Home and Community-Based Services (HCBS) Quality Measure Set Reporting Requirements in the *Ensuring Access to Medicaid Services* Final Rule and for the Money Follows the Person (MFP) Grant Recipients

October 2024

About the HCBS Quality Measure Set

- In July 2022, CMS released the first-ever HCBS Quality Measure Set through State Medicaid Director Letter (SMDL) # 22-003
  - Intended to promote more common and consistent use within and across states of nationally standardized quality measures in HCBS programs
  - Implementation of the HCBS Quality Measure Set creates opportunities for CMS, states, and territories to promote health equity and reduce disparities in health outcomes among people receiving HCBS
- In April 2024, CMS released a Center for Medicaid and CHIP Services (CMCS) Informational Bulletin describing the specific HCBS Quality Measure Set reporting requirements for Money Follows the Person (MFP) recipients and a CMCS Informational Bulletin updating the HCBS Quality Measure Set
- In May 2024, CMS published the *Ensuring Access to Medicaid Services* final rule which required all states to start reporting on the HCBS Quality Measure Set in 2028

Measures Included in the Current Version of the HCBS Quality Measure Set

- Includes measures derived from four **experience of care surveys**
  - HCBS Consumer Assessment of Healthcare Providers and Systems® (HCBS CAHPS®)
  - National Core Indicators-Aging and Disabilities (NCI-AD)™
  - National Core Indicators®-Intellectual and Developmental Disabilities (NCI®-IDD)
  - Personal Outcome Measures® (POM)
- Also includes nationally standardized measures that use **assessment and/or case management record data** or **claims and/or encounter data**

Home and Community-Based Services (HCBS) Quality Measure Set Reporting Requirements in the *Ensuring Access to Medicaid Services* Final Rule

Background

- The *Ensuring Access to Medicaid Services* final rule (Access final rule) was published in May 2024
- The Access final rule includes a number of provisions focused on HCBS:
  - Strengthens oversight of person-centered service planning in HCBS
  - Requires states to meet nationwide incident management system standards for monitoring HCBS programs
  - Requires states to establish a grievance system in FFS HCBS
  - Requires that states report on the percentage of payments for certain HCBS that is spent on compensation for direct care workers
  - Requires that a minimum percentage of payments for certain HCBS is spent on compensation for direct care workers, subject to certain flexibilities and exemptions
  - Requires states to report on waiting lists in waiver programs and on service delivery timeliness for certain HCBS
  - Requires states to report on a standardized set of HCBS quality measures, and sets requirements for CMS to develop and update the measure set
  - Promotes public transparency related to the administration of Medicaid-covered HCBS through public reporting of quality, performance, and compliance measures

HCBS Provisions: Focused on Improving Access and Quality, Promoting Health Equity, and Strengthening the HCBS Workforce

- **Person-Centered Service Planning and Reporting Requirements** (§§ 441.301(c), 441.450(c), 441.540(c), 441.725(c), 441.311(b)(3), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))
- **Incident Management Systems and Critical Incident Reporting Requirements** (§§ 441.302(a)(6), 441.464(e), 441.570(e), 441.745(a)(1)(v), 441.745(b)(1)(i), 441.311(b)(1) and (2), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))
- **FFS Grievance Systems** (§§ 441.301(c)(7), 441.464(d)(5), 441.555(e), and 441.745(a)(1)(iii))
- **Waiting List and Access Reporting Requirements** (§§ 441.311(d), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))
- **HCBS Payment Adequacy Reporting Requirements** (§§ 441.311(e), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))
- **HCBS Payment Adequacy Minimum Performance Level** (§§ 441.302(k), 441.464(f), 441.570(f), and 441.745(a)(1)(vi))
- **HCBS Quality Measure Set and Reporting Requirements** (§§ 441.312, 441.474(c), 441.585(d), 441.745(b)(1)(v), 441.311(c), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))
- **Website Transparency** (§§ 441.313, 441.486, 441.595, and 441.750)

HCBS Access Provisions: Applicability Dates

2026

- FFS grievance systems

2027

- Incident management system
- Critical incident reporting and minimum performance level
- Person-centered planning reporting and minimum performance level
- Waiver waiting list reporting
- Access reporting
- HCBS payment adequacy reporting readiness
- Website transparency

2028

- HCBS Quality Measure Set reporting
- HCBS payment adequacy reporting

2029

- Electronic incident management system

2030

- HCBS payment adequacy minimum performance level

2031

2032

HCBS Quality Measure Set and Reporting Requirements (§§ 441.312, 441.474(c), 441.585(d), 441.745(b)(1)(v), 441.311(c), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))

Requires states to report on a standardized set of HCBS quality measures and sets requirements for CMS to develop and update the measure set

Prior Requirements	Final Rule	Applicability Date
No prior regulatory requirements	Sets the process for CMS to develop and update, no more frequently than every other year, the HCBS Quality Measure Set through a process that allows for public input and comment, including through the Federal Register	No later than December 31, 2026

HCBS Quality Measure Set and Reporting Requirements (cont.) (§§ 441.312, 441.474(c), 441.585(d), 441.745(b)(1)(v), 441.311(c), 441.474(c), 441.580(i), and 441.745(a)(1)(vii))

Requires states to report on a standardized set of HCBS quality measures and sets requirements for CMS to develop and update the measure set

Prior Requirements	Final Rule	Applicability Date
No prior regulatory requirement	• Requires states to report every other year on mandatory measures in the HCBS Quality Measure Set and establish performance targets and quality improvement strategies • Also allows for reporting on additional voluntary measures and for CMS to report on certain measures on a state's behalf	Beginning July 9, 2028
No prior regulatory requirement	Phases in requirements for stratification of data for certain measures by race, ethnicity, sex, age, rural/urban status, disability, language, or other factors	25%: July 9, 2028 50%: July 9, 2030 100%: July 9, 2032

Website Transparency (§§ 441.313, 441.486, 441.595, and 441.750)

Promotes public transparency related to the administration of Medicaid-covered HCBS through public reporting of quality, performance, and compliance measures

Prior Requirements	Final Rule	Applicability Date
No prior regulatory requirement	Requires the state to operate a website (either directly or by linking to managed care plan websites) that provides the results of the HCBS reporting requirements and meets availability and accessibility requirements	Beginning July 9, 2027
No prior regulatory requirement	Requires CMS to report on its website the results of the HCBS reporting requirements that states report to CMS	Beginning July 9, 2027

CMS Response to Comments in the *Access Rule* Preamble (slide 1 of 2)

- "We assure States that CMS will not update the measure set to add new measures or retire existing measures more frequently than every other year…CMS intends to retain each of the measures in the measure set for at least 5 years to ensure the availability of longitudinal data, unless there are serious issues associated with the measures (such as related to measure reliability or validity) or States' use of the measures (such as excessive cost of State data collection and reporting or insurmountable technical issues with State reporting on the measures)."
- "We will make technical updates and corrections to the HCBS Quality Measure Set annually as appropriate."

CMS Response to Comments in the *Access Rule* Preamble (slide 2 of 2)

- "For each of the measures in the HCBS Quality Measure Set that are identified as mandatory for States to report, or are identified as measures for which we will report on behalf of States, States should establish and describe the quality improvement strategies to achieve the performance targets for those measures."
- "We expect to align with Department of Health and Human Services (HHS) data standards for stratification, based on the disaggregation of the 1997 Office of Management and Budget (OMB) Statistical Policy Directive No 15. We expect to update HCBS Quality Measure Set reporting stratification categories if there are any changes to OMB or HHS Data Standards."

Early Reporting of the HCBS Quality Measure Set under the Money Follows the Person (MFP) Demonstration

About the MFP Demonstration

- Money Follows the Person (MFP) is a long-standing grant-funded demonstration designed with four goals:
  - Increase the use of HCBS rather than institutional LTSS under Medicaid;
  - Eliminate barriers or mechanisms that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary LTSS in the settings of their choice;
  - Increase the ability of state Medicaid programs to assure continued provision of HCBS to eligible individuals who choose to transition from an institutional to a community setting; and
  - Ensure that procedures are in place to provide quality assurance for eligible individuals receiving Medicaid HCBS and to provide for continuous quality improvement in such services.
- Currently, 41 states and territories are participating in MFP.

HCBS Quality Measure Set Reporting Requirements for MFP Grant Recipients

- MFP Terms and Conditions require MFP grant recipients to implement the HCBS Quality Measure Set
- MFP grant recipients are required to report on the HCBS Quality Measure Set every other year for their section 1915(c), 1915(i), 1915(j), and 1915(k) programs and any section 1115 demonstrations that include HCBS
  - Reporting must include all eligible individuals (or a representative sample of eligible individuals) receiving HCBS under these authorities.
  - Reporting is not limited to MFP program participants receiving HCBS under those authorities; MFP grant recipients are expected to report in the aggregate across all of their HCBS programs and are not expected to report separately for each HCBS program.

HCBS Quality Measure Set Reporting Requirements for MFP Grant Recipients (cont.)

- For the initial implementation of the HCBS Quality Measure Set, MFP grant recipients are expected to report on a subset of the measures in the measure set and to develop a quality improvement plan related to two measures of their choice
- The first year of reporting will be 2026
  - CMS expects that reporting in 2026 will be no earlier than September 1, 2026
- States and territories can include the costs associated with planning, implementation, and ongoing use of the HCBS Quality Measure Set in their MFP budgets

2026 MFP Reporting Requirements

Mandatory/ Voluntary	Measure	Data Source/Data Collection Method	Delivery System
Mandatory	Experience of care survey(s) for each of the major population groups included in the state's or territory's HCBS programs (specific measures to be determined)	Survey	FFS/MLTSS
Mandatory	LTSS-1: LTSS Comprehensive Assessment and Update	Assessment/Case Management Record	FFS/MLTSS
Mandatory	LTSS-2: LTSS Comprehensive Care Plan and Update	Case Management Record	FFS/MLTSS
Voluntary	LTSS-3: LTSS Shared Care Plan with Primary Care Practitioner	Case Management Record	FFS/MLTSS
Voluntary	LTSS-4: LTSS Reassessment/Care Plan Update after Inpatient Discharge	Assessment/Case Management Record	FFS/MLTSS
Voluntary	MLTSS-5: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls	Case Management Record	MLTSS
Mandatory	LTSS-6: LTSS Admission to a Facility from the Community	Claims/Encounter Data	FFS/MLTSS
Mandatory	LTSS-7: LTSS Minimizing Facility Length of Stay	Claims/Encounter Data	FFS/MLTSS
Mandatory	LTSS-8: LTSS Successful Transition After Long-Term Facility Stay	Claims/Encounter Data	FFS/MLTSS
Voluntary	HCBS-10: Self-direction of services and supports among Medicaid beneficiaries receiving LTSS through managed care organizations	Case Management Record	MLTSS
Voluntary	MLTSS: Plan All-Cause Readmission (HEDIS)	Claims/Encounter Data	MLTSS

Questions?

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