

Request for Information: Recommended Measure Set for Medicaid-Funded Home and Community-Based Services

SUMMARY

This request for information (RFI) seeks public input on a draft set of recommended quality measures for Medicaid-funded home and community-based services (HCBS). This RFI seeks feedback on the potential benefits of and challenges that could result from a nationally available set of recommended quality measures for voluntary use by states, managed care organizations, and other entities engaged in the administration and/or delivery of HCBS. CMS is also requesting stakeholder comment on the purpose and organization of the recommended measure set, the criteria used to select measures, and a preliminary draft set of measures for assessing the quality and outcomes of Medicaid-funded HCBS.

Comments should be submitted electronically to HCBSMeasuresRFI@cms.hhs.gov no later than November 18, 2020. Please note your organization name and type (e.g., state agency, managed care organization, provider) in your response.

I. Introduction

The Centers for Medicare & Medicaid Services (CMS) and states have worked for decades to support the increased availability and provision of high quality HCBS for Medicaid beneficiaries. HCBS provide individuals who need assistance (such as personal care, homemaker services, and adult day health services) the opportunity to receive services in their own homes or in the community as opposed to institutional settings. Through this RFI, we seek input on a draft set of recommended measures for Medicaid-funded HCBS that is intended for voluntary use by states and other entities. This is a request for information only. Questions are provided throughout the document. A full list of questions is also provided at the end. Respondents are encouraged to provide complete but concise responses to the questions outlined in this RFI. Please note that a response to every question is not required.

II. Background

Millions of Americans, including children, non-elderly adults, and older adults, need long-term services and supports (LTSS) because of disabling conditions, chronic illness, and other factors. Medicaid is the primary payer across the nation for these services, although private payers (e.g., out-of-pocket spending by individuals, long-term care insurance) and other public payers (e.g., Veterans Health Administration, state and local programs, Medicare) also account for some LTSS spending nationally.¹ Medicaid allows for the coverage of LTSS through several vehicles and over a continuum of settings, ranging from institutional care, such as in nursing facilities, to

¹ Office of the Assistant Secretary for Planning and Evaluation. February 8, 2018. An Overview of Long-Term Services and Supports and Medicaid: Final Report. Retrieved from <https://aspe.hhs.gov/basic-report/overview-long-term-services-and-supports-and-medicare-final-report>.

HCBS.² Medicaid coverage of HCBS varies by state and can include a combination of medical and non-medical services, such as (but not limited to): case management, homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. HCBS programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illness, and provide opportunities for Medicaid beneficiaries to receive services in their own homes and communities rather than in institutions.

From the beginning of the Medicaid program in 1965, state Medicaid programs were required to provide medically necessary nursing facility care for most eligible individuals age 21 or older, but coverage for HCBS was generally not included.³ However, over the past several decades, states have used several federal authorities,⁴ as well as federally funded grant programs,⁵ to develop a broad range of HCBS to provide alternatives to institutionalization for eligible Medicaid beneficiaries.

Consistent with many beneficiaries' preferences of where they would like to receive their care, HCBS have become a critical component of the Medicaid program and are part of a larger framework of progress toward community integration of older adults and people with disabilities that spans efforts across the federal government. As a result of these efforts, Medicaid spending on HCBS now exceeds spending on institutional services. In fiscal year (FY) 1986, HCBS expenditures accounted for less than 10 percent of the approximately \$13 billion in federal and state expenditures for all Medicaid LTSS, including nursing home expenditures.⁶ By FY 2016, HCBS expenditures accounted for \$94 billion, or 57 percent, of the \$167 billion spent nationally on Medicaid LTSS.⁷

The dramatic growth in Medicaid HCBS spending and use over the past several decades resulted from dedicated efforts by policymakers, advocates, and beneficiaries who worked for decades to alter what has been commonly referred to as an "institutional bias" in Medicaid LTSS. However,

² See <https://www.medicaid.gov/medicaid/long-term-services-supports/index.html> for more information on LTSS and <https://www.medicaid.gov/medicaid/home-community-based-services/index.html> for more information on HCBS.

³ Wenzlow, Audra, Steve Eiken and Kate Sredl. 2016. Improving the Balance: The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS), FY 1981-2014. Retrieved from <https://www.medicaid.gov/sites/default/files/2019-12/evolution-ltss-expenditures.pdf>.

⁴ These authorities include Medicaid state plan personal care services and Social Security Act (the Act) section 1915(c) waivers, section 1915(i) state plan HCBS, section 1915(j) self-directed personal assistant services, and section 1915(k) Community First Choice. See <https://www.medicaid.gov/medicaid/home-community-based-services/index.html> for more information on these authorities. Some states also use demonstration authority under section 1115(a) of the Act to test home and community based service strategies. See <https://www.medicaid.gov/medicaid/section-1115-demonstrations/index.html> for more information.

⁵ Federally funded grant programs, such as the Money Follows the Person demonstration, which was initially authorized through the Deficit Reduction Act and continues to operate in 43 states, and the Balancing Incentive Program, which provided financial incentives over four years (FY 2011-2015) to 13 states to increase access to HCBS, have been designed to shift Medicaid's long-term care spending from institutional care to HCBS.

⁶ Wenzlow, Audra, Steve Eiken and Kate Sredl. 2016. Improving the Balance: The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS), FYs 1981-2014. Retrieved from <https://www.medicaid.gov/sites/default/files/2019-12/evolution-ltss-expenditures.pdf>.

⁷ <https://www.medicaid.gov/sites/default/files/2019-12/ltssexpenditures2016.pdf>

as the number of beneficiaries receiving Medicaid HCBS and spending on HCBS has increased, so has the need to ensure the availability and provision of high quality services that promote positive outcomes and cost-effective delivery of care, while minimizing provider burden.

HHS, states, and other entities have taken a number of steps over the past decade, in particular, to strengthen the capacity of states and the federal government to monitor, oversee, and improve the quality and effectiveness of services and to assure beneficiary health and safety. For example, in 2014, CMS made revisions to the quality oversight structure originally established in 2004 for section 1915(c) HCBS waiver programs.⁸ At the center of this framework is reporting on state-developed performance measures designed to reflect the operations of waiver programs across important domains that CMS defined, such as beneficiary health and welfare (safety), financial accountability, and service provision and delivery. CMS has also promoted the development of new quality measures,⁹ standardized tools and instruments,¹⁰ and other innovations related to HCBS through initiatives such as the Testing Experience and Functional Tools (TEFT) demonstration,¹¹ the Balancing Incentive Program,¹² and the Medicaid Innovation Accelerator Program.¹³ As another example, for the last five years, HHS's Administration for Community Living's National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) has implemented a Rehabilitation Research and Training Center grant to develop, cognitively and psychometrically test, and gain National Quality Forum (NQF)¹⁴ approval for HCBS quality measures. This work will continue for another 5 years. Additionally, NIDILRR is conducting a competition of a new cycle of funding under this mechanism, in the summer of 2020. The new cycle of work, among other things, will increase the capacity of the field to conduct research on HCBS topics. Many states have also made substantial investments related to monitoring, overseeing, and improving the quality of HCBS.¹⁵

⁸ https://www.medicaid.gov/sites/default/files/2019-12/3-cmcs-quality-memo-narrative_0.pdf

⁹ See <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html> and <https://www.medicaid.gov/medicaid/managed-care/ltss/index.html> for examples.

¹⁰ See <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html> and <https://www.medicaid.gov/medicaid/ltss/teft-program/functional-assessment-standardized-items/index.html> for examples.

¹¹ <https://www.medicaid.gov/medicaid/ltss/teft-program/index.html>

¹² <https://www.medicaid.gov/medicaid/ltss/balancing/incentive/index.html>

¹³ <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/index.html>

¹⁴ NQF (<https://www.qualityforum.org/Home.aspx>) is a private non-profit organization and is currently designated as the consensus-based entity with a contract with HHS under Section 1890 of the Social Security Act (the Act). As required under section 1890, the CBE is required to: synthesize evidence and convene key stakeholders to make recommendations on an integrated national strategy and priorities for health care performance measurement in all applicable settings; and provide for the endorsement of standardized health care performance measures and establish and implement a process to ensure that measures endorsed are updated (or retired if obsolete) as new evidence is developed. See https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/CMS-RTC-Quality-Measurement-March-1-2019_508.pdf for more information.

¹⁵ National Quality Forum (NQF). "Quality in Home- and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement." Final Report. Washington, DC: NQF, September 2016. http://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living_Addressing_Gaps_in_Performance_Measurement.aspx

Despite these and other recent advances, notable gaps and challenges related to HCBS quality remain. In particular, a 2016 NQF report commissioned by the Department of Health and Human Services (HHS) on “Quality in Home- and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement” indicates that, unlike other types of health care services, “HCBS lacks any standardized set of quality measures...[and] consensus as to what HCBS quality entails.” The report also recommends that HHS develop “a core set of standard measures for use across the HCBS system, along with a menu of supplemental measures that are tailorable to the population, setting, and program.”¹⁵ This RFI is intended to solicit feedback on a draft set of recommended measures for Medicaid-funded HCBS that is designed specifically to address this recommendation. It also aligns with CMS’s Meaningful Measures¹⁶ initiative, which identifies CMS’s highest priorities for quality measurement and improvement. We may also use the feedback we receive through this RFI to inform other CMS initiatives, including the Medicaid and CHIP Scorecard,¹⁷ the Adult and Child Core Sets,¹⁸ and the future Medicaid and CHIP Quality Rating System.¹⁹

III. About the Draft HCBS Recommended Measure Set

A. Purpose

The HCBS recommended measure set is intended as a resource for voluntary use by states, managed LTSS (MLTSS) plans, providers, and other entities to support more consistent use of HCBS quality measures, including to meet the section 1915(c) assurances and sub-assurances²⁰ or other CMS requirements, and to create opportunities to have comparative quality data on HCBS programs and services, including for the purposes of value-based purchasing and alternative payment models. It is also intended to reduce some of the burden that states and others may experience in identifying and using HCBS quality measures. By providing states and other entities with a set of standard measures to assess HCBS quality and outcomes and by facilitating access to information on those measures, CMS may be able to reduce the time and resources expended on identifying, assessing, and implementing measures for use in HCBS programs. The suggested measure set supports CMS’s strategic initiatives, “Ensuring Safety & Quality,” “Transforming Medicaid,” and “Innovating Payment Models.”²¹

- **Questions:**
 - **What is the value in having a standard set of recommended quality measures for voluntary use by states, managed care organizations, and other entities engaged in the administration and/or delivery of HCBS?**

¹⁶ See <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page> for more information.

¹⁷ See <https://www.medicaid.gov/state-overviews/scorecard/index.html> for more information.

¹⁸ See <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html> for more information.

¹⁹ See <https://www.medicaid.gov/Medicaid/downloads/improving-the-quality-of-care-for-medicaid-beneficiaries-fact-sheet.pdf> and <https://www.regulations.gov/document?D=CMS-2018-0140-0001> for more information.

²⁰ https://www.medicaid.gov/sites/default/files/2019-12/3-cmcs-quality-memo-narrative_0.pdf

²¹ <https://www.cms.gov/about-cms/story-page/our-16-strategic-initiatives.html>

- **What benefits or challenges would result from the public release of a recommended set of quality measures?**

B. Content

The recommended measure set will be comprised of measures that are intended to assess quality across a broad range of domains identified as measurement priorities for HCBS. According to CMS’s Measures Management System Blueprint, a quality measure, or performance measure, is a “numeric quantification of healthcare quality for a designated accountable healthcare entity, such as hospital, health plan, nursing home, or clinician. A healthcare performance measure is a way to calculate whether and how often the healthcare system does what it should. Measures are based on scientific evidence about processes, outcomes, perceptions, or systems that relate to high-quality care.”²²

To be included in the measure set, a measure must be clearly defined and expressed as a rate, proportion, or ratio that is calculated with (1) a numerator that counts the number of processes or outcomes that qualify for the measure, and (2) a denominator, which counts the number of people eligible for the process or for whom the outcome is relevant. A measure must also have clearly defined exclusion criteria that can be used to identify who should be removed from the measure population.²³

C. Organization

CMS proposes to organize the measure set into two main parts, a base set of measures and an extended set of measures, with appendices for additional information and context.²⁴ The base set will be comprised of a small number of measures that are intended for use in their entirety as a set of measures to promote widespread adoption of common measures and create opportunities for comparative data (e.g., across states, MLTSS plans, or populations). The extended set will be comprised of a larger number of measures from which states, MLTSS plans, and other entities could select to supplement the base set and address their priorities and needs.

For both the base set and the extended set, CMS proposes to organize the measures using the eleven HCBS quality domains described in NQF’s 2016 report on “Quality in Home- and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement.”²⁵ This organization is intended to help ensure that the measure set addresses a

²² Centers for Medicare & Medicaid Services (CMS). “Blueprint for the CMS Measures Management System.” Version 15.0, September 2019. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MMS-Blueprint.html>.

²³ <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/NTM-What-is-a-Quality-Measure-SubPage>

²⁴ Except where the base set or extended set is specifically identified, any reference to the “measure set” in this document refers broadly to both the base set and the extended set.

²⁵ CMS also considered organizing the measures using the “Meaningful Measures” framework, which is a CMS framework for identifying the highest priorities for quality measurement and improvement. Meaningful Measures is intended as a broader framework for measures across the health system and is not specific to HCBS. As a result, CMS is proposing to organize the measures using an HCBS-specific framework rather than Meaningful Measures. However, CMS intends to include information on how the measure set aligns with Meaningful Measures, as well as

broad and diverse range of areas related to HCBS quality measurement priorities.²⁶ CMS is particularly interested in recommendations for measures that address domains for which there are no base set and/or extended set measures listed.

- **Questions:**
 - **Do you think that the measure set should be organized into a base set and an extended set? Why or why not?**
 - **Do you agree with organizing the measures by NQF domain? If not, is there a different organizing framework that you would recommend?**
 - **Which domains in the NQF report are most important to address through the recommended measure set?**

D. Measure Selection Criteria

Consistent with the Blueprint for the CMS Measures Management System²⁷ and NQF measure evaluation criteria,²⁸ measures will be selected for inclusion in the measure set based on the following criteria:

- *Importance to Measure and Report:* Extent to which the specific measure focus is important to making significant gains in quality and improving outcomes for a specific high-impact aspect of care where there is variation in or overall poor performance.
- *Scientific Acceptability of the Measure Properties:* Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results, including across HCBS populations, when implemented.
- *Feasibility:* Extent to which the specifications (including measure logic) require data that are readily available or that could be captured without undue burden and can be implemented for performance measurement. This criterion also includes whether measure specifications and any instruments needed to collect data are publicly available at no cost.
- *Usability and Use:* Extent to which states, HCBS programs, MLTSS plans, or other entities are using or could use performance results for both accountability and performance improvement. For example, whether a measure can be used to support the

other CMS initiatives, in the recommended measure set. See <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html> for more information on Meaningful Measures.

²⁶ The domains include: 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; and Consumer Leadership in System Development. Definitions for each NQF domain are embedded within the recommended measure set. The subdomains and subdomain definitions are also provided in the recommended measure set for informational purposes. However, because of the limited number and breadth of HCBS measures available, the measures are not organized by subdomain.

²⁷ CMS. "Blueprint for the CMS Measures Management System." Version 15.0, September 2019.

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MMS-Blueprint.html>.

²⁸ NQF. "Measure Evaluation Criteria and Guidance for Evaluating Measures for Endorsement." September 2018. <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=88439>.

existing reporting requirements associated with the section 1915(c) assurances and sub-assurances²⁹ or other CMS requirements will be considered as part of this criterion.

- *Related and Competing Measures*: Extent to which there are related measures (i.e., measures that address either the same topic or the same population) and/or competing measures (i.e., measures that address both the same topic and the same population) in the measure set.

CMS also intends to take into account the following additional criteria in selecting measures for inclusion:

- *Level at Which Measure Can Be Applied*: Whether the measure can be applied at the statewide, delivery system, and/or population levels.
- *Type of Measure*: Whether the measure is a structural, process, or outcome measure.³⁰
- **Questions:**
 - **Are there changes that CMS should make to the measure selection criteria?**
 - **Which of the criteria are most important and should be prioritized?**

Due to the lack of tested and validated HCBS measures, measurement burden (e.g., financial cost associated with data collection, staffing resources required for data analysis and reporting), and other challenges (e.g., lack of timely access to Medicare data on Medicaid HCBS beneficiaries who also have Medicare coverage) associated with some available measures, there are limitations to strictly applying the criteria. For instance, most HCBS measures that have been tested are survey-based measures that states and other entities have indicated have high measurement burden³¹ (e.g., HCBS CAHPS, National Core Indicators, National Core Indicators-Aging and Disabilities). As another example, some MLTSS measures require access to Medicare data that MLTSS plans have reported challenges with accessing if the plan is not also responsible for delivering and managing dually eligible beneficiaries' Medicare benefits. In these examples,

²⁹ https://www.medicaid.gov/sites/default/files/2019-12/3-cmcs-quality-memo-narrative_0.pdf

³⁰ *Structural measures* focus on features of a healthcare organization or provider that are relevant to the capacity to provide high quality care. *Process measures* focus on activities or steps performed for, on behalf of, or by a person related to their care. There should be a scientific basis for believing that the process, if executed well, will increase the probability of achieving a desired outcome. Process measures are the most common type of quality measure. *Outcome measures* assess the results of care. They focus on the person's health state, health status, or change in health status resulting from care. Some outcome measures are intermediate outcome measures that examine the change produced by an intervention, which leads to a longer-term outcome (e.g., an intervention that prevents falls and, in turn, reduces the risk of serious injury and/or mortality among the elderly). Sources: CMS. "Blueprint for the CMS Measures Management System." Version 15.0, September 2019. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MMS-Blueprint.html>; and NQF. "Measure Evaluation Criteria and Guidance for Evaluating Measures for Endorsement." September 2018. <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=88439>.

³¹ While survey-based measures can be labor intensive and be costly to conduct, they are often necessary to assess experience of care and other person-reported outcomes that help states determine how well HCBS program and services meet individuals' goals and improve their quality of life. See <https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbs-quality-measures-brief-2-person-reported-outcome.pdf> for more discussion of person-reported outcome measures.

the measures score reasonably well on the Scientific Acceptability of the Measure Properties criterion, but there are notable limitations related to the Feasibility criterion.

CMS is proposing to use the criteria as a guide, rather than a standard, in selecting the measures. We intend to more strictly apply the Importance to Measure, Feasibility, and Scientific Acceptability criteria to the base set than to the extended set. If the Scientific Acceptability criterion is waived or relaxed for any measures in the initial version of the recommended measure set (e.g., because of a lack of available measures with adequately established reliability and validity in an important measurement domain), CMS expects to waive or relax this criterion temporarily or provisionally while the measure steward assesses the psychometric properties of the measure; any measures that do not meet the Scientific Acceptability criterion may be removed or replaced with other measures after a reasonable time period if the measure steward is unable to demonstrate that the measure is valid and reliable. In addition, when assessing a measure on the Scientific Acceptability criterion, CMS intends to take into account whether a measure has been endorsed by a consensus-based entity (e.g., National Quality Forum³²), an accreditation body, or other independent entity, but is not requiring that measures in the measure set be endorsed at this time.

- **Question:**
 - **Should the base and extended measure sets only include measures that have undergone testing and validation?**
 - **How important is it for measures in the base set and/or extended set to be endorsed by a consensus-based entity, an accreditation body, or other independent entity?**
 - **Should CMS prioritize, for inclusion in the measure set, measures that have been endorsed by any particular entity?**

The Usability and Use and Related and Competing Measures criteria will be taken into consideration in selecting measures for both the base set and the extended set, but will not be applied rigorously to either. In particular, the Usability and Use criterion will be difficult to fully assess for some measures due to the lack of publicly available information on the extent to which the measures are currently in use.

- **Questions:**
 - **Should there be differences in how the measure selection criteria described above are applied to measures that are important to measure and/or are in wide use by states and/or managed care organizations?**
 - **Should the base and extended measure sets cross all HCBS populations? If no, what special populations should be addressed in the extended set? What types of measures, if any, would apply only to a suggested population(s)?**

³² <https://www.qualityforum.org/Home.aspx>

Measures that are in the public domain and rely on publicly available instruments will be prioritized for the measure set. However, there are measures and measure concepts³³ currently in use by states and MLTSS plans that are proprietary and/or rely on the use of proprietary instruments that are available for a fee. As a result, measures that are not in the public domain and/or rely on proprietary instruments that are available for a fee, could be included in the measure set, particularly if there is publicly available data on the measures. To the extent feasible, a measure that is publicly available at no cost and focused on the same or a similar measure concept will be offered as an alternative to each proprietary measure that is included in the base set. For instance, the draft base set includes a choice of measures on similar measure concepts from the National Core Indicators (NCI), National Core Indicators-Aging and Disabilities (NCI-AD), and the HCBS CAHPS experience of care survey.^{34,35}

- **Questions:**
 - **Should the base set and/or the extended set only include measures that are in the public domain and are available at no charge?**
 - **Is it important to offer publicly available measures that are free of charge as alternatives to any proprietary measures included in the base set?**
 - **Should publicly available measures be offered as alternatives to any proprietary measures included in the extended set?**
 - **How important is it to include experience of care survey measures in the measure set?**

CMS intends to prioritize measures that can be applied at the statewide, delivery system, and population levels. However, most HCBS measures have not been specified and tested at each of these levels. It also may not be possible to apply all of the measures at all levels due to small sample sizes, data limitations, or other reasons. As a result, the measures included in the measure set may not necessarily be appropriate for or feasible to use at all of these levels. In the initial version of the measure set, CMS intends to provide information on the level at which each measure can be applied.

- **Questions:**
 - **Are there any measurement domains or areas for which it is important to have population-specific measures?**

³³ A *measure concept* is defined as “an idea for a measure (or a description of an existing or potential assessment tool or instrument) that includes a description of the measure, including planned target and population,” while a *measure* is defined as “a fully developed metric that includes detailed specifications and may have undergone scientific testing.” Source: National Quality Forum. A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I’s for Health Equity. Washington, DC: National Quality Forum; 2017. https://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities_The_Four_I_s_for_Health_Equity.aspx.

³⁴ The HCBS CAHPS survey instrument is publicly available at no charge, while NCI and NCI-AD are proprietary and available to states for a fee.

³⁵ It is important to recognize that, although a choice of instruments is included in the base set, measure results from different instruments should not be compared with each other, due to methodological and other differences between the instruments. The measures that are included from each of these instruments under some domains also differ substantially from each other.

- **How important is it for measures included in the base set to be applicable across delivery system types (e.g., fee for service, managed care, self-direction)?**

There are three main types of measures (structural, process, and outcome).³⁶ Based on stakeholder feedback, CMS expects to prioritize outcome measures for inclusion in the base set and the extended set. However, all three types of measures are eligible for inclusion, both because of the lack of available HCBS outcome measures and because process and structural measures can assess important processes or features of care that directly impact outcomes.

- **Questions:**
 - **Some stakeholders have indicated a preference for decreasing reliance on process measures and the focus on compliance in HCBS quality measurement programs, instead putting an increased focus on quality improvement and the use of outcome measures. Would greater focus on quality and outcomes facilitate the provision of Medicaid-funded HCBS? If so, how?**
 - **What specific existing process or structural measures generate the most valuable information for measuring and improving quality or outcomes?**
 - **Are there specific measures that your organization is using for compliance purposes that you would recommend for inclusion in the recommended measure set? Please be specific both about the measures suggested and how they are being used by your organization.**
 - **CMS intends to include information in the recommended measure set on how each measure can be used to support reporting requirements associated with the section 1915(c) assurances and sub-assurances or other CMS requirements. How can CMS further reduce measurement and reporting burden through this recommended measure set?**

IV. Limitations

CMS views the initial development of both the base and extended measure sets as an important step forward in our efforts to strengthen HCBS quality measurement and reporting nationally,

³⁶ *Structural measures* focus on features of a healthcare organization or provider that are relevant to the capacity to provide high quality care. *Process measures* focus on activities or steps performed for, on behalf of, or by a person related to their care. There should be a scientific basis for believing that the process, if executed well, will increase the probability of achieving a desired outcome. Process measures are the most common type of quality measure. *Outcome measures* assess the results of care. They focus on the person's health state, health status, or change in health status resulting from care. Some outcome measures are intermediate outcome measures that examine the change produced by an intervention, which leads to a longer-term outcome (e.g., an intervention that prevents falls and, in turn, reduces the risk of serious injury and/or mortality among the elderly). Sources: Centers for Medicare & Medicaid Services (CMS). "Blueprint for the CMS Measures Management System." Version 15.0, September 2019. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/MMS-Blueprint.html>; and National Quality Forum (NQF). "Measure Evaluation Criteria and Guidance for Evaluating Measures for Endorsement." September 2018. <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=88439>.

but recognizes that there are a number of limitations of the measure set and HCBS quality measurement overall. These limitations include:

- A lack of available quality measures to include in the base set and/or the extended set for some NQF domains;
- High measurement burden and other challenges associated with some quality measures;
- A lack of publicly available information on the extent to which some quality measures are currently in use;
- A limited number of outcome measures that have been tested and validated; and
- A limited number of quality measures that have been tested and validated at the statewide, delivery system, and population levels.

Anecdotally, some stakeholders have reported to CMS that many of the currently available measures are too clinically focused and/or do not assess key areas of focus for HCBS. Stakeholders have also noted that some measures may not be appropriate for all purposes (e.g., value-based purchasing and alternative payment models) for which states or other entities may be interested in using HCBS quality measures. In addition, some stakeholders have raised concerns that a recommended measure set will lead to reduced state flexibility to select performance measures for HCBS programs.

CMS will establish processes and mechanisms for ongoing feedback and dialogue on the recommended measure set and on our broader efforts to address gaps and limitations in HCBS quality measures. Over time, CMS expects to update the recommended measure set as new measures are developed, if meaningful distinctions or improvements in performance on specific measures can no longer be made, to address stakeholder concerns, or for other reasons.

- **Questions:**
 - **How often should the measure set be reviewed for potential retirement of included measures and/or addition of new measures?**
 - **How often should the base set and/or the extended set be updated?**

CMS intends to include the following information in the recommended measure set: brief measure specifications, including (at a minimum) data source, numerator, denominator, and exclusion criteria; measure steward³⁷ and where to obtain detailed measure specifications for each measure; an assessment of the extent to which each measure meets the measure selection criteria described in this document; and whether a measure can be used to address or measure compliance with existing CMS requirements (e.g., section 1915(c) assurances and subassurances, home and community-based settings requirements³⁸) or aligns with other CMS initiatives (e.g., Meaningful Measures³⁹). CMS will provide technical assistance and other resources to support the implementation and use of the measure set and other HCBS quality measures.

- **Questions:**

³⁷ The measure steward is the entity that owns the measure and is responsible for maintaining it.

³⁸ See <https://www.medicaid.gov/medicaid/hcbs/guidance/settings/index.html> for more information.

³⁹ See <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html> for more information.

- Are there other components of measure specifications (beyond those described above) that should be included in the measure set?
- Is there other information about the measures that CMS should include in the measure set?
- Does your organization experience any barriers with collecting data for quality measurement purposes?
- Does your organization experience any barriers with accessing data systems for quality measurement purposes?
- Does your organization experience any barriers to using data to improve quality?

V. Draft Recommended Measure Set, In Brief⁴⁰

A. Potential Measures for Initial Implementation

Base Set (intended to be adopted in their entirety as a set of measures)

- MLTSS measures:
 - MLTSS-1: LTSS Comprehensive Assessment and Update (CMS)
 - MLTSS-2: LTSS Comprehensive Care Plan and Update (CMS)
 - MLTSS-3: LTSS Shared Care Plan with Primary Care Practitioner (CMS)
 - MLTSS-6: LTSS Admission to an Institution from the Community (CMS) (MLTSS equivalent of HCBS-1 below)
 - MLTSS-7: LTSS Minimizing Institutional Length of Stay (CMS)
- FFS measure:
 - HCBS-1: Admission to an Institution from the Community Among Medicaid Fee-for-Service (FFS) HCBS Users (CMS) (FFS equivalent of MLTSS-6 above)
- Measures from one or more of the following instruments: HCBS CAHPS survey, National Core Indicators (NCI), National Core Indicators-Aging and Disabilities (NCI-AD)
 - If the state or another entity is conducting the HCBS CAHPS survey:⁴¹
 - Choosing the Services That Matter to You Composite Measure (Q 56, 57)
 - Community Inclusion and Empowerment Composite Measure (Q 75, 77, 78, 79, 80, 81)
 - Personal Safety & Respect Composite Measure (Q 64, 65, 68)
 - Physical Safety Single-Item Measure (Q 71)
 - Staff Are Reliable and Helpful Composite Measure (Q 13, 14, 15, 19, 37, 38)
 - Staff Listen and Communicate Well Composite Measure (Q 28, 29, 30, 31, 32, 33, 41, 42, 43, 44, 45)
 - Transportation to Medical Appointments Composite Measure (Q 59, 61, 62)
 - If the state is participating in NCI:⁴²
 - Everyday Choice Scale Composite Measure (NCI 80, 82, 86)
 - Life Decision Composite Measure (NCI 78, 79, 84, 85, 88)

⁴⁰ Additional information on each measure is provided in section VI.

⁴¹ Requires implementation of the entire survey. See next section for a list of questions that comprise each measure.

⁴² Requires implementation of the entire instrument.

- NCI 17: Percentage of people who report there are places where they are afraid or scared
- NCI 18: Percentage of people who report they have someone they can talk to if they are ever scared
- NCI 41: Percentage of people who say their case manager/service coordinator asks what they want
- NCI 50: The percentage of people who say they were able to choose the services they get as part of their service plan
- NCI 53: Percentage of people who report staff treat them with respect
- NCI 54: Percentage of people who say their staff come and leave when they are supposed to
- NCI 55: Percentage of people who have a way to get to places they need to go (such as medical appointments)
- NCI 56: Percentage of people who have a way to get to places they want to go (for fun, visit others, or to get out of their home)
- NCI 87: Percent of people who report they can change their case manager if they want to
- If the state is participating in NCI-AD:⁴³
 - NCI-AD-3: Percentage of people in group settings who are able to choose their roommates
 - NCI-AD-4: Percentage of people who get up and go to bed when they want to
 - NCI-AD-5: Percentage of people who can eat their meals when they want to
 - NCI-AD-6: Percentage of people in group settings who are able to furnish and decorate their room however they want to
 - NCI-AD-10: Percentage of people whose support staff do things the way they want them done
 - NCI-AD-13: Percentage of people whose support staff show up and leave when they are supposed to
 - NCI-AD-22: Percentage of people who have transportation when they want to do things outside of their home
 - NCI-AD-23: Percentage of people who have transportation to get to medical appointments when they need to
 - NCI-AD-24: Percentage of people who feel safe around their support staff
 - NCI-AD-25: Percentage of people who are ever worried for the security of their personal belongings
 - NCI-AD-26: Percentage of people whose money was taken or used without their permission in the last 12 months
 - NCI-AD-27: Percentage of people whose support staff treat them with respect
 - NCI-AD-31: Percentage of people in group settings whose visitors are able to come at any time
 - NCI-AD-33: Percentage of people who can choose or change what kind of services they get
 - NCI-AD-34: Percentage of people who can choose or change when and how often they get their services

⁴³ Requires implementation of the entire instrument.

- NCI-AD-35: Percentage of people who can choose or change their support staff
- NCI-AD-42: Percentage of people who felt their preferences and needs were being heard at the last service planning meeting

Extended Set (additional measures from which to select to address state-specific priorities and needs)

- MLTSS measures
 - MLTSS-4: LTSS Reassessment/Care Plan Update after Inpatient Discharge (CMS)
 - MLTSS-5: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls (NCQA)
 - MLTSS-8: LTSS Successful Transition After Long-Term Institutional Stay (CMS)
 - HCBS-10: Self-direction of services and supports among Medicaid beneficiaries receiving LTSS through managed care organizations (CMS)
 - Plan All-Cause Readmission (HEDIS)
 - Flu Vaccination (HEDIS) (adults 18-64 only)
- Functional Assessment Standardized Items (FASI)⁴⁴ measures:
 - FASI-1: Identification of Person-Centered Priorities (CMS)
 - FASI-2: Documentation of a Person-Centered Service Plan (CMS)
- If the state or another entity is conducting the HCBS CAHPS survey:⁴⁵
 - Case Manager Is Helpful Composite Measure (Q 49, 51, 53)
 - Unmet Needs Single-Item Measures (Q 18, 22, 25, 27, 40)
- If the state is participating in NCI:⁴⁶
 - NCI 1: Percentage of people who like where they live
 - NCI 2: Percentage of people who would like to live somewhere else
 - NCI 8 and BI 49: Proportion of people who express they want a job who have a related goal in their service plan
 - NCI 10: Percentage of people with a paid job in the community who like where they work
 - NCI 19: The percentage of people who have friends who are not staff or family members.
 - NCI 21: Percentage of people who want more help to make new friends or keep in contact with the friends they have.
 - NCI 22: Percentage of people who can see their friends when they want to
 - NCI 26: The percentage of people who report that they often feel lonely
 - NCI 27: Percent of people who can see or communicate with their family when they want to
 - NCI 29: Percentage of people who are able to go out and do the things they like to do as much as they want to

⁴⁴ For more information, see <https://www.medicaid.gov/medicaid/ltss/teft-program/functional-assessment-standardized-items/index.html>.

⁴⁵ Requires implementation of the entire survey. See next section for a list of questions that comprise each measure.

⁴⁶ Requires implementation of the entire instrument.

- NCI 32 and BI 61: Percentage of people who express they want to increase independence in functional skills who have a related goal in their service plan
- NCI 33: Percentage of people whose mail or email is read without asking them first
- NCI 34: Percentage of people who can be alone with friends or visitors in their home
- NCI 40: Percentage of people who have met or spoken with their case manager
- NCI 43: Percentage of people who took part, or had the option to take part in the last service planning meeting
- NCI 51: Percentage of people who know whom to ask if they want to change something about their services
- NCI 66: Percentage of people who would like to be in more community groups than they are now
- NCI 92: Percentage of people who can lock their bedroom if they want to
- NCI 93: Percentage of people who have participated, or had the opportunity to participate, in a self-advocacy group meeting, conference, or event
- NCI 94: Percentage of people who have voted or who had the opportunity to vote in a local state or federal election
- NCI 96: Percentage of people who feel their staff have the right training to meet their needs
- NCI 97: Percentage of people whose self-reported health is poor
- NCI 98: Percentage of people who do moderate physical activity 10 or more minutes at a time at least once per week
- NCI 99: Percentage of people who do some physical activity that makes their muscles work hard at least once per week
- BI 18-22 and BI 26-28: Percentage of people who were reported to have received preventive health screenings within recommended time frames (routine physical exam, dental exam, eye exam, hearing test, mammogram, pap test, colorectal cancer screening)
- BI 23-24: Percentage of people whose BMI is in the healthy range
- BI 25: Percentage of people who use nicotine or tobacco products
- If the state is participating in NCI-AD:⁴⁷
 - NCI-AD-1: Percentage of people who are as active in their community as they would like to be
 - NCI-AD-2: Percentage of people who get to do things they enjoy outside of their home as much as they want to
 - NCI-AD-7: Percentage of people who are able to see or talk to their friends and family when they want to
 - NCI-AD-8: Percentage of people who like how they spend their time during the day
 - NCI-AD-9: Percentage of people whose support staff change too often
 - NCI-AD-11: Percentage of people who know whom to contact if they want to make changes to their services
 - NCI-AD-12: Percentage of people who know whom to contact if they need help with services or have a complaint
 - NCI-AD-14: Percentage of people whose case manager talked to them about services that might help with their unmet needs and goals

⁴⁷ Requires implementation of the entire instrument.

- NCI-AD-15: Percentage of people who have a backup plan if their support staff do not show up
- NCI-AD-16: Percentage of people who can reach their case manager when they need to
- NCI-AD-17: Percentage of non-English speaking participants who receive information about their services in the language they prefer
- NCI-AD-18: Percentage of people who felt comfortable and supported enough to go home after being discharged from a hospital or rehabilitation facility in the past year
- NCI-AD-19: Percentage of people who had someone follow up with them after being discharged from a hospital or rehabilitation facility in the past year
- NCI-AD-20: Percentage of people who know how to manage their chronic conditions
- NCI-AD-21: Percentage of people who had somebody talk or work with them to reduce their risk of falling or being unstable
- NCI-AD-28: Percentage of people in group settings whose permission is asked before others enter their home or room
- NCI-AD-29: Percentage of people in group settings who are able to lock the doors to their room if they want to
- NCI-AD-30: Percentage of people in group settings who have enough privacy where they live
- NCI-AD-32: Percentage of people in group settings who have access to food at all times of the day
- NCI-AD-37: Percentage of people wanting a job who had someone talk to them about job options
- NCI-AD-38: Percentage of people who are involved in making decisions about their service plan
- NCI-AD-44: Percentage of people whose service plan includes what was discussed in the last service planning meeting
- NCI-AD-45: Percentage of people whose service plan reflects their preferences and choices
- Analysis of one or more measures (to be determined) in the recommended measure set by race, ethnicity, primary language, rural/urban, population type, etc.

B. Potential Measures for Later Implementation

- University of Minnesota Research and Training Center on HCBS Outcome Measurement (RTC/OM)⁴⁸ measure concepts currently in development and/or testing:
 - Percent of respondents who indicate having the choice of the services and supports they desire
 - Percent of respondents who indicate being able to make personal choices to the extent that they desire
 - Percent of respondents indicating being able to direct their services and supports as they desire
 - Percent of respondents who indicate a positive job experience
 - Percent of respondents who indicate having experienced barriers to employment

⁴⁸ For more information on the RTC/OM, see <https://rtcom.umn.edu/>.

- Percent of respondents who indicate being engaged in meaningful activities as they desire
- Percent of respondents who indicate feeling socially connected as they desire
- Percent of respondents who indicate a positive experience with transportation in their lives
- Percentage of LTSS beneficiaries living in the setting of their choice
- Percent of respondents who indicate they have experienced abuse and/or neglect
- Delivery of Services and Supports
- Degree to Which HCBS Planning Is Undertaken in a Person-Centered Manner
- Staff Understanding of the HCBS Recipients They Support and the Concepts Underlying Person-Centered Thinking & Service Delivery
- Degree to and Manner in Which Systems Support Meaningful Involvement on the Part of HCBS Recipients in the Design, Implementation, and Evaluation of the System
- Extent to which HCBS Recipients Are Actively Involved in the Design, Implementation, and Evaluation of the System
- Measures adapted from existing measures:
 - MLTSS-1, MLTSS-2, MLTSS-3, MLTSS-4, MLTSS-5, MLTSS-7, MLTSS-8, and HCBS-10 adapted for statewide and fee-for-service use (see base set and extended set measures)
 - HCBS-1/MLTSS-6 adapted for statewide use (see base set measures under this domain)
 - DUALS-1: Hospitalization for Ambulatory Care Sensitive Conditions for Dual Eligible Beneficiaries (CMS) adapted for Medicaid
 - Medicaid versions of Merit-Based Incentive Payment System (MIPS) Clinical Quality Measures
 - Quality ID #181: Elder Maltreatment Screen and Follow-Up Plan
 - Quality ID #130: Documentation of Current Medications in the Medical Record
 - Pneumococcal Vaccination (HEDIS) adapted for Medicaid
 - Flu Vaccination for Adults Ages 65 and older (HEDIS) adapted for Medicaid
 - Flu Vaccination, Pneumococcal Vaccination, and Plan All-Cause Readmission adapted for statewide and fee-for-service use (see extended set measures)
- Measures derived from existing instruments:
 - Measures (to be determined) derived from the HCBS CAHPS Supplemental Employment Module
 - Caregiver assessment measures (to be determined) derived from the interRAI-Home Care
 - Measures (to be determined) derived from the NCI Staff Stability Survey (e.g., average turnover rates)
- Other measure concepts that are not yet specified or tested:
 - Healthy days in the community
 - Person-centered planning goals are documented and realized
 - Caregiver assessment conducted
 - Positive experiences with caregiving
 - Caregiver burnout

- Caregiver training
- Caregiver access to resources
- Staff turnover or retention
- Home health and personal care aides per 100 people age 18 and older with an activity of daily living disability
- Percentage of LTSS beneficiaries receiving HCBS
- Percentage of LTSS expenditures spent on HCBS
- Potential access (e.g., provider supply and participation in Medicaid)
- Realized access (e.g., % of people who receive what is authorized in their service plan)
- Perceived access (e.g., beneficiary experience in accessing services)
- Housing accessibility
- Data sharing agreements in place for unaligned plans providing services to dual-eligible beneficiaries enrolled in multiple plans
- Percentage of dual-eligible beneficiaries in integrated care arrangements (e.g., Medicare-Medicaid plan, Program for All-Inclusive Care for the Elderly) or aligned arrangements (e.g., enrolled in a Medicare Advantage plan operated by the same parent company as the MLTSS plan the beneficiary is enrolled in)

VI. Draft Recommended Measure Set, by NQF Domain

- **Questions about the draft recommended measure set:**
 - **How many measures is ideal for inclusion in the base set?**
 - **How many measures is ideal for inclusion in the extended set?**
 - **Are there other measures that should be included in the base set or the extended set? In particular, CMS would be interested in feedback on measures that can address gaps related to specific NQF domains, including recommendations for measures that assess access to HCBS, such as measures of potential access (e.g., provider supply and participation in Medicaid), realized access (e.g., % of people who receive what is authorized in their service plan), and perceived access (e.g., beneficiary experience). CMS would also be interested in recommendations for HCBS measures that are relevant for people with behavioral health conditions.**
 - **Are there measures that have been included that you do not think should be?**
 - **Are there measures that have been misclassified by NQF domain?**
 - **Are there any measures you would recommend for use in the Medicaid and CHIP Scorecard,⁴⁹ the Adult and Child Core Sets,⁵⁰ or other CMS initiatives, such as the future Medicaid and CHIP Quality Rating System⁵¹? Please be specific both in terms of measure(s) recommended and the CMS initiative for which you are recommending them.**

⁴⁹ See <https://www.medicaid.gov/state-overviews/scorecard/index.html> for more information.

⁵⁰ See <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html> or more information.

⁵¹ See <https://www.medicaid.gov/Medicaid/downloads/improving-the-quality-of-care-for-medicaid-beneficiaries-fact-sheet.pdf> and <https://www.regulations.gov/document?D=CMS-2018-0140-0001> for more information.

- **Are there measures you think would be most useful to a beneficiary when choosing a managed care plan, a provider, or a self-directed service delivery model?**

A. NQF Domain: Service Delivery and Effectiveness⁵²

The level to which services and supports are provided in a manner consistent with a person's needs, goals, preferences, and values that help the person to achieve desired outcomes.

Potential Measures for Initial Implementation

Base Set

- None

Extended Set

- If the state or another entity is conducting the HCBS CAHPS survey:
 - Unmet Needs Single-Item Measures (Q 18, 22, 25, 27, 40)⁵³
- If the state is participating in National Core Indicators (NCI):⁵⁴
 - NCI 1: Percentage of people who like where they live
 - NCI 2: Percentage of people who would like to live somewhere else
 - NCI 40: Percentage of people who have met or spoken with their case manager
 - NCI 51: Percentage of people who know whom to ask if they want to change something about their services

⁵² Subdomains include:

- **Delivery:** The level to which the individuals who use HCBS receive person-centered services and supports. Important aspects of delivery include timely initiation, the degree to which the delivered services and supports correspond with the plan of care, the ongoing assessment of the correlation of delivery and the plan of care, adequacy of the provider network to deliver needed services, and the capacity of the system to meet existing and future demands.
- **Person's needs met and goals realized:** The level to which individuals who use HCBS receive services and supports sufficient to meet their needs and to support them in achieving their goals.
- **Person's identified goals realized** (Additional subdomain added by the University of Minnesota. See <https://rtcom.umn.edu/database/domains>.)

⁵³ Requires implementation of the entire survey. Questions include:

- Q 18: Unmet need in dressing/bathing due to lack of help: In the last 3 months, was this because there were no {personal assistance/behavioral health staff} to help you?
- Q 22: Unmet need in meal preparation/eating due to lack of help: In the last 3 months, was this because there were no {personal assistance/behavioral health staff} to help you?
- Q 25: Unmet need in medication administration due to lack of help: In the last 3 months, was this because there were no {personal assistance/behavioral health staff} to help you?
- Q 27: Unmet need in toileting due to lack of help: In the last 3 months, did you get all the help you needed with toileting from {personal assistance/behavioral health staff} when you needed it?
- Q 40: Unmet need with household tasks due to lack of help: In the last 3 months, was this because there were no {homemakers} to help you?

⁵⁴ Requires implementation of the entire instrument.

- If the state is participating in National Core Indicators-Aging and Disabilities (NCI-AD):⁵⁵
 - NCI-AD-11: Percentage of people who know whom to contact if they want to make changes to their services
 - NCI-AD-12: Percentage of people who know whom to contact if they need help with services or have a complaint
 - NCI-AD-14: Percentage of people whose case manager talked to them about services that might help with their unmet needs and goals
 - NCI-AD-15: Percentage of people who have a backup plan if their support staff do not show up
 - NCI-AD-16: Percentage of people who can reach their case manager when they need to

Potential Measures for Later Implementation

- University of Minnesota Research and Training Center on HCBS Outcome Measurement (RTC/OM) measure concept currently in development:⁵⁶
 - Delivery of Services and Supports
- Measure concept that is not yet specified or tested:
 - Percentage of LTSS beneficiaries living in the setting of their choice

B. NQF Domain: Person-Centered Planning and Coordination

An approach to assessment, planning, and coordination of services and supports that is focused on the individual's goals, needs, preferences, and values. The person directs the development of the plan, which describes the life they want to live in the community. Services and supports are coordinated across providers and systems to carry out the plan and ensure fidelity with the person's expressed goals, needs, preferences, and values.⁵⁷

Potential Measures for Initial Implementation

Base Set

⁵⁵ Requires implementation of the entire instrument.

⁵⁶ For more information on the RTC/OM, see <https://rtcom.umn.edu/>.

⁵⁷ Subdomains include:

- **Assessment:** The level to which the HCBS system and providers support persons in identifying their goals, needs, preferences, and values. This process should gather all of the information needed to inform the person-centered planning process. Re-assessments should occur on a regular basis to assure that changes in consumer goals and needs are captured and appropriate adjustments to services and supports are made.
- **Person-centered planning:** The level to which the planning process is directed by the person, with support as needed, and results in an executable plan for achieving goals and meeting needs that the person deems important. The plan includes the role of the paid and unpaid services or supports needed to reach those goals.
- **Coordination:** The level to which the services and supports an individual receives across the healthcare and social service system are complementary, integrated, and fully support the HCBS consumer in meeting his or her needs and achieving his or her goals.

- MLTSS measures:
 - MLTSS-1: LTSS Comprehensive Assessment and Update (CMS)⁵⁸
 - MLTSS-2: LTSS Comprehensive Care Plan and Update (CMS)⁵⁹
 - MLTSS-3: LTSS Shared Care Plan with Primary Care Practitioner (CMS)⁶⁰
- Measures from one or more of the following instruments: HCBS CAHPS survey, National Core Indicators (NCI), National Core Indicators-Aging and Disabilities (NCI-AD)
 - If the state or another entity is conducting the HCBS CAHPS survey:
 - Choosing the Services That Matter to You Composite Measure (Q 56, 57)⁶¹
 - If the state is participating in NCI:
 - NCI 41: Percentage of people who say their case manager/service coordinator asks what they want⁶²
 - If the state is participating in NCI-AD:
 - NCI-AD-42: Percentage of people who felt their preferences and needs were being heard at the last service planning meeting⁶³

Extended Set

- MLTSS measure:
 - MLTSS-4: LTSS Reassessment/Care Plan Update after Inpatient Discharge (CMS)⁶⁴
- Functional Assessment Standardized Items (FASI) measures:
 - FASI-1: Identification of Person-Centered Priorities (CMS)⁶⁵
 - FASI-2: Documentation of a Person-Centered Service Plan (CMS)⁶⁶

⁵⁸ Measure description: The percentage of MLTSS plan members age 18 and older who have documentation of a comprehensive assessment in a specified timeframe that includes documentation of core elements. For more information, see <https://www.medicaid.gov/media/3396>.

⁵⁹ Measure description: The percentage MLTSS plan members age 18 and older who have documentation of a comprehensive LTSS care plan in a specified timeframe that includes documentation of core elements. For more information, see <https://www.medicaid.gov/media/3396>.

⁶⁰ Measure description: The percentage of MLTSS plan members age 18 and older with a care plan that was transmitted to their primary care practitioner (PCP) or other documented medical care practitioner identified by the plan member within 30 days its development. For more information, see <https://www.medicaid.gov/media/3396>.

⁶¹ Requires implementation of the entire survey. Questions used to calculate the composite score include:

- Q 56: In the last 3 months, did your [program-specific term for “service plan”] include . . .
- Q 57: In the last 3 months, did you feel {personal assistance/behavioral health staff} knew what’s on your [program-specific term for “service plan”], including the things that are important to you?

⁶² Requires implementation of the entire instrument.

⁶³ Requires implementation of the entire instrument.

⁶⁴ Measure description: The percentage of discharges from inpatient facilities for MLTSS plan members age 18 and older for whom a reassessment and care plan update occurred within 30 days of discharge. For more information, see <https://www.medicaid.gov/media/3396>.

⁶⁵ Measure description: Percentage of individuals 18 years or older who received community-based LTSS with documented needs determined by the Functional Assessment Standardized Items AND who have identified at least 3 personal priorities related to self-care, mobility, or IADL functional needs within the reporting period. For more information, see <https://www.medicaid.gov/medicaid/ltss/teft-program/functional-assessment-standardized-items/index.html>.

⁶⁶ Measure description: Percentage of individuals 18 years or older who received community-based LTSS with documented functional needs as determined by the Functional Assessment Standardized Items assessment AND documentation of a person-centered service plan that addressed identified functional needs within the reporting

- If the state is participating in National Core Indicators (NCI):⁶⁷
 - NCI 8 and BI 49: Proportion of people who express they want a job who have a related goal in their service plan
 - NCI 32 and BI 61: Percentage of people who express they want to increase independence in functional skills who have a related goal in their service plan
 - NCI 43: Percentage of people who took part, or had the option to take part in the last service planning meeting
- If the state is participating in National Core Indicators-Aging and Disabilities (NCI-AD):⁶⁸
 - NCI-AD-37: Percentage of people wanting a job who had someone talk to them about job options
 - NCI-AD-38: Percentage of people who are involved in making decisions about their service plan
 - NCI-AD-44: Percentage of people whose service plan includes what was discussed in the last service planning meeting
 - NCI-AD-45: Percentage of people whose service plan reflects their preferences and choices

Potential Measures for Later Implementation

- University of Minnesota Research and Training Center on HCBS Outcome Measurement (RTC/OM) measure concepts currently in development:⁶⁹
 - Degree to Which HCBS Planning Is Undertaken in a Person-Centered Manner
 - Staff Understanding of the HCBS Recipients They Support and the Concepts Underlying Person-Centered Thinking & Service Delivery
- Measures adapted from existing measures:
 - MLTSS-1,⁵⁸ MLTSS-2,⁵⁹ MLTSS-3,⁶⁰ and MLTSS-4⁶⁴ adapted for statewide and fee-for-service use (would need to be re-specified and tested) (see base set and extended set measures under this domain)
 - Medicaid version of: Merit-based Incentive Payment System (MIPS) Clinical Quality Measures Quality ID #130: Documentation of Current Medications in the Medical Record⁷⁰ (would need to be re-specified and tested for Medicaid)
- Other measure concepts that are not yet specified or tested:
 - Data sharing agreements in place for unaligned plans providing services to dual-eligible beneficiaries enrolled in multiple plans

period. For more information, see <https://www.medicaid.gov/medicaid/ltss/teft-program/functional-assessment-standardized-items/index.html>.

⁶⁷ Requires implementation of the entire instrument.

⁶⁸ Requires implementation of the entire instrument.

⁶⁹ For more information on the RTC/OM, see <https://rtcom.umn.edu/>.

⁷⁰ Measure description: Percentage of visits for patients aged 18 years and older for which the MIPS eligible professional or MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. For more information, see https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2019_Measure_130_MIPSCQM.pdf.

- Percentage of dual-eligible beneficiaries in integrated care arrangements (e.g., Medicare-Medicaid plan, Program for All-Inclusive Care for the Elderly) or aligned arrangements (e.g., enrolled in a Medicare Advantage plan operated by the same parent company as the MLTSS plan the beneficiary is enrolled in)
- Person-centered planning goals are documented and realized

C. NQF Domain: Choice and Control

The level to which individuals who use HCBS, on their own or with support, make life choices, choose their services and supports, and control how those services and supports are delivered.⁷¹

Potential Measures for Initial Implementation

Base Set

- Measures from one or more of the following instruments: HCBS CAHPS survey, National Core Indicators (NCI), National Core Indicators-Aging and Disabilities (NCI-AD)
 - If the state or another entity is conducting the HCBS CAHPS survey:
 - Community Inclusion and Empowerment Composite Measure (Q 75, 77, 78, 79, 80, 81)⁷²
 - If the state is participating in National Core Indicators (NCI):⁷³

⁷¹ Subdomains include:

- **Personal choices and goals:** The level to which services and plans describe, develop, and support individual choices and life goals.
- **Choice of services and supports:** The level to which individuals who use HCBS have a choice, and are supported in making that choice, in selecting and self-directing their program delivery models, services and supports, provider(s), and setting(s)
- **Personal freedoms and dignity of risk:** The level to which individuals who use HCBS have personal freedoms and the ability to take risks.
- **Self-direction:** The level to which individuals who use HCBS, on their own or with support, have decision-making authority over their services and take direct responsibility to manage their services with the assistance of a system of available supports.

⁷² Requires implementation of the entire survey. Questions used to calculate the composite score include:

- Q 75: In the last 3 months, when you wanted to, how often could you get together with these family members who live nearby?
- Q 77: In the last 3 months, when you wanted to, how often could you get together with these friends who live nearby?
- Q 78: In the last 3 months, when you wanted to, how often could you do things in the community that you like?
- Q 79: In the last 3 months, did you need more help than you get from {personal assistance/behavioral health staff} to do things in your community?
- Q 80: In the last 3 months, did you take part in deciding what you do with your time each day?
- Q 81: In the last 3 months, did you take part in deciding when you do things each day—for example, deciding when you get up, eat, or go to bed?

⁷³ Requires implementation of the entire instrument.

- Everyday Choice Scale Composite Measure (NCI 80, 82, 86)⁷⁴
- Life Decision Composite Measure (NCI 78, 79, 84, 85, 88)⁷⁵
- NCI 50: The percentage of people who say they were able to choose the services they get as part of their service plan
- NCI 87: Percent of people who report they can change their case manager if they want to
- If the state is participating in National Core Indicators-Aging and Disabilities (NCI-AD):⁷⁶
 - NCI-AD-3: Percentage of people in group settings who are able to choose their roommates
 - NCI-AD-4: Percentage of people who get up and go to bed when they want to
 - NCI-AD-5: Percentage of people who can eat their meals when they want to
 - NCI-AD-6: Percentage of people in group settings who are able to furnish and decorate their room however they want to
 - NCI-AD-31: Percentage of people in group settings whose visitors are able to come at any time
 - NCI-AD-33: Percentage of people who can choose or change what kind of services they get
 - NCI-AD-34: Percentage of people who can choose or change when and how often they get their services
 - NCI-AD-35: Percentage of people who can choose or change their support staff

Extended Set

- MLTSS measure:
 - HCBS-10: Self-direction of services and supports among Medicaid beneficiaries receiving LTSS through managed care organizations (CMS)⁷⁷
- If the state is participating in National Core Indicators (NCI):⁷⁸
 - NCI 19: The percentage of people who have friends who are not staff or family members
 - NCI 26: The percentage of people who report that they often feel lonely

⁷⁴ Includes questions about the following: Decide daily schedule, decide how to spend free time, decide what to buy with spending money.

⁷⁵ Includes questions about the following: Input in where to choose to live, input in choosing housemates, choose or had help in choosing work, choosing day program or day activity.

⁷⁶ Requires implementation of the entire instrument.

⁷⁷ This measure assesses the offer, and selection, of self-directed services among MLTSS adult enrollees who receive home and community-based services (HCBS). The measure consists of two rates:

1. Self-direction offer rate: Percentage of HCBS users ages 18 and older enrolled in MLTSS plans and eligible for self-direction who were offered the option to self-direct their home and community-based services in the last 12 months.
2. Self-direction opt-in rate: Percentage of HCBS users ages 18 and older enrolled in MLTSS plans and eligible for self-direction who opted-in to self-direct their home and community-based services, among those who received an offer to self-direct in the last 12 months.

⁷⁸ Requires implementation of the entire instrument.

- If the state is participating in National Core Indicators-Aging and Disabilities (NCI-AD):⁷⁹
 - NCI-AD-8: Percentage of people who like how they spend their time during the day
 - NCI-AD-32: Percentage of people in group settings who have access to food at all times of the day

Potential Measures for Later Implementation

- University of Minnesota Research and Training Center on HCBS Outcome Measurement (RTC/OM) measures currently in development and testing:⁸⁰
 - Percent of respondents who indicate having the choice of the services and supports they desire
 - Percent of respondents who indicate being able to make personal choices to the extent that they desire
 - Percent of respondents indicating being able to direct their services and supports as they desire
- Measure adapted from an existing measure:
 - HCBS-10 adapted for fee-for-service and statewide use (would need to be re-specified and tested) (see extended set measures under this domain)

D. NQF Domain: Community Inclusion

The level to which people who use HCBS are integrated into their communities and are socially connected, in accordance with personal preferences.⁸¹

Potential Measures for Initial Implementation

Base Set

- Measures from one or more of the following instruments: HCBS CAHPS survey, National Core Indicators (NCI), National Core Indicators-Aging and Disabilities (NCI-AD)
 - If the state or another entity is conducting the HCBS CAHPS survey:
 - Transportation to Medical Appointments Composite Measure (Q 59, 61, 62)⁸²

⁷⁹ Requires implementation of the entire instrument.

⁸⁰ For more information on the RTC/OM, see <https://rtcom.umn.edu/>.

⁸¹ Subdomains include:

- **Social connectedness and relationships:** The level to which individuals who use HCBS develop and maintain relationships with others.
- **Meaningful activity:** The level to which individuals who use HCBS engage in desired activities (e.g., employment, education, volunteering, etc.).
- **Resources and settings to facilitate inclusion:** The level to which resources and involvement in community integrated settings are available to individuals who use HCBS.
- **Employment** (Additional subdomain added by the University of Minnesota RTC/OM. See <https://rtcom.umn.edu/database/domains/>.)
- **Transportation** (Additional subdomain added by the University of Minnesota RTC/OM. See <https://rtcom.umn.edu/database/domains/>.)

⁸² Requires implementation of the entire survey. Questions used to calculate the composite score include:

- If the state is participating in National Core Indicators (NCI):⁸³
 - NCI 55: Percentage of people who have a way to get to places they need to go (such as medical appointments)
 - NCI 56: Percentage of people who have a way to get to places they want to go (for fun, visit others, or to get out of their home)
- If the state is participating in National Core Indicators-Aging and Disabilities (NCI-AD):⁸⁴
 - NCI-AD-22: Percentage of people who have transportation when they want to do things outside of their home
 - NCI-AD-23: Percentage of people who have transportation to get to medical appointments when they need to

Extended Set

- If the state is participating in National Core Indicators (NCI):⁸⁵
 - NCI 10: Percentage of people with a paid job in the community who like where they work
 - NCI 21: Percentage of people who want more help to make new friends or keep in contact with the friends they have.
 - NCI 22: Percentage of people who can see their friends when they want to
 - NCI 27: Percent of people who can see or communicate with their family when they want to
 - NCI 29: Percentage of people who are able to go out and do the things they like to do as much as they want to
 - NCI 66: Percentage of people who would like to be in more community groups than they are now
- If the state is participating in National Core Indicators-Aging and Disabilities (NCI-AD):⁸⁶
 - NCI-AD-1: Percentage of people who are as active in their community as they would like to be
 - NCI-AD-2: Percentage of people who get to do things they enjoy outside of their home as much as they want to
 - NCI-AD-7: Percentage of people who are able to see or talk to their friends and family when they want to

Potential Measures for Later Implementation

- University of Minnesota Research and Training Center on HCBS Outcome Measurement

-
- Q 59: Medical appointments include seeing a doctor, a dentist, a therapist, or someone else who takes care of your health. In the last 3 months, how often did you have a way to get to your medical appointments?
 - Q 61: In the last 3 months, were you able to get in and out of this ride easily?
 - Q 62: In the last 3 months, how often did this ride arrive on time to pick you up?

⁸³ Requires implementation of the entire instrument.

⁸⁴ Requires implementation of the entire instrument.

⁸⁵ Requires implementation of the entire instrument.

⁸⁶ Requires implementation of the entire instrument.

(RTC/OM) measures currently in development and testing:⁸⁷

- Percent of respondents who indicate a positive job experience
- Percent of respondents who indicate having experienced barriers to employment
- Percent of respondents who indicate being engaged in meaningful activities as they desire
- Percent of respondents who indicate feeling socially connected as they desire
- Percent of respondents who indicate a positive experience with transportation in their lives
- Measures derived from an existing instrument:⁸⁸
 - Measures (to be determined) derived from the HCBS CAHPS Supplemental Employment Module⁸⁹

E. NQF Domain: Caregiver Support

The level of support (e.g., financial, emotional, technical) available to and received by family caregivers or natural supports of individuals who use HCBS.⁹⁰

Potential Measures for Initial Implementation

Base Set

- None

Extended Set

- None

Potential Measures for Later Implementation

- Measures derived from an existing instrument:

⁸⁷ For more information on the RTC/OM, see <https://rtcom.umn.edu/>.

⁸⁸ Requires implementation of the entire survey and the supplemental module.

⁸⁹ For more information, see <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html>.

⁹⁰ Subdomains include:

- **Family caregiver/natural support well-being:** The level to which the family caregiver/natural support is assisted in terms of physical, emotional, mental, social, and financial well-being.
- **Training and skill-building:** The level to which the appropriate training and skill-building activities are available to caregivers/natural supports who desire such activities.
- **Family caregiver/natural support involvement:** The level to which family caregivers/natural supports are involved in developing and executing the HCBS consumer's person-centered care plan in accordance with the preferences of the consumer and family caregiver/natural support. This involvement includes direct assessment of caregiver/natural support needs, not just their ability to provide care, and is an ongoing part of the provision of HCBS.
- **Access to resources:** The level to which the family caregiver/natural support is aware of and able to access resources (e.g., peer support, respite, crisis support, information and referral) that support overall well-being.

- Caregiver assessment measures (to be determined) derived from the interRAI-Home Care
- Other measure concepts that are not yet specified or tested:
 - Caregiver assessment conducted
 - Positive experiences with caregiving
 - Caregiver burnout
 - Caregiver training
 - Caregiver access to resources

F. NQF Domain: Workforce

The adequacy, availability, and appropriateness of the paid HCBS workforce.⁹¹

Potential Measures for Initial Implementation

Base Set

- Measures from one or more of the following instruments: HCBS CAHPS survey, National Core Indicators (NCI), National Core Indicators-Aging and Disabilities (NCI-AD)
 - If the state or another entity is conducting the HCBS CAHPS survey:
 - Staff Are Reliable and Helpful Composite Measure (Q 13, 14, 15, 19, 37, 38)⁹²

⁹¹ Subdomains include:

- **Person-centered approach to services:** The level to which the workforce’s approach to the delivery of services is tailored to the preferences and values of the consumer. This includes the use of good communication skills to solicit those preferences and values while also demonstrating respect for consumer privacy and boundaries.
- **Demonstrated competencies, when appropriate:** The level to which the workforce is able to demonstrate that services are provided in a skilled and competent manner. These skills and competencies are fostered in the workforce through the use of competency-based approaches to training and skill development.
- **Safety of and respect for the worker:** The level to which the HCBS delivery system monitors, protects, and supports the safety and well-being of the workforce.
- **Sufficient workforce numbers, dispersion, and availability:** The level to which the supply of and the demand for the HCBS workforce are aligned in terms of numbers, geographic dispersion, and availability.
- **Adequately compensated, with benefits:** The level to which the HCBS workforce is provided compensation, benefits, and opportunities for skill development as a means for ensuring a stable supply of qualified workers to meet the service and support needs of HCBS consumers.
- **Culturally competent:** The level to which the workforce is able to deliver services that are aligned with the cultural background, values, and principles of the HCBS consumer (i.e., cultural competency of the workforce) and the level to which the HCBS system trains and supports the workforce in a manner that is aligned with the cultural background, values, and principles of the HCBS workforce (i.e., cultural competency of the HCBS system).
- **Workforce engagement and participation:** The level to which front-line workers and service providers have meaningful involvement in care planning and execution when desired by the consumer; program development and evaluation; and the design, implementation, and evaluation of the HCBS system and policies.
- **Staff turnover** (Additional subdomain added by the University of Minnesota Research and Training Center on HCBS Outcome Measurement. See <https://rtcom.umn.edu/database/domains>.)

⁹² Requires implementation of the entire survey. Questions used to calculate the composite score include:

- Staff Listen and Communicate Well Composite Measure (Q 28, 29, 30, 31, 32, 33, 41, 42, 43, 44, 45)⁹³
- If the state is participating in National Core Indicators (NCI):⁹⁴
 - NCI 53: Percentage of people who report staff treat them with respect
 - NCI 54: Percentage of people who say their staff come and leave when they are supposed to
- If the state is participating in National Core Indicators-Aging and Disabilities (NCI-AD):⁹⁵
 - NCI-AD-10: Percentage of people whose support staff do things the way they want them done
 - NCI-AD-13: Percentage of people whose support staff show up and leave when they are supposed to
 - NCI-AD-27: Percentage of people whose support staff treat them with respect

Extended Set

- If the state or another entity is conducting the HCBS CAHPS survey:

-
- Q 13: In the last 3 months, how often did {personal assistance/behavioral health staff} come to work on time?
 - Q 14: In the last 3 months, how often did {personal assistance/behavioral health staff} work as long as they were supposed to?
 - Q 15: In the last 3 months, when staff could not come to work on a day that they were scheduled, did someone let you know that {personal assistance/behavioral health staff} could not come that day?
 - Q 19: In the last 3 months, how often did {personal assistance/behavioral health staff} make sure you had enough personal privacy when you dressed, took a shower, or bathed?
 - Q 37: In the last 3 months, how often did {homemakers} come to work on time?
 - Q 38: In the last 3 months, how often did {homemakers} work as long as they were supposed to?
- ⁹³ Requires implementation of the entire survey. Questions used to calculate the composite score include:
- Q 28: In the last 3 months, how often did {personal assistance/behavioral health staff} treat you with courtesy and respect?
 - Q 29: In the last 3 months, how often were the explanations {personal assistance/behavioral health staff} gave you hard to understand because of an accent or the way {personal assistance/behavioral health staff} spoke English?
 - Q 30: In the last 3 months, how often did {personal assistance/behavioral health staff} treat you the way you wanted them to?
 - Q 31: In the last 3 months, how often did {personal assistance/behavioral health staff} explain things in a way that was easy to understand?
 - Q 32: In the last 3 months, how often did {personal assistance/behavioral health staff} listen carefully to you?
 - Q 33: In the last 3 months, did you feel {personal assistance/behavioral health staff} knew what kind of help you needed with everyday activities, like getting ready in the morning, getting groceries, or going places in your community?
 - Q 41: In the last 3 months, how often did {homemakers} treat you with courtesy and respect?
 - Q 42: In the last 3 months, how often were the explanations {homemakers} gave you hard to understand because of an accent or the way the {homemakers} spoke English?
 - Q 43: In the last 3 months, how often did {homemakers} treat you the way you wanted them to?
 - Q 44: In the last 3 months, how often did {homemakers} listen carefully to you?
 - Q 45: In the last 3 months, did you feel {homemakers} knew what kind of help you needed?

⁹⁴ Requires implementation of the entire instrument.

⁹⁵ Requires implementation of the entire instrument.

- Case Manager Is Helpful Composite Measure (Q 49, 51, 53)⁹⁶
- If the state is participating in National Core Indicators (NCI):⁹⁷
 - NCI 96: Percentage of people who feel their staff have the right training to meet their needs
- If the state is participating in National Core Indicators-Aging and Disabilities (NCI-AD):⁹⁸ Measures
 - NCI-AD-9: Percentage of people whose support staff change too often

Potential Measures for Later Implementation

- Measures derived from an existing instrument:
 - Measures (to be determined) derived from the NCI Staff Stability Survey (e.g., average turnover rates)
- Other measure concepts that are not yet specified or tested:
 - Staff turnover or retention
 - Home health and personal care aides per 100 people age 18 and older with an activity of daily living disability (AARP LTSS Scorecard indicator⁹⁹)

G. NQF Domain: Human and Legal Rights

The level to which the human and legal rights of individuals who use HCBS are promoted and protected.¹⁰⁰

Potential Measures for Initial Implementation

⁹⁶ Requires implementation of the entire survey. Questions used to calculate the composite score include:

- Q 49: In the last 3 months, could you contact this {case manager} when you needed to?
- Q 51: In the last 3 months, did this {case manager} work with you when you asked for help with getting or fixing equipment?
- Q 53: In the last 3 months, did this {case manager} work with you when you asked for help with getting other changes to your services?

⁹⁷ Requires implementation of the entire instrument.

⁹⁸ Requires implementation of the entire instrument.

⁹⁹ See <http://www.longtermscorecard.org/> for more information.

¹⁰⁰ Subdomains include:

- **Freedom from abuse and neglect:** The level to which the HCBS consumer is free from abuse and neglect and the HCBS system implements appropriate prevention and intervention strategies to ensure that the HCBS consumer is free from the threat of harm, actual harm, or disregard of basic needs.
- **Optimizing the preservation of legal and human rights:** The level to which the HCBS system ensures HCBS consumers are accorded their full legal and human rights and are afforded due process in the delivery of HCBS. The preservation of these rights includes the system's ability to detect and respond to potential violations in a timely and effective manner.
- **Informed decisionmaking:** The level to which HCBS consumers, on their own or with support, are provided sufficient, understandable information in order to make decisions.
- **Privacy:** The level to which the HCBS consumer is able to maintain the desired level of privacy in terms of information sharing, access to private space, and developing and maintaining private relationships.
- **Supporting individuals in exercising their human and legal rights:** The level to which the HCBS system supports individuals in exercising their human and legal rights.

Base Set

- Measures from one or more of the following instruments: HCBS CAHPS survey, National Core Indicators (NCI), National Core Indicators-Aging and Disabilities (NCI-AD)
 - If the state or another entity is conducting the HCBS CAHPS survey:
 - Personal Safety & Respect Composite Measure (Q 64, 65, 68)¹⁰¹
 - Physical Safety Single-Item Measure (Q 71)¹⁰²
 - If the state is participating in National Core Indicators (NCI):¹⁰³
 - NCI 17: Percentage of people who report there are places where they are afraid or scared
 - NCI 18: Percentage of people who report they have someone they can talk to if they are ever scared
 - If the state is participating in National Core Indicators-Aging and Disabilities (NCI-AD):¹⁰⁴
 - NCI-AD-24: Percentage of people who feel safe around their support staff
 - NCI-AD-25: Percentage of people who are ever worried for the security of their personal belongings
 - NCI-AD-26: Percentage of people whose money was taken or used without their permission in the last 12 months

Extended Set

- If the state is participating in National Core Indicators (NCI):¹⁰⁵
 - NCI 33: Percentage of people whose mail or email is read without asking them first
 - NCI 34: Percentage of people who can be alone with friends or visitors in their home
 - NCI 92: Percentage of people who can lock their bedroom if they want to
 - NCI 94: Percentage of people who have voted or who had the opportunity to vote in a local state or federal election
- If the state is participating in National Core Indicators-Aging and Disabilities (NCI-AD):¹⁰⁶
 - NCI-AD-28: Percentage of people in group settings whose permission is asked before others enter their home or room
 - NCI-AD-29: Percentage of people in group settings who are able to lock the doors to their room if they want to
 - NCI-AD-30: Percentage of people in group settings who have enough privacy where

¹⁰¹ Requires implementation of the entire survey. Questions used to calculate the composite score include:

- Q 64: In the last 3 months, was there a person you could talk to if someone hurt you or did something to you that you didn't like?
- Q 65: In the last 3 months, did any {personal assistance/behavioral health staff, homemakers, or your case managers} take your money or your things without asking you first?
- Q 68: In the last 3 months, did any {staff} yell, swear, or curse at you?

¹⁰² Requires implementation of the entire survey. Question: In the last 3 months, did any {staff} hit you or hurt you?

¹⁰³ Requires implementation of the entire instrument.

¹⁰⁴ Requires implementation of the entire instrument.

¹⁰⁵ Requires implementation of the entire instrument.

¹⁰⁶ Requires implementation of the entire instrument.

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Potential Measures for Later Implementation

- University of Minnesota Research and Training Center on HCBS Outcome Measurement (RTC/OM) measure currently in development and testing:¹⁰⁷
 - Percent of respondents who indicate they have experienced abuse and/or neglect
- Measure adapted from an existing measure:
 - Medicaid version of: Merit-Based Incentive Payment System (MIPS) Clinical Quality Measures Quality ID #181: Elder Maltreatment Screen and Follow-Up Plan (would need to be re-specified and tested)¹⁰⁸

H. NQF Domain: Equity

The level to which HCBS are equitably available to all individuals who need long-term services and supports.¹⁰⁹

Potential Measures for Initial Implementation

Base Set

- None

Extended Set

- If the state is participating in National Core Indicators-Aging and Disabilities (NCI-AD):¹¹⁰
 - NCI-AD-17: Percentage of non-English speaking participants who receive information about their services in the language they prefer

¹⁰⁷ For more information on the RTC/OM, see <https://rtcom.umn.edu/>.

¹⁰⁸ Measure description: Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening tool on the date of encounter AND a documented follow-up plan on the date of the positive screen. For more information, see https://qpp.cms.gov/docs/QPP_quality_measure_specifications/COM-Measures/2019_Measure_181_MIPSCQM.pdf.

¹⁰⁹ Subdomains include:

- **Equitable access and resource allocation:** The extent to which consumers of HCBS have equitable access and ability to obtain needed services and supports (e.g., housing, transportation, employment services) and the extent to which the HCBS system is able to support that access through equitable allocation of resources and minimization of barriers (e.g., environmental, geographic) to access.
- **Transparency and consistency:** The extent to which laws, regulations, and policies are equitably administered and information is publicly available.
- **Availability:** The extent to which a service or support is equitably available to individuals seeking or receiving HCBS.
- **Reduction in health disparities and service disparities:** The extent to which the HCBS system minimizes disparities in health outcomes and services.

¹¹⁰ Requires implementation of the entire instrument.

- Analysis of one or more measures (to be determined) in the recommended measure set by race, ethnicity, primary language, rural/urban, population type, dual-eligible status (whether jointly enrolled in Medicare and Medicaid), etc.

Potential Measures for Later Implementation

- Measure concepts that are not yet specified or tested:
 - Housing accessibility
 - Potential access (e.g., provider supply and participation in Medicaid)
 - Realized access (e.g., % of people who receive what is authorized in their service plan)
 - Perceived access (e.g., beneficiary experience in accessing services)

I. NQF Domain: Holistic Health and Functioning

The extent to which all dimensions of holistic health are assessed and supported.¹¹¹

Potential Measures for Initial Implementation

Base Set

- None

Extended Set

- MLTSS measure:
 - MLTSS-5: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls (NCQA)¹¹²
 - Plan All-Cause Readmission (HEDIS)¹¹³

¹¹¹ Subdomains include:

- **Individual health and functioning:** The level to which all aspects of an HCBS consumer's health and functioning (including physical, emotional, mental, behavioral, cognitive, and social) are assessed and supported.
- **Health promotion and prevention:** The level to which the HCBS system focuses on the prevention of adverse health and functional outcomes and promotes the highest levels of health and functioning, across all dimensions of holistic health.

¹¹² Measure description: This measure assesses falls prevention in MLTSS enrolled older and disabled adults. The measure has three rates:

- A) Screening for Future Fall Risk: Percentage of MLTSS enrollees aged 18 years and older who were screened for future fall risk at least once within 12 months
- B) Falls Risk Assessment: Percentage of MLTSS enrollees aged 18 years and older with a history of falls who had a risk assessment for falls completed within 12 months
- C) Plan of Care for Falls: Percentage of MLTSS enrollees aged 18 years and older with a history of falls who had a plan of care for falls documented within 12 months.

For more information, see <https://www.medicaid.gov/media/3396>.

¹¹³ Measure description: Assesses the rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge. For more information, see <https://www.ncqa.org/hedis/measures/plan-all-cause-readmissions/> and https://www.ncqa.org/wp-content/uploads/2019/10/HEDIS-2019-Measures_Summary-of-Changes-1.pdf.

- Flu Vaccination (HEDIS)¹¹⁴ (adults 18-64 only)
- If the state is participating in National Core Indicators (NCI):¹¹⁵
 - NCI 97: Percentage of people whose self-reported health is poor
 - NCI 98: Percentage of people who do moderate physical activity 10 or more minutes at a time at least once per week
 - NCI 99: Percentage of people who do some physical activity that makes their muscles work hard at least once per week
 - BI 18-22 and BI 26-28: Percentage of people who were reported to have received preventive health screenings within recommended time frames (routine physical exam, dental exam, eye exam, hearing test, mammogram, pap test, colorectal cancer screening)
 - BI 23-24: Percentage of people whose BMI is in the healthy range
 - BI 25: Percentage of people who use nicotine or tobacco products
- If the state is participating in National Core Indicators-Aging and Disabilities (NCI-AD):¹¹⁶
 - NCI-AD-18: Percentage of people who felt comfortable and supported enough to go home after being discharged from a hospital or rehabilitation facility in the past year
 - NCI-AD-19: Percentage of people who had someone follow up with them after being discharged from a hospital or rehabilitation facility in the past year
 - NCI-AD-20: Percentage of people who know how to manage their chronic conditions
 - NCI-AD-21: Percentage of people who had somebody talk or work with them to reduce their risk of falling or being unstable

Potential Measures for Later Implementation

- Measures adapted from existing measures:
 - Pneumococcal Vaccination (HEDIS)¹¹⁷ adapted for Medicaid (would need to be re-specified and tested)
 - Flu Vaccination for Adults Ages 65 and older (HEDIS)¹¹⁸ adapted for Medicaid

¹¹⁴ Measure description: *Flu Vaccinations for Adults Ages 18-64*: The percentage of adults 18–64 years of age in commercial and Medicaid plans who report receiving an influenza vaccination between July 1 of the measurement year and the date when the commercial CAHPS 5.0H survey was completed; *Flu Vaccinations for Adults Ages 65 and Older*: The percentage of Medicare beneficiaries 65 years of age and older who report receiving an influenza vaccination between July 1 of the measurement year and the date when the Medicare CAHPS survey was completed. For more information, see <https://www.ncqa.org/hedis/measures/flu-vaccinations/> and https://www.ncqa.org/wp-content/uploads/2019/10/HEDIS-2019-Measures_Summary-of-Changes-1.pdf.

¹¹⁵ Requires implementation of the entire instrument.

¹¹⁶ Requires implementation of the entire instrument.

¹¹⁷ Measure description: Assesses adults 65 years older who report ever having received one or more pneumococcal vaccinations. For more information, see <https://www.ncqa.org/hedis/measures/pneumococcal-vaccination-coverage-for-older-adults/> and https://www.ncqa.org/wp-content/uploads/2019/10/HEDIS-2019-Measures_Summary-of-Changes-1.pdf.

¹¹⁸ Measure description: *Flu Vaccinations for Adults Ages 18-64*: The percentage of adults 18–64 years of age in commercial and Medicaid plans who report receiving an influenza vaccination between July 1 of the measurement year and the date when the commercial CAHPS 5.0H survey was completed; *Flu Vaccinations for Adults Ages 65 and Older*: The percentage of Medicare beneficiaries 65 years of age and older who report receiving an influenza vaccination between July 1 of the measurement year and the date when the Medicare CAHPS survey was

- (would need to be re-specified and tested)
 - MLTSS-5, Flu Vaccination, Pneumococcal Vaccination, and Plan All-Cause Readmission adapted for statewide and fee-for-service use (would need to be re-specified and tested) (see extended set measures under this domain)
 - DUALS-1: Hospitalization for Ambulatory Care Sensitive Conditions for Dual Eligible Beneficiaries¹¹⁹ (CMS) adapted for Medicaid (would need to be re-specified and tested)
- Other measure concepts that are not yet specified or tested:
 - Healthy days in the community

J. NQF Domain: System Performance and Accountability

The extent to which the system operates efficiently, ethically, transparently, and effectively in achieving desired outcomes.¹²⁰

Potential Measures for Initial Implementation

Base Set

- FFS measure:
 - HCBS-1: Admission to an Institution from the Community Among Medicaid Fee-for-Service (FFS) HCBS Users¹²¹ (CMS) (FFS equivalent of MLTSS-6)
- MLTSS measures:
 - MLTSS-6: LTSS Admission to an Institution from the Community¹²² (CMS) (MLTSS equivalent of HCBS-1)

completed. For more information, see <https://www.ncqa.org/hedis/measures/flu-vaccinations/> and https://www.ncqa.org/wp-content/uploads/2019/10/HEDIS-2019-Measures_Summary-of-Changes-1.pdf.

¹¹⁹ Measure description: Measures the sum of number of inpatient admissions and observation stays for chronic conditions (e.g. diabetes complications, COPD) and acute conditions (e.g., bacterial pneumonia, pressure ulcers).

¹²⁰ Subdomains include:

- **Financing and service delivery structures:** The level to which the system is appropriately financed and has the infrastructure in place to increase the proportion of people served in home and community settings and to meet the needs of consumers.
- **Evidence-based practice:** The level to which services are delivered in a manner that is consistent with the best available evidence.
- **Data management and use:** The level to which the system collects data in a manner that is consistent with best practices (i.e., complete, reliable, and valid), makes data publicly available, and uses data for performance improvement.

¹²¹ Measure description: The number of fee-for-service (FFS) HCBS Medicaid beneficiary admissions to an institution from the community during the measurement year, per 100,000 months of HCBS use. Three rates are reported across four age groups (18 to 64, 65 to 74, 75 to 84, and 85 and older):

1. Short-Term Stay (1 to 20 days)
2. Medium-Term Stay (21 to 100 days)
3. Long-Term Stay (greater than or equal to 101 days)

For more information, see <https://www.medicaid.gov/Medicaid/downloads/mltss-rebal-measures-webinar.pdf>.

¹²² Measure description: The number of admissions to an institutional facility among MLTSS plan members age 18 and older residing in the community for at least one month. The number of short-term, medium-term, or long-term admissions is reported per 1,000 member months. Enrollee months reflect the total number of months each enrollee

- MLTSS-7: LTSS Minimizing Institutional Length of Stay¹²³ (CMS)

Extended Set

- MLTSS measure:
 - MLTSS-8: LTSS Successful Transition After Long-Term Institutional Stay¹²⁴ (CMS)

Potential Measures for Later Implementation

- Measures adapted from existing measures:
 - HCBS-1/MLTSS-6 adapted for statewide use (would need to be re-specified and tested) (see base set measures under this domain)
 - MLTSS-7 and MLTSS-8 adapted for statewide and fee-for-service use (would need to be re-specified and tested) (see base set and extended set measures under this domain)
- Other measure concepts that are not yet specified or tested:
 - Percentage of LTSS beneficiaries receiving HCBS
 - Percentage of LTSS expenditures spent on HCBS

K. NQF Domain: Consumer Leadership in System Development

The level to which individuals who use HCBS are well supported to actively participate in the design, implementation, and evaluation of the system at all levels.¹²⁵

is enrolled in the program and residing in the community for at least one day of the month. The following three rates are reported across four age groups (ages 18 to 64, ages 65 to 74, ages 75 to 84, and age 85 and older):

1. Short-Term Stay. The rate of admissions resulting in a short-term stay (1 to 20 days) per 1,000 MLTSS member months.
2. Medium-Term Stay. The rate of admissions resulting in a medium-term stay (21 to 100 days) per 1,000 MLTSS member months.
3. Long-Term Stay. The rate of admissions resulting in a long-term stay (greater than or equal to 101 days) per 1,000 MLTSS member months.

For more information, see <https://www.medicaid.gov/media/3396>.

¹²³ Measure description: The proportion of admissions to an institutional facility among MLTSS plan members age 18 and older that result in successful discharge to the community (community residence for 60 or more days) within 100 days of admission. This measure is reported as an observed rate and a risk-adjusted rate. For more information, see <https://www.medicaid.gov/media/3396>.

¹²⁴ Measure description: The proportion of long-term institutional facility stays among MLTSS plan members age 18 and older, which result in successful transitions to the community (community residence for 60 or more days). This measure is reported as an observed rate and a risk-adjusted rate. For more information, see <https://www.medicaid.gov/media/3396>.

¹²⁵ Subdomains include:

- **System supports meaningful consumer involvement:** The level to which the HCBS system facilitates and provides supports for active consumer participation in the design, implementation, and evaluation of the HCBS system.
- **Evidence of meaningful consumer involvement:** The level to which individuals who use HCBS have meaningful involvement in the design, implementation, and evaluation of the HCBS system.
- **Evidence of meaningful caregiver involvement:** The level to which family caregivers/natural supports of

Potential Measures for Initial Implementation

Base Set

- None

Extended Set

- If the state is participating in National Core Indicators-Aging and Disabilities (NCI-AD):¹²⁶
 - NCI 93: Percentage of people who have participated, or had the opportunity to participate, in a self-advocacy group meeting, conference, or event

Potential Measures for Later Implementation

- University of Minnesota Research and Training Center on HCBS Outcome Measurement (RTC/OM)¹²⁷ measure concepts currently in development:
 - Degree to and Manner in Which Systems Support Meaningful Involvement on the Part of HCBS Recipients in the Design, Implementation, and Evaluation of the System
 - Extent to which HCBS Recipients Are Actively Involved in the Design, Implementation, and Evaluation of the System

VII. Full List of Questions Included in the RFI

All of the questions included throughout the document are provided below. A full list of questions is also provided at the end. Respondents are encouraged to provide complete but concise responses to the questions outlined in this RFI. Please note that a response to every question is not required.

- What is the value in having a standard set of recommended quality measures for voluntary use by states, managed care organizations, and other entities engaged in the administration and/or delivery of HCBS?
- What benefits or challenges would result from the release of a recommended set of quality measures?
- Do you think that the measure set should be organized into a base set and an extended set? Why or why not?
- Do you agree with organizing the measures by NQF domain? If not, is there a different organizing framework that you would recommend?
- Which domains in the NQF report are most important to address through the recommended measure set?
- Are there changes that CMS should make to the measure selection criteria?
- Which of the criteria are most important and should be prioritized?

individuals who use HCBS have meaningful involvement in the design, implementation, and evaluation of the HCBS system.

¹²⁶ Requires implementation of the entire instrument.

¹²⁷ For more information on the RTC/OM, see <https://rtcom.umn.edu/>.

- Should the base and extended measure sets only include measures that have undergone testing and validation?
- How important is it for measures in the base set and/or extended set to be endorsed by a consensus-based entity, an accreditation body, or other independent entity?
- Should CMS prioritize, for inclusion in the measure set, measures that have been endorsed by any particular entity?
- Should there be differences in how the measure selection criteria described above are applied to measures that are important to measure and/or are in wide use by states and/or managed care organizations?
- Should the base and extended measure sets cross all HCBS populations? If no, what special populations should be addressed in the extended set? What types of measures, if any, would apply only to a suggested population(s)?
- Should the base set and/or the extended set only include measures that are in the public domain and are available at no charge?
- Is it important to offer publicly available measures that are free of charge as alternatives to any proprietary measures included in the base set?
- Should publicly available measures be offered as alternatives to any proprietary measures included in the extended set?
- How important is it to include experience of care survey measures in the measure set?
- Are there any measurement domains or areas for which it is important to have population-specific measures?
- How important is it for measures included in the base set to be applicable across delivery system types (e.g., fee for service, managed care, self-direction)?
- Some stakeholders have indicated a preference for decreasing reliance on process measures and the focus on compliance in HCBS quality measurement programs, instead putting an increased focus on quality improvement and the use of outcome measures. Would greater focus on quality and outcomes facilitate the provision of Medicaid-funded HCBS? If so, how?
- What specific existing process or structural measures generate the most valuable information for measuring and improving quality or outcomes?
- Are there specific measures that your organization is using for compliance purposes that you would recommend for inclusion in the recommended measure set? Please be specific both about the measures suggested and how they are being used by your organization.
- CMS intends to include information in the recommended measure set on how each measure can be used to support reporting requirements associated with the section 1915(c) assurances and sub-assurances or other CMS requirements. How can CMS further reduce measurement and reporting burden through this recommended measure set?
- How often should the measure set be reviewed for potential retirement of included measures and/or addition of new measures?
- How often should the base set and/or the extended set be updated?
- Are there other components of measure specifications (beyond those described above) that should be included in the measure set?
- Is there other information about the measures that CMS should include in the measure set?
- Does your organization experience any barriers with collecting data for quality measurement purposes?

- Does your organizations experience any barriers with accessing data systems for quality measurement purposes?
- Does your organization experience any barriers to using data to improve quality?
- How many measures is ideal for inclusion in the base set?
- How many measures is ideal for inclusion in the extended set?
- Are there other measures that should be included in the base set or the extended set? In particular, CMS would be interested in feedback on measures that can address gaps related to specific NQF domains, including recommendations for measures that assess access to HCBS, such as measures of potential access (e.g., provider supply and participation in Medicaid), realized access (e.g., % of people who receive what is authorized in their service plan), and perceived access (e.g., beneficiary experience). CMS would also be interested in recommendations for HCBS measures that are relevant for people with behavioral health conditions.
- Are there measures that have been included that you do not think should be?
- Are there measures that have been misclassified by NQF domain?
- Are there any measures you would recommend for use in the Medicaid and CHIP Scorecard,¹²⁸ the Adult and Child Core Sets,¹²⁹ or other CMS initiatives, such as the future Medicaid and CHIP Quality Rating System¹³⁰? Please be specific both in terms of measure(s) recommended and the CMS initiative for which you are recommending them.
- Are there measures you think would be most useful to a beneficiary when choosing a managed care plan, a provider, or a self-directed service delivery model?

VIII. Collection of Information Requirements

Please note that this is a request for information (RFI) only. In accordance with the implementing regulations of the Paperwork Reduction Act of 1995 (PRA), specifically 5 CFR 1320.3(h)(4), this general solicitation is exempt from the PRA. Facts or opinions submitted in response to general solicitations of comments from the public, published in the Federal Register or other publications, regardless of the form or format thereof, provided that no person is required to supply specific information pertaining to the commenter, other than that necessary for self-identification, as a condition of the agency's full consideration, are not generally considered information collections and therefore not subject to the PRA.

We note that this is a RFI only. This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal (RFP), applications, proposal abstracts, or quotations. This RFI does not commit the U.S. Government to contract for any supplies or services or make a grant award. Further, we are not seeking proposals through this RFI and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. We note that not

¹²⁸ See <https://www.medicaid.gov/state-overviews/scorecard/index.html> for more information.

¹²⁹ See <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html> for more information.

¹³⁰ See <https://www.medicaid.gov/Medicaid/downloads/improving-the-quality-of-care-for-medicaid-beneficiaries-fact-sheet.pdf> and <https://www.regulations.gov/document?D=CMS-2018-0140-0001> for more information.

responding to this RFI does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request. In addition, we note that CMS will not respond to questions about the policy issues raised in this RFI.

We will actively consider all input as we update and refine the measure set. We may or may not choose to contact individual responders. Such communications would be for the sole purpose of clarifying statements in the responders' written responses. Contractor support personnel may be used to review responses to this RFI. Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur cost for which reimbursement would be required or sought. All submissions become U.S. Government property and will not be returned. In addition, we may publically post the public comments received or a summary of those public comments.