AGS Geriatrics Healthcare Professionals
Leading Change. Improving Care for Older Adults.

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Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2453-NC
Mailstop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicaid Program; 2028 Medicaid Home and Community-Based Services Quality Measure Set

Dear Dr. Oz:

The American Geriatrics Society (AGS) greatly appreciates the opportunity to submit comments on the 2028 Medicaid Home and Community-Based Services (HCBS) Quality Measure Set to the Centers for Medicare and Medicaid Services (CMS). AGS is a not-for-profit society devoted to improving the health, independence, and quality of life of all older adults. Our 6,000+ members include geriatricians, geriatrics nurse practitioners, social workers, family practitioners, physician associates, pharmacists, and internists who are pioneers in serious illness care for older individuals, with a focus on championing interprofessional teams, eliciting personal care goals, and treating older people as whole persons. AGS is an anti-discriminatory organization. We believe in a society where we all are supported by and able to contribute to communities and where bias and discrimination no longer impact healthcare access, quality, and outcomes for older adults and their care partners. AGS advocates for policies and programs that support the health, independence, and quality of life of all of us as we age.

We applaud CMS' efforts to strengthen the HCBS Quality Measure Set and promote applicable measures for the population served by HCBS programs. We believe these measures will help improve the life experience of innumerable older Americans who want to retain their dignity while remaining in their homes. AGS advocates for robust choice for older adults and their families, which requires access to a full range of long-term services and supports (LTSS) — skilled nursing facility and congregate living; home-based and community-based services; and other alternative programs — for preventing or delaying nursing home placement. Below, we offer our recommendations to ensure that the 2028 HCBS Quality Measure Set best addresses the unique healthcare needs of older adults and reflects the quality metrics that we believe are most appropriate for measuring care for all of us as we age.

Mandatory Measures

General Comments

AGS supports the proposal to include the 23 mandatory measures in the 2028 HCBS Quality Measure Set and allow states to have the flexibility to choose the subset of measures to report based on the programs each state delivers and the populations they serve. We believe this would standardize the evaluation of care for patients served under HCBS programs and provide the opportunity for states to select the measures and surveys that allow them to make the most meaningful changes. We recommend ensuring the states' selected measures and surveys are appropriate for the populations served and organizations administering the programs with applicable rationales and an approval and implementation process.

Participant-Reported Experience of Care Surveys

We appreciate CMS' inclusion of measures that apply a person-centered approach and for patients to report on their experience of care from their own perspectives, allowing the opportunity for them to feel heard and understood, which is a key goal and benefit of geriatrics. Geriatrics health professionals focus on the 5Ms of geriatrics: **M**ultimorbidity, What **M**atters, **M**edication, **M**entation, and **M**obility.[1] Multimorbidity describes the older person who has more complex needs often due to multiple chronic conditions, frailty, and/or complex psychosocial needs. What Matters, Medication, Mentation, and Mobility describe the four main areas where geriatrics health professionals focus their clinical attention and form the basis for the age-friendly health systems framework that is focused on ensuring that all older people have access to this type of coordinated care, while also making sure personal needs, values, and preferences are at the heart of that care.[2]

AGS strongly supports the proposal to require states to report on the participant-reported experience of care survey measures for each of the major population groups, including older adults. Given that HCBS is often provided to vulnerable adults and these measures directly represent the satisfaction of patients on the care received, we believe it is critically important to capture and assess the participants' experiences. This would also support the analysis of patient care within HCBS programs across states as well as the success of these programs based on different factors (e.g., goals, safety, disability, mental health status). Considering that follow-up and accountability are essential for the measures, we also encourage including a plan that allows evaluation of low-scoring surveys that include root cause analysis and an action plan formation for programs to address areas of improvement with consideration of geography (i.e., rural areas compared to urban areas). Additionally, patient-reported surveys should include a method that enhances the participant's engagement with the survey while ensuring that limitations such as hearing, vision, cognition, and function, are not impediments to reporting on experience of care measures.

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[1] Tinetti M, Huang A, Molnar F. The Geriatrics 5M's: a new way of communicating what we do. *J Am Geriatr Soc.* 2017;65(9):2115. doi:10.1111/jgs.14979

[2] Mate KS, Berman A, Laderman M, Kabcenell A, Fulmer T. Creating age-friendly health systems - a vision for better care of older adults. *Healthc.* 2018;6(1):4-6. doi:10.1016/j.hjdsi.2017.05.005

LTSS-1 and LTSS-2

We appreciate the proposal to include the LTSS-1: Comprehensive Assessment and Update and LTSS-2: Comprehensive Person-Centered Plan and Update measures as part of the mandatory measure set. These measures, if implemented as meaningful assessments of what matters to participants beyond the purpose of documentation, would ensure that patients have a plan established each year or during enrollment for comprehensive care and provide the ability to track how elements of the care plan are assessed on a routine basis. AGS believes that each participant should receive a comprehensive needs assessment with a follow-up plan on social, behavioral, medical, and physical domains with subsequent goals, interventions, and applicable timing for appropriate responsiveness to the needs in each domain coupled with actions for change. Following through on care plans and the measurement of success is vital for LTSS-1 and LTSS-2 so that the metrics are not a perfunctory collection of information. Well-paired patient-reported outcome measures should be instructed for participants with specific needs noted in the care plan that is an accurate and true representation of what matters most to each participant and ultimately benefits their care. This approach is in keeping with the principles of person-centered care, which are to put patients at the center of decision-making about the care that they will receive.[3] We encourage requiring formalized recommendations in the care plan to ensure closed-loop communication of the changes that are needed. A common example that is encountered in reviewing comprehensive care plans for older adults is the sign-off of the documented hours of home health assistance approved in the care plan without making explicit recommendations on whether the hours are sufficient.

Given the challenge with data collection for LTSS-1 and LTSS-2, AGS believes it would be acceptable for states to report on the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness and Data Information Set (HEDIS) equivalent. However, we oppose the use of the Functional Assessment Standardized Items (FASI) Performance Measure 1: Identifying Personal Priorities for FASI Needs (FASI-1) and FASI Performance Measure 2: Alignment of Person-Centered Service Plan with Functional Needs as Determined by FASI (FASI-2). The FASI-1 and FASI-2 measures are limited compared to LTSS-1 and LTSS-2, simplifying the elements of care, and do not fully accommodate the multitude of domains that may be important to a patient. Although the FASI measures may help to streamline the most salient elements of care, we are concerned that they are not comprehensive enough to replace LTSS-1 and LTSS-2, particularly for patients whose most important needs are related to cognition, behavioral health, caregiving, safety, communication, or community-living. For example, functional assessments alone may miss significant drivers of care quality and goal-concordant support for those living with cognitive impairment or serious mental illness.

CAHPS Measures and POM

AGS is concerned about the mandatory composite measure HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS): Choosing the Services that Matter to You exclusion of people who failed any of the cognitive screening items. We believe it is crucial to capture and improve quality metrics for patients with cognitive limitations who are at higher risk for fragmented care. Furthermore, access to resources to meet health needs such as nutrition and transportation, which impact well-being as well as ability to treat all illnesses in patients, are also important considerations in care of Alzheimer’s disease and related dementias, particularly in caregiving. Emerging research has shown how societal and

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[3] The American Geriatrics Society Expert Panel on Person-Centered Care. Person-centered care: a definition and essential elements. *J Am Geriatr Soc*. 2016;64(1):15-18. doi:10.1111/jgs.13866

economic conditions (e.g., food security, physical environment) may influence and be influenced by caregiving health outcomes in dementia.[4] As an example, dementia caregivers have greater challenges in engaging patients in meaningful social and physical activities, key aspects of cognition and function, when residing in low or medium-income neighborhoods compared to those living in high-income areas.[5] AGS recommends the consideration of approaches to substitute with a surrogate or care partner voice or utilization of a proxy in measures for patients with cognitive limitations.

We acknowledge that HCBS programs may not be able to directly address some of the items in the HCBS CAHPS: Planning Your Time and Activities composite measure and the Personal Outcome Measures® (POM): People Live in Integrated Environments. We also recognize that not all states are equipped to collect the data for POM: People Live in Integrated Environments in HCBS programs. However, the data captured in the HCBS CAHPS: Planning Your Time and Activities composite measure and the POM: People Live in Integrated Environments can provide significant information on patients' goals and needs regarding their time, activities, and environments and identify self-reported issues and gaps that are meaningful indicators of health, such as social isolation and the inability to access needed resources. Understanding a patient's individualized needs on these items would inform how to modify care plans and work towards meeting the goals expressed by the patient around activities of daily living (ADLs) and instrumental activities of daily living (IADLs) that support overall well-being as well as opportunities to be integrated in their community. While there may not be direct approaches for some healthcare teams to resolve these issues, the teams would be able to identify other ways in which to address the gaps in need. AGS believes the HCBS CAHPS: Planning Your Time and Activities composite measure and the POM: People Live in Integrated Environments measure should only be removed if the other measures adequately reflect and identify these factors. Should CMS finalize removal of the measures from the mandatory set, we recommend their inclusion as voluntary measures and that CMS continue collecting this data though the benchmark may be low.

NCI-AD and NCI-IDD Measures

CMS proposes to exclude the National Core Indicators – Aging and Disabilities (NCI-AD™) Measures and NCI – Intellectual and Developmental Disabilities (NCI®-IDD) Measure that the HCBS Quality Measure Set Review Workgroup recommended for addition. The four measures, 1) NCI-AD: Percentage of People Who Have Access to Mental Health Services if They Want Them; 2) NCI-AD: Percentage of People Who Have Needed Assistive Equipment and Devices; 3) NCI-AD: Percentage of People Who Know Whom to Contact if They Have a Complaint About Their Services; and 4) NCI-IDD: Percentage of People Who Report That They Know Whom to Talk to if They Want to Change Services, are imperative to the populations served in HCBS programs as well as the success of HCBS. While AGS acknowledges that there are challenges with cross-survey alignment, we urge CMS to reconsider this proposal and include these measures as mandatory to ensure that states are consistently evaluating patients' accessibility of mental health services, assistive equipment and devices needs, and knowledge of contacts to provide feedback on services and communicate needs on service changes.

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[4] Leykum LK, Penney LS, Dang S, et al. Recommendations to improve health outcomes through recognizing and supporting caregivers. *J Gen Intern Med*. 2022;37(5):1265-1269. doi:10.1007/s11606-021-07247-w

[5] Gaugler JE, Borson S, Epps F, Shih RA, Parker LJ, McGuire LC. The intersection of social determinants of health and family care of people living with Alzheimer's disease and related dementias: a public health opportunity. *Alzheimers Dement*. 2023;19(12):5837-5846. doi:10.1002/alz.13437

Stratification Reporting

General Comments

AGS supports CMS' proposal to require states to report stratified data for the five identified mandatory measures (LTSS-1, LTSS-2, LTSS-6, LTSS-7, and LTSS-8) as a starting point. Stratified reporting of most survey measures is of critical importance to understanding any underlying details in the data reported that would support identifying population-level variations in access to care, care planning, service delivery, and care outcomes. This is especially essential for rural communities, older adults who typically have more complex needs, and other historically underserved groups that are at higher risk for poorer outcomes. We believe that data stratification should be utilized in a way that is appropriate and relevant for the populations served. This provides the opportunity for health systems to establish and implement creative responses to identified issues from stratified data, such as the adoption of age-friendly approaches that help to ensure care reaches those who need it most.

Feasibility, Burden, and Privacy

AGS believes the proposed measures are feasible for states to stratify without undue burden. Although it may be challenging, we believe states should make an effort to stratify the data for all the measures, including the mandatory participant-reported survey measures. Stratification of patient-report measures would ensure that the surveys that cover important aspects of care are utilized to evaluate and improve HCBS programs and care and service delivery. At the same time, we support CMS determining the number of mandatory measures that would require stratification using the percentage of the likely maximum number of measures that states would need to report rather than the total number of proposed measures.

Given privacy may be a concern for programs with small numbers of participants, CMS may want to consider setting a cut-off for the number of beneficiaries under which stratification is mandatory or keeping the surveys anonymous and instead connecting surveys to location (e.g., county) to reduce privacy risks.

Stratifying by Geography and Other Factors

AGS supports the requirement for states to stratify data by geography and to move towards Rural-Urban Commuting Area Codes. We believe it may be helpful to include a mix of urban and rural participants in a single subset to review the average success of a program and to avoid the overreporting of low-standard care that is secondary to rural location limitations. Further, data stratification by location will allow the development and implementation of quality improvement initiatives that address the known barriers in rural HCBS programs. We also support allowing CMS to report results on the states' behalf on administrative measures. The administrative LTSS measures may be more feasible for data stratification by geography than the proposed mandatory LTSS-1 and LTSS-2 measures which would require updating systems and tracking individuals in the populations served.

It is also important to understand how health systems are addressing the needs of their constituents. Access to care may be impacted without the collection of individual information about the membership of a population on race, gender, and other key identifiers. These effects are amplified with increasing frailty and complexity of care, particularly for older adults who are living in the community and their care partners. We encourage CMS to consider requiring states to stratify by eligibility group, age, race, and gender in future measure sets. As a first step, CMS may want to ask states to attempt data stratification by these factors and request feedback on the feasibility.

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Thank you for taking the time to review our feedback and recommendations. For additional information or if you have any questions, please do not hesitate to contact Anna Kim at akim@americangeriatrics.org.

Sincerely,

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