



## Measuring Quality in Home and Community-Based Services (HCBS): Key Considerations for Health Plans

Home and community-based services (HCBS) encompass a broad range of services and supports designed to help older adults and people with disabilities live in their homes and communities rather than in institutional settings, such as nursing facilities. In July 2022, the Centers for Medicare & Medicaid Services (CMS) released the first ever HCBS quality measure set to “promote consistent quality measurement within and across state Medicaid HCBS programs”.<sup>1</sup> Quality measurement in HCBS supports states, health plans, and providers in ensuring members are receiving HCBS that reflect their preferences, assuring health and welfare, improving health outcomes, and promoting effectiveness of services and supports. While states can develop their own performance indicators and measures for each HCBS waiver program, all states operating section 1915(c) HCBS waivers are required to develop a quality assurance program and quality improvement strategy. These are complimentary approaches to quality that states must consider:

- **Quality assurance** tends to focus on compliance with rules and regulations. For example, federal regulations require each state that operates a section 1915(c) HCBS waiver program to demonstrate compliance with six major assurances, including administrative authority, level of care, qualified providers, service plan, health and welfare, and financial accountability.<sup>2</sup>
- **Quality improvement** involves continuous adaptation to align with a member’s preferences and expectations.<sup>3</sup> A quality improvement strategy must also “describe the roles and responsibilities of all who have a role in any aspect of discovery remediation or systems improvement.”<sup>4</sup> Health plans might play a role in engaging stakeholders to collect data for quality improvement, so it is important to understand federal quality assurance regulations and the quality improvement goals of the state.

This brief provides key considerations for understanding states’ efforts to implement quality improvement and the role of health plan quality in HCBS.

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### Key Considerations

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<sup>1</sup> Centers for Medicare & Medicaid Services. (2022). *CMS Releases First-Ever Home- and Community-Based Services Quality Measure Set*. Retrieved from <https://www.medicare.gov/federal-policy-guidance/downloads/smd22003.pdf>.

<sup>2</sup> Centers for Medicare & Medicaid Services. (n.d.). *Reframing Approaches to Quality Management in HCBS from the Individual’s Perspective*. Retrieved from <https://www.medicare.gov/medicaid/home-community-based-services/downloads/reframing-approaches-jan-2021.pdf>.

<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

## Adopt Health Plan Quality Measures

The HCBS quality set, established in July 2022, is the first-ever quality measure set developed by CMS to standardize quality measures across all HCBS programs.<sup>7</sup> While use of this measure set is voluntary at this time, CMS plans to incorporate use of the measure set into the reporting requirements for specific authorities and programs; thus, it is highly encouraged for states to use. States can use the measure set to improve health equity as well as quality outcomes. It provides states with tools to better understand and compare health outcomes across groups receiving HCBS, which can ultimately help reduce health disparities and ensure that people with disabilities, and older adults enrolled in Medicaid, have access to and receive high-quality services in the community.<sup>8</sup> The measure set identifies measures that address HCBS quality and outcomes in the following key priority areas:<sup>9</sup>

- **Access:** beneficiary and caregiver awareness of resources that support overall well-being and HCBS;
- **Rebalancing:** finding a more equitable balance between spending on institutional care and HCBS care in communities; and
- **Community integration:** ensuring the self-determination, independence, empowerment, and full inclusion of children and adults with disabilities and older adults in all parts of society.

The HCBS quality set is comprised of measures that assess quality across a broad range of areas identified as measurement priorities for HCBS. The measure set includes claims-based measures, measures derived from various experience of care surveys, and several other nationally standardized and tested measures in key areas. Examples of HCBS quality measures included in the measure set are:

- **The HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS) Measures.** CAHPS surveys ask patients to report on their experiences with a range of healthcare services at

## LTSS Rebalancing

When the Medicaid program was first created in 1965, states were required to provide institutional services.<sup>5</sup> This led to institutional settings providing most government supported LTSS. Over the past several decades, states have used federal authorities to develop HCBS and provide alternatives to institutionalization. Rebalancing LTSS systems from institutional to community-based care helps to “reinforce the delivery of high-quality person-centered care, facilitate progress toward community integration of older adults and individuals with disabilities,” and curb spending growth.<sup>6</sup> Since 2013, HCBS accounts for more than 50 percent of total Medicaid LTSS expenditures, surpassing the percentage of institutional LTSS expenditures. CMS published the [Long-Term Services and Supports Rebalancing Toolkit](#) to support states in continuing to enhance HCBS and rebalance LTSS systems from institutional to community-based care.

<sup>12</sup>Centers for Medicare & Medicaid Services. (2020). *Long-Term Services and Supports Rebalancing Toolkit*. Retrieved from <https://www.medicare.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf>.

<sup>13</sup>Centers for Medicare & Medicaid Services. (2020). *Long-Term Services and Supports Rebalancing Toolkit Fact Sheet*. Newsroom. Retrieved from <https://www.cms.gov/newsroom/fact-sheets/long-term-services-and-supports-ltss-rebalancing-toolkit-fact-sheet>.

<sup>7</sup> Ibid.

<sup>8</sup> Home Health Care News. (2022). CMS Announces Unprecedented Quality Measure Set for Home- and Community-Based Services. Retrieved from <https://homehealthcarenews.com/2022/07/cms-announces-unprecedented-quality-measure-set-for-home-and-community-based-services/>.

<sup>7</sup>AHRQ. (2022). CAHPS Patient Experience Surveys and Guidance. Retrieved from <https://www.ahrq.gov/cahps/surveys-guidance/index.html>.

<sup>8</sup> Centers for Medicare & Medicaid Services. (2022). *CMS Releases First-Ever Home- and Community-Based Services Quality Measure Set*. Retrieved from <https://www.medicare.gov/federal-policy-guidance/downloads/smd22003.pdf>.

multiple levels of the delivery system. Some CAHPS surveys ask about patients' experiences with healthcare providers, such as doctors, clinics, and hospice teams, or with care for specific health conditions. Other surveys ask enrollees about their experiences with health plans and related programs.<sup>7</sup> [The HCBS CAHPS Survey](#) was developed by CMS for voluntary use by states and is designed to facilitate comparisons across the various state Medicaid HCBS programs.<sup>10</sup> The survey measures Medicaid beneficiaries' experiences with the Medicaid HCBS delivered by providers. The [National Quality Forum](#) (NQF), an organization that endorses quality measures in healthcare, endorsed 19 quality measures developed from the survey.<sup>11</sup> Below are the measurement domains developed by NQF to highlight the important topics for quality measurements in HCBS:<sup>12</sup>

- Service Delivery and Effectiveness
  - Person-Centered Planning and Coordination
  - Choice and Control
  - Community Inclusion
  - Caregiver Support
  - Workforce
  - Human and Legal Rights
  - Equity
  - Holistic Health and Functioning
  - System Performance and Accountability
  - Consumer Leading in System Development
- **National Core Indicators (NCI).** The National Core Indicators for Intellectual and Developmental Disabilities (NCI-IDDD) and National Core Indicators for Aging and Disabilities (NCI-AD) are two data sets from survey instruments that help states assess key indicators related to community living.<sup>13</sup> Forty-eight states and the District of Columbia use the NCI-IDDD and 24 states use NCI-AD.<sup>14</sup> State reports from [NCI](#) and [NCI-AD](#) measures are available to the public.
  - **Personal Outcome Measures (POM).** POM measures assess the care experience of population(s) included in HCBS programs (e.g., older adults, adults with intellectual and developmental disabilities, adults with physical disabilities, adults with serious mental illness).<sup>15</sup> POM measures included in the HCBS quality set assess whether “people... realize personal goals; choose services; are free from abuse and neglect; have the best possible health; live in integrated environments; interact with other members of the community; and participate in the life of the community.”

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<sup>9</sup> Centers for Medicare & Medicaid Services. (n.d.). *Measuring and Improving Quality in Home and Community-Based Services (HCBS). Medicaid*. Retrieved from <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/measuring-and-improving-quality-home-and-community-based-services-hcbs/index.html>.

<sup>10</sup> Medicaid and CHIP Payment and Access Commission. (2021). *Quality of Home- and Community-Based Services*. Retrieved from <https://www.macpac.gov/subtopic/quality-of-home-and-community-based-services/>.

<sup>11</sup> National Quality Forum. (2016). *Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement*. Retrieved from [https://www.qualityforum.org/Publications/2016/09/Quality\\_in\\_Home\\_and\\_Community-Based\\_Services\\_to\\_Support\\_Community\\_Living\\_Addressing\\_Gaps\\_in\\_Performance\\_Measurement.aspx](https://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living_Addressing_Gaps_in_Performance_Measurement.aspx).

<sup>14</sup> National Core Indicators. (2022) Welcome to National Core Indicators (NCI): People Driven Data to Promote Positive Change. Retrieved from <https://www.nationalcoreindicators.org/>.

<sup>15</sup> Ibid.

<sup>16</sup> The Council on Quality and Leadership (CQL) (2022). *Personal Outcome Measures*. Retrieved from <https://www.c-q-l.org/tools/personal-outcome-measures/>.

## Measuring Quality in HCBS: Key Considerations for Health Plans

- **Quality Measures for Managed LTSS (MLTSS).** CMS developed a set of standardized MLTSS quality measures for managed care organizations (MCOs).<sup>16</sup> States that deliver their HCBS programs through MLTSS can use either the MLTSS measures listed or their Healthcare Effectiveness Data and Information Set (HEDIS) equivalents:<sup>17</sup>

MLTSS Measure	HEDIS Measure Equivalent
MLTSS-1: LTSS Comprehensive Assessment and Update	Long-Term Services and Supports-CAU
MLTSS-2: LTSS Comprehensive Care Plan and Update	Long-Term Services and Supports-CPU
MLTSS-3: LTSS Shared Care Plan with Primary Care Provider	Long-Term Services and Supports-SCP
MLTSS-4: LTSS Reassessment/Care Plan Update After Inpatient Discharge	Long-Term Services and Supports-RAU

In addition to these four MLTSS measures, there are four additional MLTSS measures without HEDIS equivalents that also serve to improve HCBS program outcomes. These eight measures provide information about assessment and care planning processes with MLTSS members, as well as LTSS rebalancing.<sup>18</sup> They also help inform states of their ranking and progress in factors such as community integration and individual choice.<sup>19</sup>

Additionally, CMS published HCBS quality measure issue briefs to summarize major developments in HCBS quality measures. These briefs can support stakeholders seeking to implement quality measures in their HCBS programs. The three issue briefs focus on:

- [Person-Centered Assessments and Care Plans](#)
- [Person-Reported Outcomes](#)
- [Rebalancing the Long-Term Services and Supports System toward HCBS](#)

### Adopt Operational Protocols

- **Adopt a Quality Rating System (QRS).** Quality rating systems can help beneficiaries understand performance differences between health plans.<sup>20</sup> States use ratings for plan oversight, to inform contracting decisions with managed care plans and to refine state goals for the state's quality strategy.<sup>21</sup> In 2016, CMS required that states contracting with comprehensive, risk-based MCOs adopt the Medicaid managed care QRS developed by CMS within three years of

<sup>17</sup>Centers for Medicare & Medicaid Services, (n.d.). *Measures for Medicaid Managed Long Term Services and Supports Plans*. Retrieved from <https://www.medicaid.gov/media/3396>.

<sup>18</sup>Centers for Medicare & Medicaid Services. (2022). *Medicaid Managed Long-Term Services and Supports (MLTSS) Measures Technical Specifications and Resource Manual*. Retrieved from <https://www.medicaid.gov/medicaid/managed-care/downloads/mltss-tech-specs-res-manual.pdf>.

<sup>19</sup>Centers for Medicare & Medicaid Services. (n.d.). *Managed Long Term Services and Supports FAQ*. Retrieved from <https://www.medicaid.gov/medicaid/managed-care/lts/mltss-faq/index.html>.

<sup>20</sup>Bradley, V., Bourne, M.L., Bershady, J., & Young, A. (2017). *Priority Measures of Quality in LTSS: NCI & NCI-AD*. Retrieved from <http://www.advancingstates.org/sites/nasud/files/Priority%20measures%20of%20quality%20in%20LTSS.pdf>.

<sup>21</sup>Medicaid and CHIP Payment and Access Commission (MACPAC) (2021). *Quality Rating Systems in Medicaid Managed Care Final Report*. Retrieved from <https://www.macpac.gov/wp-content/uploads/2021/03/Quality-Rating-Systems-in-Medicaid-Managed-Care.pdf>.

<sup>22</sup>ibid.

the final rule.<sup>22</sup> However, as of October 2022, Medicaid is developing the QRS for managed care which will include requirements for MLTSS plans. Most states are waiting until the federal Medicaid QRS methodology is released to determine an approach, but some early-adopter states have implemented quality rating systems in an effort to drive improvement, engage beneficiaries, and enhance accountability in their Medicaid managed care programs.<sup>23</sup>

- **Collect Data from Case Managers.** Case managers (and support brokers in self-directed programs) are often in a valuable position to help assess the quality of HCBS. They can help members ensure that provider agencies and individual workers comply with member preferences, change providers when necessary, and alert the plan to any quality concerns about specific providers or individual workers. Case managers can gather information about members' experiences through assessments, reassessments, and ad hoc conversations. The health plan can use this information to update member care plans, if necessary.
- **Conduct Member and Caregiver Surveys.** Some states conduct member and caregiver surveys as a means of improving quality. Examples of such surveys include the [HCBS CAHPS Survey](#), [NCI-IDD](#), and [NCI-AD](#). Since administration of these surveys is voluntary, states vary in which survey(s) they use and how often they administer surveys based on their LTSS populations. Since 2019, 41 out of 50 states administered at least one out of the three experience of care surveys to LTSS beneficiaries.<sup>24</sup>
- **Compare the Person-Centered Service Plan to the Services Provided.** States with HCBS waivers are required to develop individualized care plans with participants. The member and/or family are given the opportunity to express how they need supports and services delivered and provide feedback about services received. To measure the extent to which services are provided in a manner consistent with the needs, preferences, and strengths of the individual and/or family, health plans can ensure members have a copy of their service plan; monitor the member's progress toward meeting their service plan goals by collecting data from case managers and conducting member and caregiver surveys; and review and update the service plan at least every 12 months, when there is a change in the member's condition, or at the member's request.<sup>25</sup> Electronic Visit Verification (EVV) of personal care services (PCS) and home health care services (HHCS) that require an in-home visit by a provider is required as of January 1, 2020, by the 21<sup>st</sup> Century Cures Act, Section 12006.<sup>26</sup> EVV systems and related reports are designed to ensure that services are provided when scheduled and support health plans in verifying services are delivered. Members receiving substantially fewer services than their plan authorizes for them could require additional providers, a different service mix, or adjustments to the care plan.

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<sup>23</sup>Centers for Medicare & Medicaid Services. (2016). *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability (42 CFR 438.334)*. Retrieved from <https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered>.

<sup>24</sup>Ibid.

<sup>25</sup>Centers for Medicare & Medicaid Services (n.d.). State Use of Experience of Care Surveys for Beneficiaries Using Long-Term Services and Supports. Retrieved from <https://www.medicaid.gov/state-overviews/scorecard/state-use-patient-surveys-ltss-beneficiaries/index.html>.

<sup>26</sup>Centers for Medicare & Medicaid Services. (2015). *Key Message and Tips for Providers: Person-Centered Service Plans*. Retrieved from <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/key-messages-Person-Centered-Service-Plans-%5BSeptember-2015%5D.pdf>.

<sup>27</sup>Centers for Medicare & Medicaid Services. (n.d.). *Frequently Asked Questions: Section 12006 of the 21<sup>st</sup> Century Cures Act*. Retrieved from <https://www.medicaid.gov/federal-policy-guidance/downloads/faq051618.pdf>.

## Monitor and Incentivize Providers

Health plans are likely to have a formal licensure process for facility-based providers, a certification process, and an annual review for other supports. One way to monitor quality is by outlining relevant items to examine during provider reviews. However, a limitation to this method is that data is collected only periodically. Customer satisfaction surveys and case manager input can also help plans monitor providers more frequently. The [North Carolina DHHS Review Tools](#) for Initial and Routine Monitoring – Licensed Independent Practitioners is one framework developed by North Carolina’s Department of Health and Human Services (DHHS) to monitor HCBS providers that combines a scoring methodology with a comments section.

Some states are implementing value-based payment (VBP) strategies as part of their HCBS quality improvement strategy. VBP is a reimbursement model that rewards plans and providers based on the quality of care they provide, instead of compensating providers based on the volume of services. CMS is focusing on VBP to “increase state adoption of strategies that tie together quality, cost, and outcomes in support of community-based long-term services and supports (LTSS) programs.”<sup>27</sup> As part of the CMS focus on VBP reform, a recent [Medicaid Innovation Accelerator Program](#) (IAP) highlighted community integration through LTSS, including a VBP track for HCBS. Measuring quality in HCBS is a critical component of VBP and health plans can use their understanding of VBP to help states reach their quality measurement goals.

## Employ Incident Reporting/Management Systems

States are required to design and implement “an effective [incident management] system for assuring waiver participant health and welfare.”<sup>28</sup> Understanding federal and specific state requirements regarding critical incident reporting and having timely access to critical incident reports will allow health plans to assist the state in administering their incident management system and will support the welfare of members. Critical incidents include abuse, neglect, and/or exploitation; unexpected or frequent hospitalizations; deaths; serious injuries that require medical intervention or result in hospitalization; medication errors; inappropriate use of restraints; and other incidents or events that involve harm or risk of harm to participants.<sup>29</sup> In 2019, CMS launched a national incident management survey to states that operate 1915(c) waivers and found that 32 of 45 (71 percent) of the surveyed states operate more than one incident management system.<sup>30</sup> States might operate different incident management systems depending on the waiver recipient population. Due to the variance in what is considered a critical incident and the systems that track them, health plans may want to understand the specific requirements of their state’s incident management system(s) and the health plan’s role in reporting and tracking.

The Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) seeks to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. This brief is intended to support health plans and providers in integrating and coordinating care for dually eligible beneficiaries. It does not convey current or anticipated health plan or provider requirements. For additional information, please go to <https://www.resourcesforintegratedcare.com/>. The list of resources in this guide is not exhaustive. Please submit feedback to [RIC@lewin.com](mailto:RIC@lewin.com).

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<sup>28</sup>Centers for Medicare & Medicaid Services. (n.d.). Measuring and Improving Quality in Home and Community-Based Services (HCBS). Medicaid. Retrieved from <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/measuring-and-improving-quality-home-and-community-based-services-hcbs/index.html>.

<sup>29</sup>Centers for Medicare & Medicaid Services. (n.d.). *Findings From the 1915(c) Waiver Incident Management Survey: Incident Management Systems and Processes*. Retrieved from <https://www.medicaid.gov/medicaid/home-community-based-services/downloads/ims-national-overview-part1.pdf>.

<sup>30</sup>Ibid.

<sup>31</sup>Ibid.