Purpose of the HCBS Quality Measure Set

The HCBS Quality Measure Set is intended to promote more common and consistent use, within and across states, of nationally standardized quality measures in HCBS programs, and to create opportunities for CMS and states to have comparative quality data on HCBS programs. In doing so, it is expected to support states with improving the quality and outcomes of HCBS. 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 nationally standardized 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.

While use of this measure set is voluntary at this time, CMS plans to incorporate use of the measure set into the reporting requirements for specific authorities and programs, including the Money Follows the Person (MFP) program and future section 1115 demonstrations that include HCBS. Additional information will be made available to states that are participating in the MFP program and that deliver HCBS through section 1115 demonstrations; states are not expected to make any changes to their measurement and reporting activities in their MFP programs or their section 1115 demonstrations until they receive additional information from CMS. CMS also encourages states to use the measure set to assess quality and outcomes in HCBS programs authorized under other federal authorities, including section 1915(c) waiver programs, section 1915(i) state plan services, section 1915(j) self-directed personal assistance services, and section 1915(k) Community First Choice. In addition, while some of the measures included in the measure set are applicable for only certain delivery system types, CMS encourages states to use the measure set, to the extent that measures are applicable to a specific HCBS program, regardless of delivery system type. As noted previously, a second guidance document, which is forthcoming, will describe how states can use the measure set to meet federal requirements for their HCBS programs (such as required reporting under section 1915(c) waivers and quality reporting in managed care programs).

Measures Included in the HCBS Quality Measure Set

The HCBS Quality Measure Set is comprised of measures that assess quality across a broad range of domains identified as measurement priorities for HCBS. 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 target process, condition, event, or outcome expected for the target population, and (2) a denominator that counts the number of people eligible for the process or for whom the outcome is relevant.[26] A measure must also have clearly defined exclusion criteria that can be used to identify who should be removed from the measure population.

In addition to claims-based measures and measures that require assessment or other beneficiary records, the HCBS Quality Measure Set extensively leverages existing beneficiary surveys used

[26] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/NTM-What-is-a-Quality-Measure-SubPage.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.