The HCBS Quality Measure Set: An Introduction

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Background

In 2022, approximately 8 million Americans required long-term services and supports (LTSS), with millions more projected to need such services before they reach the age of 65.[1] LTSS recipients include older adults, people with disabilities, and people with chronic illness. Medicaid is the primary payer for LTSS and allows for coverage of LTSS under several authorities and in a variety of settings. These settings range from institutional settings, such as nursing facilities, to home and community-based settings (HCBS), including care provided in an individual's own home or the broader community.

Per-enrollee expenditures tend to be higher for individuals receiving care in institutional settings compared to those utilizing HCBS.[2] Coupled with the strong and consistent preference among LTSS beneficiaries to remain in their homes or communities, the fact that HCBS typically cost less than institutional care, has prompted a shift in federal and state policy priorities, leading to increased investments in the expansion and strengthening of HCBS.

The COVID-19 pandemic highlighted many systemic vulnerabilities in the U.S. healthcare system, and LTSS programs were no exception. State LTSS systems faced acute challenges, particularly in maintaining an adequate workforce to deliver essential services. These workforce shortages significantly limited the ability of many individuals to access the services and supports they need, further emphasizing the fragility of the care infrastructure and the need for improvement.

In response to this public health emergency, the American Rescue Plan Act (ARPA) of 2021 allocated targeted funds to help states enhance, expand, and strengthen their HCBS programs. States were granted flexibility to use these funds in a variety of ways, including expanding eligibility, increasing the variety of service offerings, improving care infrastructure, promoting community inclusion, strengthening the direct care workforce, providing flexibility in who could be paid to provide care, and addressing the specific needs of certain populations.[3]

As reliance on HCBS continues to grow, so does the importance of ensuring that these services are not only accessible but also high quality. The increasing demand for HCBS has heightened the need for robust quality measurement, accountability, and systems that support positive outcomes for the individuals these services are designed to serve.

The HCBS Quality Measure Set

QMS DEVELOPMENT

The Centers for Medicare & Medicaid Services (CMS) has taken significant steps toward advancing quality and accountability in Medicaid-funded HCBS. As part of this effort, CMS issued a Request for Information titled *Recommended Measure Set for Medicaid-Funded Home and Community-Based Services*. The request invited feedback from stakeholders on the potential benefits and challenges of implementing a standardized national quality measure set for use by states, managed care organizations (MCOs), and other entities involved in the delivery of HCBS. It included detailed questions and background information related to the proposed measure set's purpose, content, organization, and selection criteria, along with a draft list of proposed measures for public review. Stakeholders were encouraged to submit comments through November 18, 2020.[4]

The public health emergency that began in 2020 consumed much of CMS' attention. However, in July, 2022, CMS issued a State Medicaid Director Letter (SMD-22-003) formally releasing the first *Home and Community-Based Services Quality Measure Set* (HCBS QMS).[5] This standardized set of quality measures was developed to promote consistent data collection, facilitate national comparisons, and drive quality improvement across Medicaid HCBS programs.[6] Although participation is voluntary, CMS strongly encouraged states to adopt the QMS across all relevant Medicaid authorities that provide HCBS services.

The HCBS QMS includes measures that focus on key domains such as access to services, LTSS rebalancing, community integration, health outcomes, safety, and the delivery of person-centered care. Each measure was selected using a process aligned with the CMS Measures Management Blueprint and the National Quality Forum's evaluation criteria. These criteria included the importance of the measure, scientific validity and reliability, feasibility of implementation, usability, and potential for duplication with existing measures.

The HCBS QMS includes both qualitative and quantitative quality measures which, together, aim to provide a comprehensive

understanding of how services are delivered and how they are experienced by individuals receiving care.

The largest portion of the measure set focuses on experience of care. States are required to ensure that all major HCBS participant populations are represented in survey data collection. These populations include older adults, children[1], individuals with intellectual and developmental disabilities (I/DD), individuals with physical disabilities, and individuals with serious mental illness. By surveying these groups, states can more accurately assess the quality of services across key populations and better tailor program improvements to meet varying needs. The quantitative measures included six developed by CMS for managed long-term services and supports (MLTSS) programs.[7]

On April 11, 2024, CMS released an informational bulletin announcing updates to the HCBS QMS.[8] These updates include the addition of fee-for-service (FFS) versions of the six MLTSS measures, as well as the removal of the flu vaccinations measure. CMS indicated that additional updates are forthcoming to ensure the QMS evolves with emerging best practices and continued progress in HCBS quality measure development.

QMS STRUCTURE

The qualitative section of the QMS is focused on environment of care data (systems and processes in place to maintain a safe, functional, and supportive physical environment for patients, staff, and visitors). It identifies four nationally recognized survey instruments, each designed to capture person-reported outcomes and perspectives across populations and service settings:

- National Core Indicators – Intellectual and Developmental Disabilities (NCI®-IDD)
- National Core Indicators – Aging and Disability (NCI-AD™)
- HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Personal Outcome Measures (POM®)

These tools focus on critical domains such as individual satisfaction, autonomy, community inclusion, and overall quality of life, providing valuable insight into how individuals perceive the supports they receive.

The quantitative section of the QMS includes 15 standardized measures, divided into two sets: eight measures specific to MLTSS delivery systems and seven focused on FFS delivery systems. These measures are grouped into three key categories:

- Assessment and care planning
- Falls risk assessment
- Rebalancing and utilization

This structure enables states to evaluate service delivery across core operational and outcome-focused domains.

States with hybrid LTSS systems (i.e., those utilizing both MLTSS and FFS delivery models) are required to implement both sets of measures to ensure full representation and comparability across service systems. This dual application is critical for capturing a complete picture of system performance and identifying areas for targeted quality improvement. [9]

Money Follows the Person (MFP) and the HCBS QMS

MFP was authorized by Congress in 2005 as part of the Deficit Reduction Act.[10] Since its inception, MFP has played a pivotal role in transforming LTSS. MFP has been reauthorized multiple times, most recently under the Consolidated Appropriations Act of 2023, through 2027.[11]

MFP is a demonstration program that supports states while they rebalance their LTSS systems from institutional to home and community-based care.[12] Through this program, states are empowered to support individuals—primarily older adults and people with disabilities—as they transition from institutional settings to the community. The program's goals are aligned with the preferences of

[1] At the time of this brief, surveys were in development for the children's population but had not yet been included in the measure set.

the populations it serves, as research consistently shows that most individuals prefer to live in their own homes or within community settings whenever possible.[13]

In 2024, CMS directed MFP grant recipients to use the HCBS QMS to report on all Medicaid HCBS under section 1915(c), (i), (j), and (k) authorities, and section 1115 HCBS demonstrations. These reporting requirements begin in the fall of 2026 and will occur biannually after the first reporting period. In 2025, 41 out of 56 states and territories are MFP grantees and are subject to these quality reporting requirements.[14] Many grantees are engaged with CMS, providing input to help shape the final implementation of the QMS.

MFP grant funds may be used to support states in implementing the HCBS QMS. This funding flexibility extends to developing a quality management strategy and plan, conducting experience of care surveys, and collecting and analyzing data for measures constructed from claims and/or encounter data and assessment and case management records.

Despite this funding flexibility, many states anticipate significant challenges in complying with the new reporting standards. These challenges include increased administrative workload—often exacerbated by persistent workforce shortages—inadequate time for comprehensive data collection, and limitations in technological infrastructure necessary to meet reporting demands. These barriers underscore the need for continued federal support and technical assistance as states adapt to this evolving quality framework.

QMS Reporting Requirements under the Access Rule

The Ensuring Access to Medicaid Services (Access Rule) final rule, published May 10, 2024, marks a significant step toward improving transparency and accountability in Medicaid-funded HCBS. Under this rule, all states must report on their HCBS QMS biennially, beginning in 2028.[15] The version of the QMS used to fulfill these reporting requirements may differ from the QMS currently employed for reporting under the MFP demonstration. This distinction underscores the sustained importance and evolving nature of the QMS.

At the time of this publication, the Access Rule remains in effect, and states are advised to continue preparing for its full implementation. This includes taking steps to build the infrastructure necessary for robust quality data collection, stakeholder engagement, and cross-agency coordination. However, there is a degree of uncertainty regarding the future of the final rule under the current federal administration, which may influence the rule's longevity and scope.

The 2028 Quality Measure Set

The HCBS QMS used to fulfill the requirements of the Access Rule may differ from the QMS currently in use for reporting under the MFP program. While both reporting frameworks aim to enhance quality and accountability in Medicaid-funded HCBS, they have distinct policy purposes and timelines. As a result, the measures included, data collection methods, and reporting expectations may vary between the two programs. States participating in both initiatives will need to align their quality measurement strategies carefully to meet the specific requirements of each, while minimizing duplication and administrative burden.

As the HCBS QMS continues to evolve, aligning its design and implementation with multiple federal initiatives presents both opportunities and challenges. In response, CMS and its partners are working to ensure that the QMS remains adaptable, efficient, and aligned with strategic priorities. This work includes engaging expert stakeholders and workgroups to refine the measure set and prepare for QMS implementation in 2028.

CMS has convened an HCBS Measure Set Workgroup, managed by Mathematica, which will advise CMS on changes to the QMS for 2028 reporting.[16]

The workgroup will meet regularly to identify gaps in the HCBS QMS and recommend improvements to CMS. Their recommendations may involve adding new or removing measures that no longer meet the needs of the program. The group's insights will help ensure that the QMS evolves to remain relevant, actionable, and aligned with the priorities of states and the populations they serve.

As part of its deliberative process, the workgroup will evaluate measures for inclusion in the 2028 QMS based on three key criteria:

- Minimum technical feasibility requirements;
- Actionability and strategic alignment with program goals; and
- Other relevant considerations, such as overlap with existing measures or burden of data collection

All measures must meet the minimum technical feasibility requirements to be considered for inclusion in the final 2028 QMS. This requirement ensures that selected measures are meaningful and practical for states to implement within their infrastructure and data systems.

Conclusion

The development and implementation of the HCBS QMS marks a significant step forward in the pursuit of high-quality, person-centered care for individuals receiving Medicaid LTSS. As states rebalance their LTSS systems toward home and community-based settings, the need for standardized, actionable quality measurement is increasingly important.

The HCBS QMS offers a structured framework for assessing the delivery and experience of care across several populations, helping states identify gaps, measure progress, and inform improvement efforts. Its role in multiple federal initiatives, including the MFP demonstration and the Access Rule reporting requirements, demonstrates a broader shift toward accountability, transparency, and outcomes-based policy in Medicaid.

The evolving nature of the QMS, and its adaptation to different programmatic needs, presents challenges that require sustained investment, technical support, and stakeholder engagement. CMS's collaboration with technical experts demonstrates an intentional and cooperative approach to developing a measurement system that is comprehensive and responsive to evolving quality needs.

As the 2028 implementation deadline for Access Rule reporting approaches, states must remain proactive in preparing their systems and aligning their quality strategies. The continued refinement of the QMS will be essential to supporting states in this work and, ultimately, to ensuring that individuals receiving HCBS can access the high-quality, community-based care they deserve.

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