just like to say thanks for the robust conversation today. It's great to hear multiple experiences and perspectives and I can say that throughout the day the conversations have altered myself in my opinion from yes to no in multiple occasions. So I very much appreciate everyone speaking up about their perspective and feedback.

Patricia Rowan:

Thanks, ShaRhonda, really appreciate that. All right, we'll go to the next slide. So we will begin promptly at 11:00 Eastern tomorrow morning. We ask folks if you can sign in a few minutes early, we'll get started right at the top of the hour. One other thing I did just want to mention again is that we did have a few workgroup members who were absent today and sick or otherwise unable to submit votes at certain times of the day. We have reached out to them to give them the opportunity to submit their votes and our team will take a close look at the voting results if we do get any additional votes overnight from workgroup members. I know some of these votes were very close and, you know, a couple of extra votes in either direction could make a difference.

So tomorrow I'll provide kind of an update on whether we received any additional votes and whether that changes any of the workgroup recommendations. So with that, this concludes Day 1 of the HCBS Quality Measure Set Review workgroup meeting. I hope you enjoy the rest of your day and that you will join us again tomorrow at 11:00 Eastern. And with that, we will adjourn for the day. Thanks, everybody.