

HCBS Quality Measures Issue Brief

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Assessment and Care Planning Measures

In 2016, the National Quality Forum (NQF) defined home and community-based services (HCBS) as “an array of services and supports delivered in the home or other integrated community setting that promote the independence, health and well-being, self-determination, and community inclusion of a person of any age who has significant, long-term physical, cognitive, sensory, and/or behavioral health needs” (NQF 2016). More than 4.5 million people with disabilities used Medicaid-funded HCBS in 2017 (Musumeci et al. 2019). This number is expected to grow as the population ages and as advances in medical technology enable people with disabilities to live longer.

All Medicaid HCBS programs use two key processes to provide person-centered care that meets NQF’s goals: (1) assessing individual needs and preferences and (2) developing a care plan that specifies the types and amount of services and supports necessary to meet those needs. Quality measures enable state agencies that deliver HCBS, as well as consumers, providers, and

health plans, to gauge how well assessments and care plans are person centered, timely, and comprehensive.

This brief describes recent advances in quality measurement of **person-centered assessments and care plans** for Medicaid HCBS beneficiaries. Quality measures fall into three categories: structure,

About this series

In the last five years, the Centers for Medicare & Medicaid Services (CMS), the National Quality Forum, and private-sector groups have issued reports that describe quality measure frameworks for home and community-based services (HCBS), inventories of HCBS quality measures now in use, and lists of key measure gaps. CMS, other federal agencies, and measure developers have also developed and rigorously tested new HCBS quality measures, several of which recently became available to state Medicaid agencies.

This issue brief series summarizes major developments in HCBS quality measurement, covering three critical processes and outcomes of high quality care:

1. **Person-centered assessments and care plans**
2. **Person-reported outcomes related to experience of care, community participation, choice, and decision making**
3. **Rebalancing the long-term services and supports system toward HCBS**

These briefs aim to orient state Medicaid agencies toward current measures available to: monitor, improve, and evaluate HCBS quality; inform agencies’ selection of appropriate measures for different HCBS programs and populations; and highlight current measure gaps.

processes, and outcomes. This brief focuses on process measures, which examine whether assessment and care planning are conducted in ways that are likely to result in positive outcomes. The brief reviews the history and evolution of measures in this area, the development of new measures, the use of HCBS quality measures for different types of Medicaid HCBS programs and population groups, and remaining measure gaps. Several key points emerge from this review:

- State Medicaid programs, as well as state aging and disability agencies, have used myriad measures to evaluate the quality of HCBS services in the past 40 years, including assessments and care plans. Until recently, however, no nationally standardized measures allowed states to compare their performance against national benchmarks or with that of other states.
- Federal laws require state Medicaid agencies assess individuals' long-term service and support needs and create care plans for HCBS beneficiaries served through programs operating under any federal Medicaid authority. States can monitor compliance with these rules using their own performance measures. For the most part, states' measures track how many beneficiaries are assessed and receive a care plan within a certain period of time. Historically, few measures of assessment and care planning have focused on the quality and content of assessments, the degree to which care plans reflect beneficiary goals and preferences, and whether services in the care plan meet beneficiary needs.
- In 2018, the Centers for Medicare & Medicaid Services (CMS) released a new set of measures for evaluating the quality of assessment and care planning of Medicaid long-term services and supports (LTSS) beneficiaries enrolled in managed care plans. Unlike previous measures, they (1) are nationally standardized, (2) meet scientific reliability and validity tests, and (3) examine the degree to which assessments and care plans are comprehensive and of high quality. Although specified for use in managed LTSS programs, the

measures can be adapted for fee-for-service HCBS delivery programs.

1. Importance of assessment and care planning to HCBS beneficiaries.

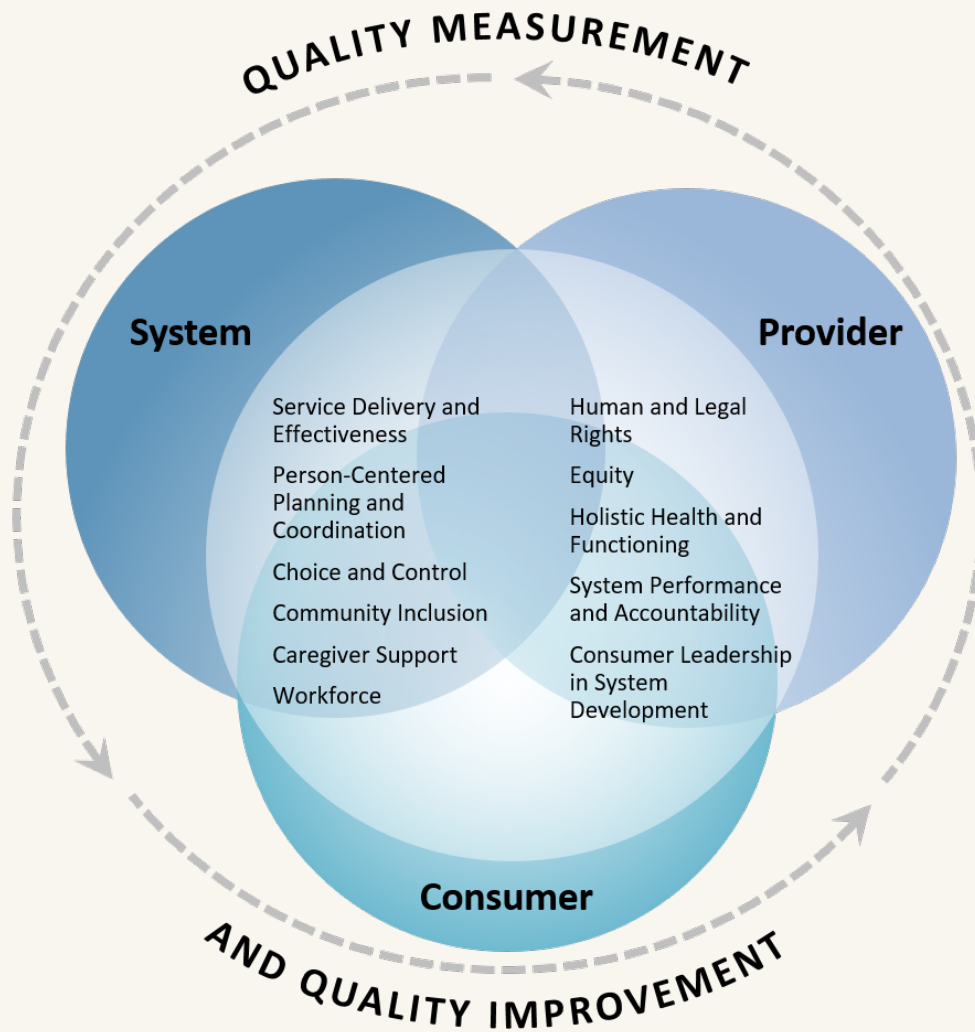
Assessments and care planning are two of three processes that comprise **person-centered planning and coordination**, one of 11 quality domains in the NQF HCBS Quality Framework (see Exhibit 1). NQF defines this domain as:

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.

Federal statutes and rules require many Medicaid HCBS programs serving beneficiaries with disabilities to conduct person-centered assessment and care planning because these processes are considered fundamental to high quality HCBS.¹ Individualized assessments and care plans identify and address the diversity of health conditions, functional abilities, and service and support needs among people with disabilities. When done well, person-centered assessment and care plans produce positive outcomes, including improved health and function, higher quality of life, and achievement of care goals (Stuck et al. 1993, Bielaszka-DuVernay 2011, Counsell et al. 2007, and Rich et al. 2012).

There is broad consensus on the standards and features that characterize high quality assessments and care plans. These standards include (1) completing

Exhibit 1. National Quality Forum home and community-based services quality measurement framework



Source: National Quality Forum. *Quality in Home- and Community-based Services to Support Community Living: Addressing Gaps in Performance Measurement Final Report*. September 2016.

assessments and care plans in a timely fashion, (2) tailoring them to each person’s goals and preferences, (3) enabling beneficiaries to choose providers and services and to self-direct services and supports, and (4) addressing each individual’s needs in a comprehensive fashion (DHHS 2014; AGS Expert Panel 2016, SCAN Foundation 2016, NCQA 2017).

2. History and evolution of assessment and care planning measures

HCBS quality measures vary by state and program. States have used myriad measures to evaluate the quality of HCBS services since 1981, when Medicaid first permitted states to use section 1915(c) waiver

programs to provide home and community-based alternatives to institutional care. Federal rules governing section 1915(c) waiver programs, which serve the largest number of HCBS beneficiaries, allow each state to develop its own performance indicators for each waiver program. The same is true for HCBS programs operating under other Medicaid state plan options, including section 1915(i) State Plan HCBS, section 1915(k) Community First Choice, and section 1915(j) self-directed personal assistance services.

States that operate Medicaid managed LTSS (MLTSS) programs under various federal authorities also have flexibility to develop their own quality and performance measures. Historically, state Medicaid agencies covered LTSS by paying providers directly on a fee-for-service basis, but Medicaid delivery and payment systems have undergone a sea change in the last 10 years. In 2018, nearly two dozen states contracted with private managed care plans, paying them a fixed monthly amount for each Medicaid enrollee. In exchange for these capitated payments, MLTSS plans deliver services to enrollees through networks of providers, such as nursing homes, home health agencies, and personal care aides. Several integrated care programs for Medicare-Medicaid dual eligibles that use a managed care delivery model, such as the Medicare-Medicaid Financial Alignment Initiative (FAI) capitated model demonstration, also cover HCBS benefits (CMS 2018). Each of these programs has unique federal reporting requirements and performance measures, which can vary by state (Giovannetti et al. 2013).

One consequence of granting states flexibility to develop their own HCBS quality measures is that HCBS programs lack a single, standardized set of quality measures (NQF 2016). HCBS performance measures now number in the hundreds nationwide, including those that examine the quality of HCBS assessment and care planning. Although this latitude allows states to tailor the measures to each program, it thwarts efforts by consumers, CMS, and state program managers to compare state performance against national benchmarks or across states.

Most HCBS assessment and care planning measures focus on timeliness rather than quality.

In addition to the lack of standardization, most HCBS assessment and care planning measures evaluate compliance with federal rules that require such processes rather than the content of the assessments or the degree to which care plans reflect participants' goals and preferences (Hartman and Lukanen 2016). For example, federal regulations require each state that operates a section 1915(c) HCBS waiver program to demonstrate compliance with six major assurances—that is, systems and processes intended to assure quality. States must submit proof to CMS that they comply with these assurances in evidence packages, which CMS must approve once after the first three years of a waiver and again every five years after that.

Two of the six assurances address needs assessment and care planning. For example, in one assurance, Level of Care Determination, states must demonstrate consistent use of assessment processes to verify that participants require an institutional level of care, one of the key eligibility criteria for section 1915(c) waiver programs. For the Service Plan assurance, states must demonstrate that “participants have a service plan that is appropriate to their need and that they receive the services/supports specified in the plan,” including the type, scope, amount, duration, and frequency specified in the service plan. To meet one of two sub-assurances in the Service Plan assurance, states must also provide evidence that service plans: (a) address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means; and (b) are updated at least annually or when warranted by changes in the waiver program participant's needs. Federal rules issued in 2014 further specify that service plans must be developed through a “person-centered planning process that addresses health and [LTSS] needs in a manner that reflects individual preferences and goals.”²

Although the assurances are common across states, each state can create its own performance indicators for each assurance, and in most states, the

indicators simply measure compliance with federal requirements, such as whether most (86 percent) level of care assessments are updated annually.³ Similarly, there are only two types of mandatory assessment and care planning measures for FAI Medicare-Medicaid Plans: (1) the share of members with a completed assessment or care plan and (2) those completed within specified periods of time after initial enrollment.⁴

HCBS care plan measures across states are equally diverse and in many cases limited to measuring whether a care plan was developed at all or within a certain period after initial program enrollment. Some states' measures, however, focus on the quality of the care plans. For example, an environmental scan of seven states' 1915(c) HCBS waiver program performance measures found that all had measures of the proportion of beneficiaries whose service plan included services to match their needs, the proportion offered a choice of service providers, and the proportion who received the services outlined in their service plans (Giovannetti et al. 2013). In 2016, an American Geriatrics Society expert panel that developed standards, definitions, and core elements for person-centered care stressed that "quality indicators need to be defined for person-centered care . . . [and] a person-centered care plan may be the most significant quality indicator" (AGS Expert Panel 2016).

Differences in assessment tools complicate efforts to develop standardized measures. The multiplicity of assessment measures results in part from the wide assortment of tools used to assess individuals' HCBS needs and preferences. For example, in 2015, HCBS programs in the 50 states and the District of Columbia used 124 different tools to assess beneficiaries' functional needs—that is, their need for assistance in performing activities of daily living (ADLs), such as transferring positions, toileting, bathing, dressing, and eating. But functional ability is only one dimension of need among HCBS beneficiaries (MACPAC 2016).⁵

Similar variation in assessment instruments and measures exists in state MLTSS programs and across MLTSS health plans (Giovannetti et al. 2013; Ingram et al.

New National Center for Advancing Person-Centered Practices and Systems

The Administration for Community Living recently announced the creation of a central clearinghouse to provide information about person-centered care. The center will provide technical assistance to states on strategies and techniques to implement person-centered thinking, planning, and practices in their systems. It will also share best practices across state systems. The National Center for Advancing Person-Centered Practices and Systems is jointly funded by CMS and the Administration for Community Living. For more information, see <https://ncapps.acl.gov/about-ncapps.html>.

2013). Some states, such as Minnesota and Texas, require all MLTSS plans operating in the state to use a common state-developed assessment instrument. Other states, such as Tennessee and Wisconsin, allow each MLTSS plan to use its own assessment tools, albeit with certain restrictions, in addition to a state-performed level-of-care assessment. Some states require assessments to be completed in person, but others do not specify the mode or location. Similarly, although all health plans participating in the FAI capitated model demonstration must conduct an assessment and develop a care plan within 90 days of a person's enrollment, CMS allows each state to define the content of the assessments and care plans (CMS 2018).

Several validated functional assessment tools have been developed for HCBS beneficiaries.⁶ These tools are analogous to the standardized assessment tools that have been developed for (1) nursing home residents (the Long-Term Care Minimum Data Set, or MDS), (2) Medicare home health care patients (the Outcome and Assessment Information Set, or OASIS), and (3) post-acute care patients (Continuity Assessment Record and Evaluation, or CARE). Tools have also been designed to measure person-centered care in nursing facilities (National Nursing Home Quality Improvement Campaign, n.d.).

Frequently, quality indicators and outcome measures have been derived from data elements in these assessment tools, typically by calculating rates of improvement, stabilization, or decline in function among beneficiaries or program participants over time in each area assessed. But state Medicaid HCBS programs are not required to use these functional assessment tools and associated measures. Instead, they can use state-specific tools and measures, many of which have not been validated. Moreover, as noted, these tools focus on assessing an individual’s level of need for assistance to perform ADLs and basic functions, which is only one of many domains of importance to people with disabilities.

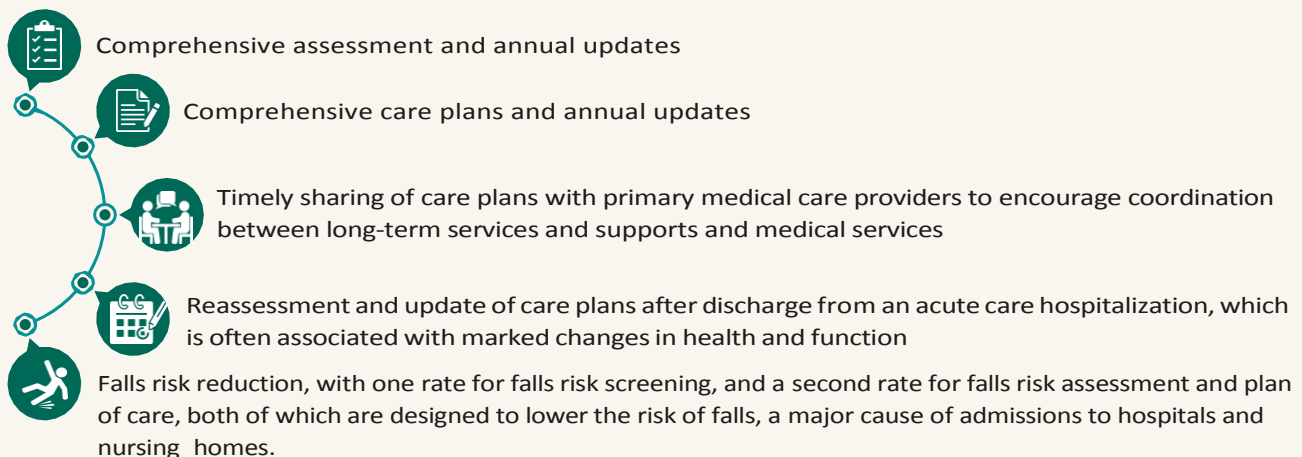
3. New assessment and care planning measures for MLTSS plans

The growth of MLTSS programs in the last 10 years led to mounting calls for validated, nationally standardized measures to enable CMS, states, health plans, and consumers to compare the performance of these plans within and across states. The U.S. Government Accountability Office investigated the availability of standardized MLTSS quality measures and concluded that they “remain in the early stages of development”

(GAO 2017). Medicaid managed care regulations released in 2016 required states to assess the quality of HCBS provided by MLTSS plans in the areas of quality of life, rebalancing, and community integration [42 CFR §438.330(c)(1) (ii)], using standard performance measures. National organizations of health plans called for developing nationally standardized measures to reduce the reporting burden for plans operating in multiple states (National MLTSS Health Plan Association 2017; United Healthcare 2016). The National Committee for Quality Assurance (NCQA), which ranks managed care plans across the country based on their performance relative to national benchmarks, also supported standardized measures to assess the quality and performance of MLTSS plans.

In 2013, CMS contracted with Mathematica and its partner NCQA to develop standardized measures that would allow for apples-to-apples comparisons across MLTSS health plans of various aspects of performance, including person-centered assessments and care plans. After field testing the measures with health plans in 2018, CMS released technical specifications for eight new MLTSS quality measures, five of which focus on the content of comprehensive, person-centered assessment and care plans (see Exhibit 2).

Exhibit 2. MLTSS quality measures for assessment and care planning



For detailed measure technical specifications, see https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltss_assess_care_plan_tech_specs.pdf

The new MLTSS plan measures represent a significant improvement over previous measures. In addition to determining the timeliness of assessments and care plans, they measure the degree to which assessments and care plans are comprehensive—that is, whether they cover a core set of elements considered by consumers and LTSS professionals to be critical to person centeredness. For example, to be considered high quality, the assessments conducted by MLTSS plans must include at least nine specified core elements that are important to people with disabilities, such as functional status, cognition, preferred living arrangements, home safety risk, medications, and caregiver involvement. To be scored as comprehensive, care plans must include at least nine core elements of a person-centered care plan, including the member’s goal; plans to address the individual’s medical, functional, and cognitive needs; an emergency plan; a list of all LTSS services to be provided; and the role (if any) of family caregivers or other natural supports.

The MLTSS measures are also flexible; they do not specify which tools or instruments must be used to assess each of these elements, but supporting documentation does cite validated assessment tools as examples (CMS 2019a). This flexibility enables each state to decide whether to require MLTSS plans to use state-specific assessment tools for each of the core elements or allow MLTSS plans to select their own. Finally, the measures were rigorously tested and shown to be statistically reliable and valid as required by the CMS Measures Management System (CMS 2019b).






Although the new quality measures were designed for use in MLTSS programs, they can be adapted for use in HCBS waiver programs. In such cases, the measure denominators change from MLTSS member months to HCBS waiver enrollment months or beneficiary months of HCBS use. States can also decide whether to require that HCBS beneficiaries be continuously enrolled (as in the MLTSS measures). Changes to measure specifications might also be necessary to reflect any differences in the datasets used to calculate the measures.

4. Selection and use of measures for HCBS programs and populations

As the amount of validated HCBS quality measures grows, it becomes important for state Medicaid officials and those in aging and disability agencies to choose the right measures for the HCBS programs and the population groups they serve.

Identify sound quality measures. Choosing the right measures begins with identifying those that meet the standards that define good quality measures. CMS and NQF use the same criteria to evaluate the soundness of measures: meaningful, scientifically valid, reliable, feasible to measure and report without undue burden, and useful to guide performance improvement (see Exhibit 3). Measures must also be defined clearly 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 that counts the number of people eligible for the process or for whom the outcome is relevant.

Exhibit 3. What makes a good quality measure?

-  1. **Important** – meaningful to stakeholders and relevant to the outcomes a system seeks to produce; for process measures, there must be good evidence that the processes lead to desired outcomes
-  2. **Scientifically valid** – accurately captures the process or outcome measured
-  3. **Reliable** – produces the same result each time
-  4. **Feasible** to construct using data that can be collected without undue burden
-  5. **Usable** – provides meaningful information to providers, health plans, or state systems on how to improve performance

Sources: CMS 2019b and National Quality Forum 2018.

To identify HCBS assessment and care planning quality measures that meet the standards for sound quality measures, state Medicaid agencies typically turn to national health care quality organizations. For example, NQF, which is currently under contract with the U.S. Department of Health and Human Services as the consensus-based entity required by section 1890 of the Social Security Act to endorse health care quality measures, applies strict evaluation standards to measures seeking its endorsement. In 2017, NQF endorsed the first set of HCBS quality measures, which are derived from the HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.⁷ NQF also published a compendium with more than 250 HCBS measures, which users can search by measure domain, target population, evidence of testing for reliability and validity, feasibility of data collection, measure developer, and other variables (NQF 2015). But none of the measures listed in the compendium's service delivery domain, which includes person-centered planning and coordination, had been tested for or met NQF's rigorous scientific reliability and validity criteria.

NCQA, which also uses rigorous measures evaluation criteria, maintains the Healthcare Effectiveness Data and Information Set (HEDIS). These measures are specifically designed to evaluate health plan performance. In May 2018, NCQA's Committee on Performance Measurement approved four MLTSS assessment and care plan measures for inclusion in the 2019 HEDIS, the first LTSS measures to become part of HEDIS.

Use of measures for different HCBS programs and populations. In theory, measures of person-centered assessment and care planning are applicable to all types of HCBS programs operating under any federal Medicaid authority, including section 1915(c) waiver programs, section 1915(i) State Plan HCBS, section 1915 (j) Self-directed Personal Assistance Services, and section 1915(k) Community First Choice Option programs, as well as HCBS covered by managed LTSS plans. They should also apply to Medicaid enrollees in integrated care plans for Medicare-Medicaid dual

enrollees, such as those participating in the FAI demonstrations, as well as Medicare Advantage Dual Eligible Special Needs Plans (SNPs) with an aligned MLTSS program and Fully Integrated Dual Eligible SNPs.

In practice, however, the federal reporting requirements governing each program could impede the use of the same measure in multiple programs because states or health plans might still have to report different measures to satisfy each program's requirements. In addition, modifications to the measure denominators might be required to reflect delivery system differences, such as specifying a minimum length of enrollment in a managed care plan to allow time for an initial assessment and care plan to be developed.

Some stakeholders also argue that different assessment and care planning tools, and different types of measures, are necessary for people with diverse characteristics and types of disabling conditions, such as frail older adults, adults younger than age 65 with physical disabilities, adults with intellectual or developmental disabilities, adults with serious mental illness, or adults with traumatic brain injury. For example, even in states that use a uniform assessment system for older adults and people with physical disabilities, states might use different assessment tools, or different modules in a common tool, for people with developmental or intellectual disabilities.

5. New measures under development and remaining measure gaps

Building on recent progress in developing standardized HCBS measures, federal agencies are supporting projects that seek to fill measure gaps. For example, CMS sponsored an effort to develop and test performance measures derived from the Functional Assessment Standardized Items (FASI), a set of questions that cover three sets of functional abilities and goals that are found in most Medicaid HCBS assessment tools: (1) self-care (for example, ADLs related to eating, dressing, and bathing); (2) mobility, including ambulation and manual or motorized wheelchair use; and (3) instrumental ADLs, such as preparing meals and shopping. It also

includes questions about the use of assistive devices as well as caregiver assistance.

CMS, which funded the development of FASI, viewed it as part of a broader effort to standardize and facilitate the electronic exchange of data about people's function across care settings. Consequently, the items and questions in the FASI instrument originated with those in the Continuity Assessment Record and Evaluation tool, which was developed for use in post-acute care settings, including skilled nursing facilities, home health agencies, and inpatient rehabilitation units, to permit comparisons across post-acute and HCBS settings.

Two measures derived from FASI questions aim to assess and compare state performance related to person-centered planning: (1) the percentage of HCBS participants needing help, as determined by a FASI assessment, who identified at least three personal priorities and (2) the percentage of HCBS participants with functional needs with a comprehensive person-centered service plan that addresses their functional needs. FASI developers recognized that functional ability is “just one component of a comprehensive, standardized assessment that informs an individual’s [HCBS] service plan and supports necessary for successful community living . . . [but it is] a good place to start in conducting a comprehensive, standardized, person-centered assessment” (Mallinson et al. 2018).

Another gap concerns measures of caregiver support, which are important complements to assessments and care plan measures for HCBS beneficiaries. A recent inventory of caregiver assessment instruments and scales listed a multitude of tools and questions available to conduct such assessments (Schwartz et al. 2012). The inventory identified gaps related to tools that assess the types and complexity of health care tasks that caregivers are expected to perform, the training provided by health care professionals, and competency in carrying out these tasks. The 2016 NQF HCBS Quality Report also noted the necessity of benchmarks for outcomes related to caregiver well-being and gaps in measures of

caregiver assessment and support, including those that measure caregiver involvement in service planning, assessment of caregiver needs, impact of caregiving, and availability of resources and training for caregivers (NQF 2016).

Conclusion

Measuring the quality of assessment and care planning processes is critically important to evaluate how well Medicaid HCBS programs provide person-centered care. Although states are permitted to develop their own measures for this purpose, they could consider using newly available validated and nationally standardized measures. Such measures enable states, consumers, providers, and health plans to compare their performance against national benchmarks or with that of other states and health plans. The newly developed measures of assessment and care planning for MLTSS programs and plans go beyond timeliness to evaluate the comprehensiveness of assessments and care plans and examine whether care plans explicitly include beneficiary goals and preferences.

Still, some would argue that the true test of the quality of assessment and care planning processes is whether they produce good outcomes. In many cases, the best way to measure outcomes is to ask beneficiaries directly about their care experience. The second brief in this series discusses the history, evolution, and recent developments in person-reported outcome measures.

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Endnotes

¹42 CFR §441.301(c)(1) for HCBS 1915(c) waiver programs; 42 CFR §441.468(b) for 1915(j) self-directed personal assistance programs; 42 CFR §441.725 for 1915(i) State Plan HCBS, which covers targeted groups of people with functional needs that are less than an institutional level of care; Social Security Act §1915(k)(1)(A)(i) for Community First Choice; 42 CFR §438.208 (c)(2) for managed long term services and supports (MLTSS) programs, and Affordable Care Act, section 2402(a).

²42 CFR Part 441.301. The U.S. Department of Health and Human Services later issued guidance regarding the process for operationalizing person-centered planning (DHHS 2014).

³Federal modifications to section 1915(c) waiver quality assurance rules in 2014 revised the threshold of compliance from 100 percent to at or below 85 percent, the point that triggers a requirement for states to implement quality improvement projects or take other remediation steps (CMS 2014).

⁴For example, Medicare-Medicaid Plan measures 2.1 and 3.2 calculate the share of members with an assessment and care plan, respectively, completed within 90 days of enrollment.

⁵The Balancing Incentive Program, designed to promote expanded access to HCBS, required the states eligible to receive grants to develop and implement a standardized assessment instrument, which covered a core set of domains. Its purpose was to ensure a uniform approach to determining eligibility for all HCBS programs in each state and identifying support needs. But the program did not require a common set of measures for evaluating the overall quality of assessments.

⁶For example, a validated functional assessment tool for people who need HCBS is the [interRAI-Home Care](#) instrument, which is used by more than a dozen states. Several states also use the Supports Intensity Scale, a validated tool developed by the American Association on Intellectual and Developmental Disabilities, for adults (16 and older) with developmental disabilities. Discussion of the Functional Assessment Standardized Items, which has also been validated, appears later in the brief.

⁷HCBS CAHPS® measures are person-reported ratings of experience with care. The second brief in this series will discuss these measures in detail.

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