



CMCS Informational Bulletin

DATE: April 11, 2024

FROM: Daniel Tsai, Deputy Administrator and Director
Center for Medicaid and CHIP Services

SUBJECT: Home and Community-Based Services (HCBS) Quality Measure Set (QMS) Reporting Requirements for Money Follows the Person (MFP) Demonstration Grant Recipients

The Home and Community-Based Services (HCBS) Quality Measure Set (QMS) is a set of nationally standardized quality measures for Medicaid-funded HCBS.¹

To receive grant funding under the Money Follows the Person (MFP) Demonstration,² states³ must develop and implement a plan for continuous quality assurance and quality improvement systems for HCBS.⁴ In 2022, the Centers for Medicare & Medicaid Services (CMS) updated the MFP Demonstration program terms and conditions (PTC) to require reporting on the HCBS QMS for all MFP Demonstration grant recipients. This informational bulletin describes the HCBS QMS reporting requirements for MFP grant recipients subject to the updated PTC. Specifically, this informational bulletin addresses requirements and expectations in the following areas:

- Population groups,
- Reporting timeframe,
- Required measures,
- Stratification, and
- Sampling.

Further, through this informational bulletin, CMS is confirming that MFP grant recipients may use administrative grant funding for implementation of the HCBS QMS.

¹ <https://www.medicare.gov/medicaid/quality-of-care/quality-improvement-initiatives/measuring-and-improving-quality-home-and-community-based-services/index.html>

² <https://www.medicare.gov/medicaid/long-term-services-supports/money-follows-person/index.html>

³ By “state,” we intend the meaning of the term as defined under 45 CFR § 75.2 as “any state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and any agency or instrumentality thereof exclusive of local governments.”

⁴ Section 6071 of the Deficit Reduction Act of 2005 (Pub. Law 109-171).

Background

On July 21, 2022, the Centers for Medicare & Medicaid Services (CMS) released the first official version of the HCBS QMS through State Medicaid Director Letter (SMD) # 22-003.⁵ CMS updated the HCBS QMS in the CMCS Informational Bulletin on the 2024 HCBS QMS. The HCBS QMS 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, including for identifying and addressing disparities in HCBS programs. In doing so, it is expected to support CMS and states with improving the quality and outcomes of HCBS and promoting health equity for people receiving Medicaid-funded HCBS. Further, implementation of the HCBS QMS will assist CMS and states in ensuring that the services received by beneficiaries are responsive to their changing needs and choices, maximize independence and self-direction, and facilitate a community-supported life.

The HCBS QMS can be used in all HCBS programs except when the identified measures are not applicable to the state's HCBS programs (e.g., managed care measures for states with only fee-for-service (FFS) HCBS programs). The HCBS QMS also includes some gaps in measurement, particularly for children receiving HCBS. CMS is working to address these gaps and will incorporate nationally standardized measures focused on the quality of HCBS for children, as well as measures to address other gaps, as they become available.

MFP Required Reporting

Population Groups

In accordance with MFP PTC 43,⁶ MFP grant recipients are required to report on the HCBS QMS to provide quality assurance for eligible individuals receiving Medicaid-funded HCBS and to provide continuous quality improvement in such services. To meet the mandatory reporting requirement, MFP grant recipients must report on the HCBS QMS for all Medicaid-funded HCBS under section 1915(c), (i), (j), and (k) authorities, as well as 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 on the HCBS QMS is

⁵ In SMD # 22-003, we described the quality measures included in the first official version of the HCBS QMS and provided information on the purpose of the HCBS QMS, measure selection criteria, organization of the QMS, and considerations for implementation. We also provided additional information regarding each measure, including: (1) whether the measure is endorsed by a consensus-based entity (CBE); (2) its measure stewards; and (3) data collection methods. We also described how states could use the HCBS QMS to promote equity, and provided information on whether each measure addresses key priority areas. See <https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf> for more information.

⁶ PTC 43 reads, "HCBS Quality Measures. The recipient must report on the HCBS Quality Measure Set, as described in State Medicaid Director Letter # 22-003, to provide quality assurance for eligible individuals receiving Medicaid HCBS and to provide for continuous quality improvement in such services, as discussed in PTC 33. The HCBS Quality Measure Set is a set of nationally standardized quality measures for Medicaid-funded HCBS that is intended to promote more common and consistent use within and across states of such nationally standardized quality measures in HCBS programs, create opportunities for CMS and states to have comparative quality data on HCBS programs, and drive improvement in quality of care and outcomes for people receiving HCBS. See <https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf> for more information."

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.

Reporting Timeframe

MFP grant recipients must report on the measures in the HCBS QMS beginning in the fall of 2026 for the 2025 performance period, and bi-annually thereafter. MFP grant recipients should adhere to the specifications and guidance detailed in the HCBS QMS summary document⁷ as well as any technical assistance (TA) resources issued by CMS for improving the completeness, accuracy, and consistency of data reported for the HCBS QMS. For the initial reporting period, the reporting will be due to CMS no earlier than September 1, 2026. CMS is currently developing reporting forms to allow for HCBS QMS reporting. Additional information regarding the reporting forms and the process for submitting the forms will be shared with MFP grant recipients as it becomes available.

Required Measures

For the initial reporting period, MFP grant recipients are expected to report on the subset of measures in the 2024 HCBS QMS identified in this informational bulletin as mandatory measures. Table 1 lists the mandatory measures for the initial reporting period. The mandatory measures were selected based on applicability across HCBS programs. CMS also considered the burden of data collection and reporting for states in selecting the measures. CMS will issue additional guidance in the future to identify the mandatory measures for subsequent reporting periods.

MFP grant recipients are expected to establish performance targets, subject to CMS review and approval, for each of the mandatory measures in the HCBS QMS. Performance targets should be submitted as part of the required MFP integrated quality management strategy and plan (PTC 31). The strategies that will be pursued to achieve the performance targets for the mandatory measures must also be described in the quality management strategy.

- ***Experience of Care Measures***

As discussed in State Medicaid Director Letter # 22-003 and the CMCS Informational Bulletin on the 2024 HCBS QMS, the HCBS QMS is designed to be used with one or more experience of care surveys to assess the experience of care of each of the major population groups included in the state's HCBS program (e.g., older adults, adults with intellectual and developmental disabilities, adults with physical disabilities, adults with serious mental illness). The HCBS QMS includes measures derived from four surveys that assess the experience of care of one or more population groups included in HCBS programs. The surveys include the HCBS Consumer Assessment of Healthcare Providers and Systems (HCBS CAHPS[®]), National Core Indicators[®]-Intellectual and Developmental Disabilities (NCI-IDD), National Core Indicators-Aging and Disability[™] (NCI-AD), and Personal Outcome Measures[®] (POM).

⁷ HCBS Quality Measure Set Measure Summaries: <https://www.medicaid.gov/media/151011>

MFP grant recipients are not expected to conduct all of the experience of care surveys included in the HCBS QMS, but they are expected to survey all of the major population groups included in their state’s HCBS programs, if a survey included in the HCBS QMS is available for that population. Some experience of care surveys have not been tested with all populations enrolled in HCBS programs. Depending on the populations served by the state’s HCBS programs and the particular survey instrument(s) that a state selects to use, MFP grant recipients may need to use multiple experience of care surveys to ensure that all major population groups are included. MFP grant recipients are only expected to use as many surveys as are necessary to assess the experience of care for the major population groups included in the state’s HCBS programs.

States that conduct the HCBS CAHPS Survey will be expected to report the results to the HCBS CAHPS survey database managed by the Agency for Healthcare Research and Quality; CMS plans to obtain the survey results through the HCBS CAHPS database. For states that conduct NCI-AD, CMS plans to work with ADvancing States and Human Services Research Institute (HSRI) to set up a process to obtain the survey results and avoid separate reporting to CMS. For states that conduct NCI-IDD, CMS plans to work with the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and HSRI to set up a process to obtain the survey results and avoid separate reporting to CMS. States that conduct POM will be expected to submit the survey results to CMS.

- ***Other Measures***

In addition to reporting on the measures included in the experience of care survey(s) selected by the state, MFP grant recipients are required to report on two assessment/case management record measures (LTSS-1 and LTSS-2) and three rebalancing measures that use administrative (i.e., claims and encounter) data (LTSS-6, LTSS-7, and LTSS-8). At the state’s option, CMS can report on the administrative data measures (LTSS-6, LTSS-7, and LTSS-8) using data from the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files.

Table 1: 2026 HCBS QMS Mandatory Measures for MFP Grant Recipients

CBE #	Measure Steward	Measure Name	Data Source/Data Collection Method	Delivery System
NA	ADvancing States, HSRI; NASDDDS, HSRI; CQL; CMS	Experience of care survey(s) for each of the major population groups included in the state’s HCBS programs (specific measures to be determined ⁸)	Survey	FFS/MLTSS
NA	CMS	MLTSS-1 and FFS LTSS-1: Comprehensive Assessment and Update	Case Management Record	FFS/MLTSS

⁸ The HCBS QMS includes an extensive number of experience of care measures. CMS expects to focus on a subset of the experience of care measures in the QMS for the initial reporting period. CMS will engage with states and other interested parties to identify a smaller subset of measures from these surveys for mandatory MFP reporting for the initial reporting period.

CBE #	Measure Steward	Measure Name	Data Source/Data Collection Method	Delivery System
NA	CMS	MLTSS-2 and FFS LTSS-2: Comprehensive Person-Centered Plan and Update	Case Management Record	FFS/MLTSS
NA	CMS	MLTSS-6 and FFS LTSS-6: Admission to a Facility from the Community	Administrative Data	FFS/MLTSS
3457	CMS	MLTSS-7 and FFS LTSS-7: Minimizing Facility Length of Stay	Administrative Data	FFS/MLTSS
NA	CMS	MLTSS-8 and FFS LTSS-8: Successful Transition after Long-Term Facility Stay	Administrative Data	FFS/MLTSS

Abbreviations: CBE = consensus-based entity; CQL = The Council on Quality and Leadership; FFS = fee-for-service; MLTSS = managed long-term services and supports; NA = not applicable (not endorsed by a CBE)

Stratification

HCBS QMS data stratified by factors such as race and ethnicity, sex, and geography will enable CMS and states to identify the health outcomes of underserved populations as well as potential differences in health outcomes between populations. Stratified data can also inform the design and adoption of quality improvement initiatives that address the drivers of health disparities experienced by underserved populations.

MFP grant recipients may elect to report stratified data on any HCBS QMS measure, but they are not required to stratify data for the initial MFP reporting period. However, CMS does plan to implement requirements for stratification in the future using a phased-in approach in which a subset of measures is identified for stratification initially and the number of measures required for stratification is increased over time.

CMS has identified three stratification categories that are commonly used by states and for which there are existing data standards established by the Office of Management and Budget (OMB) or commonly used by other CMS and Department of Health and Human Services (HHS) programs:

- Race and ethnicity, using the disaggregation of the 1997 OMB minimum race and ethnicity categories⁹ as specified in the 2011 HHS standards;¹⁰
- Sex, defined as biologic sex using the 2011 HHS standards; and
- Geography, using a minimum standard of core-based statistical area (CBSA)¹¹ with recommendations to move towards Rural-Urban Commuting Area Codes (RUCA).¹² For data consistency, states using CBSAs should code “metropolitan statistical areas” as

⁹ <https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf>

¹⁰ <https://aspe.hhs.gov/reports/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-disability-0>

¹¹ <https://www.census.gov/geographies/reference-maps/2020/geo/cbsa.html>

¹² <https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/>

“urban” and code “micropolitan statistical areas” and “non-CBSA areas” as “rural.” States using RUCA Codes should code “metropolitan areas” as “urban” and code “micropolitan areas,” “small towns,” and “rural areas” as “rural.”

MFP grant recipients that elect to report stratified data are encouraged to use these stratification categories.

Sampling

Depending upon the size and scope of the state’s HCBS programs, it may be sufficient and more cost-effective to draw representative samples, using statistically valid random sampling of beneficiaries, rather than collect data on the entire population, in order to gather information and make inferences about an aspect of overall program quality. Oversampling¹³ may be necessary to stratify data on key demographic and other beneficiary characteristics which can increase the cost of implementation. In its oversight role, CMS does not prescribe sampling methods for states to use. However, we expect states to follow the sampling requirements included in the technical specifications developed by measure stewards for each of the measures, as well as to use sound and reasonable processes to gather information from which conclusions about quality can be drawn and acted upon. MFP grant recipients are strongly advised to consult with a statistician or research methodologist when designing sampling plans.

MFP Funding to Support Implementation and Use of the HCBS QMS

MFP grant recipients may use MFP administrative grant funding to fully cover the cost of implementing and using the HCBS QMS to assess quality and outcomes for Medicaid beneficiaries receiving HCBS, as well as to develop and implement the integrated quality management strategy and plan required under PTC 31.¹⁴ These costs may include, but are not limited to, costs associated with staff and contractors, survey vendors, and systems changes. MFP grant recipients should include these costs in their annual budget requests for supplemental funding.

Technical Assistance

Technical assistance is available to support states with implementation of the HCBS QMS. To request technical assistance, please send an email to mfpdemo@cms.hhs.gov.

¹³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5508166/>

¹⁴ CMS also reminds states that, under Medicaid, enhanced federal financial participation (FFP) is available at a 90 percent Federal Medical Assistance Percentage (FMAP) for the design, development, or installation of improvements of mechanized claims processing and information retrieval systems, in accordance with applicable federal requirements. Enhanced FFP at a 75 percent FMAP is also available for operations of such systems, in accordance with applicable federal requirements. Receipt of these enhanced funds is conditioned upon meeting a series of standards and conditions to ensure investments are efficient and effective. For more information, see <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16004.pdf>. In addition, states can receive 75 percent enhanced match for External Quality Review (EQR) activities. For more information on EQR, see <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care-quality/quality-of-care-external-quality-review/index.html>.