Understanding What Works:
Measuring and Monitoring Quality in Medi-Cal's Home and Community-Based Services

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About the Authors

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Introduction

By the year 2030, over one million Californians will need assistance with the activities of daily living and will need to rely on systems that provide "long-term services and supports" for help with tasks such as taking medications, preparing meals, and getting dressed.[1] Most older adults and people with disabilities prefer to receive this type of care in their own homes and communities.[2] Home and community-based services (HCBS) allow people with functional limitations to have those preferences honored — to live safely and independently, rather than moving to institutional settings such as nursing facilities.

California's Medi-Cal program — the largest Medicaid program in the country in terms of expenditures and enrollees — spends an estimated $22 billion per year to provide essential HCBS to older adults and people with physical or cognitive disabilities, serious mental illness, and disabling chronic conditions.[3] As California experiences rapid population aging,[4] the need for these services will increase. However, few data are currently collected to monitor the quality and outcomes of HCBS, which is essential to ensuring timely and reliable access to high-quality services.

HCBS, combined with institutional long-term care, are collectively referred to as long-term services and supports (LTSS). California's Department of Health Care Services (DHCS) oversees Medi-Cal LTSS, although LTSS benefits are administered by multiple departments across the California Health and Human Services Agency. Some HCBS (e.g., In-Home Supportive Services, home health services) are available to all qualifying Medi-Cal enrollees through California's Medicaid State Plan, while other services are available to specific types of Medi-Cal enrollees through waivers to the State Plan. These waivers allow states to offer services not otherwise available through Medicaid.[5]

CalAIM (California Advancing and Innovating Medi-Cal) is a multiyear initiative introduced by DHCS to improve the quality of life and health outcomes across the Medi-Cal program. With implementation of CalAIM's delivery system, program, and payment reforms, evidence-based approaches for systematic measurement of HCBS quality will become increasingly important to health plans responsible for managing these services, and to state stakeholders monitoring the impact of this transition. Under the proposed reforms, Medi-Cal will shift the balance from fee-for-service delivery of LTSS to Managed LTSS (MLTSS) models in which managed care plans deliver some LTSS to Medi-Cal enrollees statewide by 2027. Other core components of CalAIM, **Enhanced Care Management and Community Supports (In Lieu of Services)**,[6] provide HCBS-like services aimed at supporting Medi-Cal enrollees with complex needs; implementation began in January 2022. Across these reforms, the increasing role of Medi-Cal managed care plans (MCPs) in overseeing existing and new forms of Medi-Cal HCBS and the shared interest among state stakeholders and MCPs in ensuring high-quality care underscore the importance of a robust approach to quality monitoring for these services.

Terms Defined

Home and community-based services (HCBS). A variety of health and human services delivered in the home or community to allow those with functional limitations to live safely and independently in their homes or communities. Examples of Medi-Cal HCBS programs include the California Community Transitions Program, Community-Based Adult Services, and In-Home Supportive Services.

Long-term services and supports (LTSS). An umbrella term that encompasses both institutional/nursing facility care and HCBS. Managed LTSS, or MLTSS, in California refers to LTSS delivered by Medi-Cal managed care plans.

Challenges currently facing California's HCBS system include waiting lists for some programs, gaps and inequities in access to HCBS, regional variation in availability of home and community-based options to meet consumer needs, direct care workforce shortages, and budget constraints that limit capacity for investment in quality improvement efforts. Understanding these challenges, California is investing in its HCBS future through several efforts including California's **Master Plan for Aging**.[7] This 10-year blueprint outlines strategies to attain a series of ambitious goals to improve aging across the lifespan for Californians, including substantial investments in HCBS infrastructure and LTSS delivery system innovation.[8] These goals were reflected in California's $4.6 billion HCBS Spending Plan stemming from the federal American Rescue Plan Act of 2021.[9] The plan provides essential funding for long-term investment in HCBS infrastructure. In addition, California has received federal approval for funding to develop an **HCBS Gap Analysis and Roadmap**,[10] providing a critical pathway to evaluate current capabilities and gaps in California's approach to quality monitoring in HCBS and to identify opportunities for improvement. These proposed examinations of and changes to California's HCBS system bring opportunities to improve measurement of HCBS quality for Medi-Cal's seniors and people with disabilities, including those enrolled in Medi-Cal only and those enrolled in both Medi-Cal and Medicare (dually eligible enrollees).

This report describes challenges and opportunities related to measuring, reporting, and monitoring the quality of HCBS sponsored by Medi-Cal, including data issues, preconditions to ensure readiness and successful implementation of quality monitoring, considerations of equity, and examples of HCBS quality measurement efforts in other states that may inform efforts in California. Though many different public and private agencies and organizations provide a variety of HCBS in California, the focus of this report is HCBS paid for by Medi-Cal.

Challenges to Assessment of HCBS Quality

HCBS Quality Measurement Is Different from Health Care Quality Measurement

Assessment of HCBS quality is necessary to inform consumers, compare effectiveness of different HCBS delivery models, and inform value-based payment and performance improvement. However, measurement of HCBS quality poses some unique challenges, making it difficult to apply the approaches used in health care settings to HCBS.[11] Some of the challenges around measuring HCBS quality include the following:

- There is little consensus on how to define HCBS quality or on how quality measures should be used to improve services or consumer outcomes.
- The self-directed and nonmedical nature of many HCBS are meant to meet individual needs and preferences, which can make standardized and objective assessments of quality difficult.
- The decentralized nature of HCBS creates barriers to standardized data collection and reporting, as Medi-Cal HCBS are provided by multiple agencies within the state: DHCS, the California Department of Social Services, the California Department of Developmental Services, and the California Department of Aging.
- The limited use of electronic health records for assessment and care documentation, and lack of consistently collected data on HCBS consumers and the types of services they receive, limit the capacity to consistently measure HCBS quality and equity.

HCBS Quality Standards Could Differ by Setting, Service Type, and Population Served

Many distinct types of HCBS serve different populations with different needs (see boxes). California's Medi-Cal program provides HCBS through Medicaid State Plan options and through various federal waiver programs serving different populations with distinct eligibility criteria and benefits. Recent HCBS quality measure development efforts by the Centers for Medicare & Medicaid Services (CMS) have focused on a unified measurement approach with harmonization across settings and populations. However, aspects of HCBS quality may be unique to settings, services, or consumer characteristics, thereby making the selection of measures challenging.

Although variation in quality standards by type of service is perhaps the most salient, consumers' characteristics and settings are also important drivers of variation. For example, measures to assess the quality of care for people with intellectual and developmental disabilities may not apply in the same way for consumers with physical or age-related disabilities. The constellation of service needs for people with intellectual and developmental disabilities may influence how care is coordinated, how consumers manage self-direction of their care, the extent to which they involve their family caregivers (and whether HCBS supports are provided to their caregivers), and the number of state agencies that oversee the set of HCBS provided. Similarly, dually eligible enrollees may use more HCBS than Medi-Cal-only enrollees, given their higher likelihood of having comorbid conditions that require assistance, more frequent transitions across settings of care, and higher intensity of care.

Given these types of variation, improving the quality of HCBS requires measures applicable to the service type while balancing the burden of data collection by providers and oversight of services provided by multiple state agencies serving populations requiring multiple types of HCBS.

Examples of HCBS

- Personal care (e.g., assistance with dressing, bathing, toileting, eating, transferring to or from a bed or chair)
- Home health care (e.g., skilled nursing care; occupational, speech, or physical therapy)
- Center-based adult day care / adult day health programs
- Congregate meal sites
- Home-delivered meal programs
- Case management
- Caregiver training
- Respite care
- Transportation
- Durable medical equipment
- Home repairs and modifications
- Home safety assessments
- Homemaker and chore services
- Information and referral services
- Financial services
- Legal services (e.g., help preparing a will)
- Telephone reassurance (e.g., "friendly visitor" phone calls to homebound or isolated people)

Note: This list is not comprehensive.

Source: "**Home- and Community-Based Services**," Centers for Medicare & Medicaid Services, last modified December 1, 2021.

HCBS Consumer Vignettes

Lee is an 82-year-old woman who lived alone until suffering a stroke. She received rehabilitative services in a skilled nursing facility and has returned home with the assistance of her daughter. Lee still needs some assistance with activities of daily living, and her daughter is concerned about Lee's ability to live safely at home. Lee is referred to the local Program of All-Inclusive Care for the Elderly (PACE). Through the PACE program, Lee receives daily assistance from a personal care aide. A van arrives several days a week to transport her to the PACE Center, where she participates in physical and occupational therapy to regain her mobility and independence.

Miguel is a 38-year-old man with developmental disabilities. He lives with his parents, his primary caregivers. They are paid through In-Home Supportive Services for tasks such as housework, errands, and accompanying Miguel to medical and therapy appointments. Miguel attends an adult day center several days a week and also receives speech, hearing, and language services.

Equity in HCBS

Recognizing the role that social determinants play in health and the quality of care that people receive, advancing inclusion and equity is a central goal of California's Master Plan for Aging and a central focus of Medi-Cal. Historically, federal law requires state Medicaid programs to cover institutional LTSS but does not require states to cover the full range of HCBS necessary to meet the needs of community-dwelling older adults and people with disabilities.[12] As a result, access to HCBS varies widely within states, often leading to gaps and inequities in enrollment and use of services. In California, many HCBS are provided through waiver programs with limited capacity, and availability of HCBS providers varies by county. Many Medi-Cal enrollees have limited English proficiency and face language or cultural barriers in accessing HCBS. Disparities have persisted over time in Medi-Cal HCBS use and expenditures by age, gender, race/ethnicity, and geography,[13] although routine ability to assess for such disparities is limited by gaps in demographic data collection and reporting.[14] These disparities are often compounded by underlying barriers such as lack of affordable and accessible housing.[15] The challenges associated with stable and affordable housing, comprehensive community supports, and access to culturally and linguistically competent HCBS threaten the quality of HCBS.

Framework for HCBS Quality Assessment

Measures to assess HCBS quality can be categorized into several measurement domains: structures, processes, and outcomes of HCBS, including functional outcomes as well as consumer experience outcomes (Table 1 on page 7). To address the challenges facing California's HCBS system, robust assessment of HCBS quality would address a combination of measures across each of these domains.

Table 1. Framework for Home and Community-Based Services Quality Assessment

MEASUREMENT DOMAIN	MEASUREMENT EXAMPLES
Structures	▸ Home care agency staffing ratios ▸ Personal care competencies and training ▸ Percentage using family caregiver supports, by demographic characteristics
Processes	▸ Timely completion of comprehensive assessment and care planning ▸ Timely initiation of participant-directed services following authorization ▸ Number of people on 1915(c) HCBS waiver waiting lists
Outcomes	**Functional** ▸ Percentage with unmet mental health needs ▸ Percentage with stable functional status ▸ Number of transitions across settings **Consumer Experience** ▸ Satisfaction with coordination by case manager ▸ Percentage offered self-directed care services ▸ Choice in social and community activities

Data Collection, Quality Assessment, and Reporting

Current Medi-Cal HCBS Data Collection Approaches

An important precondition for assessment of HCBS quality in California is a standardized approach to data collection and reporting. However, California currently lacks universal data collection and reporting standards for Medi-Cal HCBS programs, and minimal data are publicly reported.[16] Data for different HCBS programs are posted on department or federal websites at varying frequency. Publicly reported data for community programs and services are often limited to the number and location of facilities. The California Department of Aging (CDA) reports monthly enrollment data for Community-Based Adult Services (CBAS) centers, and CBAS centers report participant characteristics twice annually including disability status/needs and type of services provided.[17] All HCBS waiver programs publicly report the number of people receiving waiver services and the number on waiting lists, but very little demographic data are reported for these individuals. The exception is the Department of Developmental Services, which publicly reports consumer demographic data including age, race/ethnicity, language, and disability on the Regional Center Oversight Dashboard.[18] The dashboard also includes 1915(c) HCBS waiver performance measures and annual consumer satisfaction data from the National Core Indicator survey.[19]

In-Home Supportive Services (IHSS), the largest Medi-Cal HCBS program in California, has the most extensive data collection and reporting. IHSS sponsors in-home services for people with functional needs who meet program eligibility criteria, providing nonmedical services such as personal

care assistance, house cleaning, and grocery shopping, as well as some paramedical services such as G-tube feedings and catheter changes. IHSS may also provide protective supervision for those with mental impairment or mental illness who need to be observed 24 hours a day to protect them from injuries or hazards. DHCS delegates administration of the IHSS program to the California Department of Social Services (CDSS), and county IHSS agencies handle day-to-day administration of the program. CDSS monitors quality of IHSS delivered by county agencies, including adherence to policies and procedures (e.g., processing applications within the allotted time, conducting home visits appropriately, adhering to procedures for critical incidents). CDSS also administers an annual consumer satisfaction survey to assess experiences with care, including the extent to which the IHSS program meets consumer needs.

For a detailed examination of issues related to HCBS data, see ***Using Data for Good: Toward More Equitable Home and Community-Based Services in Medi-Cal***.[20]

Considerations for Measure Selection

Table 2 outlines key selection criteria for HCBS quality measures suitable for implementation in California, including questions to assess the appropriateness of measures within these selection criteria (see page 9). Relevant stakeholders to inform measure selection include consumers and advocacy groups, experts in quality measurement, HCBS providers and managed care plans, and leaders who can represent the state's policy goals and priorities related to managed care and value-based payment.

Selection of Structural Measures

Structural measures to assess HCBS quality may include measures of workforce capacity (e.g., availability of providers, provider training and competencies, worker retention), staffing (e.g., agency staffing ratios, care coordinator caseloads), availability of support for family caregivers (e.g., training, respite services, referral resources), and availability of language services. Such measures are consistent with the goals identified in California's Master Plan for Aging, which include diversifying the pipeline of direct care workers in HCBS, expanding online training platforms for direct care workers, expanding respite care for family caregivers, and improving cultural competency and language access. Quality measures related to workforce capacity may be particularly useful to incentivize greater access to providers.

Structural measures of LTSS "rebalancing" assess the extent to which LTSS are delivered in home and community-based settings versus institutional settings. Examples of LTSS rebalancing measures include the share of Medicaid enrollees receiving care in home or community settings versus institutions, and the number of people who transition from a nursing home or other institution to the community each year. CMS has also released technical specifications for several standardized measures of rebalancing for MLTSS plans that allow for comparisons within and across states: admission to an institution from the community, minimizing institutional length of stay, and successful transition after long-term institutional stay.[21]

Selection of Process Measures

Process measures used in HCBS often focus on timely completion of processes of care or delivery of services. Examples include timeliness of assessment/reassessment, timeliness of service plan development, timely receipt of services following authorization, and percentage of complaints/grievances received and resolved.[22] For HCBS

Table 2. Considerations for Selection of Home and Community-Based Services Quality Measures for Implementation in California

Aligned with State Policy Goals
► Are the measures relevant to addressing gaps in access to HCBS or quality of care?
► Are the measures aligned with state policy goals identified in California's Master Plan for Aging (e.g., can assess expanded access to HCBS for Medi-Cal enrollees, diversification of HCBS direct care workforce, improved cultural competency, and language access)?
► Are the measures aligned with CalAIM reforms (e.g., measures are applicable to Enhanced Care Management and Community Supports)?
Matter to Consumers
► Are the quality measures consumer-centered? Do they measure aspects of care that matter to HCBS consumers and their families?
► Have HCBS consumers and advocacy groups been engaged in decisions about measure development, selection, and implementation?
► How well has the diversity of consumer perspectives been represented and addressed?
► Are data on quality measures available to consumers to facilitate accountability?
► Do the measures allow providers sufficient flexibility to meet diverse consumer needs and preferences?
Are Highly Reliable, Valid, and Feasible
► Are the measures reliable (i.e., replicable and consistent)?
► Do the measures reliably assess care quality across service types and consumer subgroups in California?
► Are the measures valid (e.g., measures assess the intended constructs; measures distinguish good from poor quality of care)?
► What is the administrative burden of data collection, analysis, and reporting for Medi-Cal managed care plans and/or providers (e.g., what measures are derived from clinical data or administrative claims versus consumer surveys)? Do providers have flexible ways of meeting client preferences and needs while also ensuring equity and quality control?
► For outcome measures, is risk adjustment feasible? Can the information needed for risk adjustment be collected and applied to the measure?
Useful for Value-Based Payment and Performance Improvement
► Do the measures provide actionable information for quality improvement efforts?
► Can Medi-Cal managed care plans or providers be held accountable for their performance on the measures?
► For outcome measures, what risk adjustment is necessary at the plan or provider level to account for enrollee characteristics and level of need to facilitate comparisons of performance?

waiver and demonstration programs, the number of people on waiting lists may also be an important measure of access to care. New MLTSS measures for assessment and care planning developed by CMS are intended to improve upon previous process measures by monitoring the degree to which HCBS assessments and care plans are comprehensive and cover a core set of person-centered elements.[23] Ideally, process measures can be used to encourage processes of care delivery that lead to improved outcomes for Medi-Cal HCBS consumers. For example, CMS' MLTSS measure for falls risk assessment and prevention focuses on processes shown to reduce fall risk, including completion of a falls risk screening/assessment and a plan of care.

Selection of Outcome Measures

Outcome measures used in HCBS encompass a wide range of outcomes including two key domains: functional and consumer experience outcomes. Functional outcomes may include physical health, emergency department visits, hospital (re)admissions, falls, and transitions across settings. Measures of acute care utilization and other health and safety-related outcomes may be useful to assess whether care coordination and access to services are adequate to meet consumer needs. Given the heterogeneity of HCBS consumers, outcome measures typically require risk adjustment at the plan or provider level to account for consumer characteristics and level of need in order to make fair comparisons of performance.

States use various surveys and assessments to collect information on consumer experiences with HCBS including the HCBS CAHPS Survey, the National Core Indicators-Aging and Disabilities (NCI-AD), and state-developed tools.[24] Measurement domains include consumer satisfaction with care, adequacy of or access to services, choice and control (i.e., the extent to which HCBS consumers can make life choices, choose their services and supports, and control how those services and supports are delivered), community participation (i.e., the extent to which HCBS consumers are integrated into the community and socially connected in accordance with their preferences), and quality of life.[25] Existing surveys also provide options for assessment of consumer satisfaction with HCBS care providers, including questions focused on respect, communication, and autonomy.

Consumer experience measures are typically assessed using surveys administered by phone or in person. Quality measures that rely on surveys to capture person-reported outcomes may not be feasible for some HCBS consumers, such as older adults with cognitive impairment or dementia, so considerations of burden and differential measurement by population or condition are required.

Options for Medi-Cal HCBS Quality Measurement Approaches

Existing quality measures provide options for standardized assessment and public reporting of HCBS quality across different settings and populations (Table 3 on page 11). Options for measuring consumer experiences with HCBS include the **Consumer Assessment of Healthcare Providers and Systems (CAHPS) HCBS Survey**[26] and the National Core Indicators,[27] which are currently collected by CDSS. CMS recently developed eight nationally standardized MLTSS quality measures[28] to evaluate performance of MLTSS plans. The measures address comprehensive assessment and care planning, falls risk assessment and prevention, and LTSS system rebalancing (i.e., rebalancing from institutional settings to HCBS). The LTSS State Scorecard,[29] an annual report ranking state LTSS performance across various dimensions, includes options for measuring LTSS quality at the state level. Some states require managed care plans that coordinate LTSS to obtain the National Committee for Quality Assurance (NCQA) LTSS Distinction for Health Plans,[30] a 12-month process in which plans

implement a quality improvement framework for LTSS. The framework focuses on implementation of best practices for person-centered care planning, effective care transitions, and measuring quality improvement to support people's ability to live in their preferred setting. Recognizing the challenges of measurement across domains, CMS sought public input on a draft set of recommended measures for Medicaid-funded HCBS, to be composed of quality measures for a range of domains identified as measurement priorities for HCBS.[31]

California's Medi-Cal managed care plans and HCBS provider organizations would likely face significant challenges reporting the exemplary measures listed in the table, and other types of quality measures. The challenges include administrative burden and lack of infrastructure for data collection and validation. As noted in Table 2, determination of alignment with state policy goals and challenges to implementation are key to accelerating the state's HCBS quality measurement efforts.

Table 3. Nationally Standardized Quality Measures for Home and Community-Based Services

MEASURE SET / DESCRIPTION	MEASUREMENT DOMAINS	DATA SOURCE	PUBLIC REPORTING
HCBS CAHPS Survey[32] Questionnaire with a maximum of 69 core items to measure consumer experience with Medicaid HCBS providers. Developed by CMS for voluntary use by state Medicaid programs, including fee-for-service HCBS programs and MLTSS programs. Designed to facilitate comparisons across the hundreds of state Medicaid HCBS programs throughout the country serving older adults and people with disabilities. States with adequate sample sizes may consider using survey metrics in value-based purchasing initiatives. Among other metrics, the survey items support scale measures (or composites).	**Consumer Experience Outcomes** ▸ Getting needed services ▸ Communication with providers ▸ Case managers ▸ Choice of services ▸ Medical transportation ▸ Personal safety ▸ Community inclusion and empowerment	Surveys administered by an interviewer in person or by telephone	State Medicaid agencies and managed care plans can submit survey results to a database managed by AHRQ, which aggregates survey data and produces reports that allow comparisons across states and HCBS program types.
National Core Indicators (NCI)[33] and **National Core Indicators-Aging and Disabilities (NCI-AD)**[34] Voluntary effort by state Medicaid, aging, and disability agencies to measure and track their own performance on core indicators — standard measures used to assess consumer experiences with publicly funded services provided in intellectual and developmental disability (I/DD) systems, nursing homes / skilled nursing facilities, and home and community-based programs. There are two distinct but related sets of measures: the NCI for those with I/DD and the NCI-AD for older adults and people with physical disabilities.	**Consumer Experience Outcomes** ▸ Service planning ▸ Rights ▸ Community inclusion ▸ Choice and decisionmaking ▸ Health and care coordination ▸ Safety ▸ Relationships	Annual in-person surveys administered to a random sample of consumers	The NCI/NCI-AD project teams interpret each state's data and produce publicly available reports that can inform quality improvement efforts and allow comparisons of state performance with national norms.

Table 3. Nationally Standardized Quality Measures for Home and Community-Based Services, *continued*

MEASURE SET / DESCRIPTION	MEASUREMENT DOMAINS	DATA SOURCE	PUBLIC REPORTING
MLTSS Quality Measures[35] Nationally standardized MLTSS quality measures that allow comparisons of plan performance within and across states. Developed and tested by Mathematica and NCQA under a CMS contract to fill the gap in LTSS measures specified for health plan reporting. States that choose to use these measures can require reporting via their contracts with MLTSS plans and/or D-SNPs. Four of the measures are included in HEDIS; NCQA began publishing plan ratings on these measures in 2020.	**Structures** ▸ LTSS Admission to an Institution from the Community ▸ LTSS Minimizing Institutional Length of Stay ▸ LTSS Successful Transition After Long-Term Institutional Stay **Processes** ▸ LTSS Comprehensive Assessment and Update* ▸ LTSS Comprehensive Care Plan and Update* ▸ LTSS Shared Care Plan with Primary Care Practitioner* ▸ LTSS Re-Assessment / Care Plan Update After Inpatient Discharge* ▸ Screening, Risk Assessment, and Plan of Care to Prevent Future Falls	Administrative and claims data from MLTSS plans	NCQA publicly reports plan ratings for the HEDIS MLTSS measures.
LTSS Scorecard[36] Annual report released by the AARP Public Policy Institute, The SCAN Foundation, and The Commonwealth Fund to measure state performance for creating a high-quality LTSS system. The scorecard measures LTSS system performance using 26 indicators across five dimensions (see measurement domains). States are ranked from highest to lowest on each indicator.	**Structures** ▸ Support for Family Caregivers ▸ Effective Transitions **Consumer Experience Outcomes** ▸ Affordability and Access ▸ Choice of Setting and Provider ▸ Quality of Life and Quality of Care	Compilation of state data from numerous sources, including several national surveys	AARP releases state scorecard reports annually.
NCQA LTSS Distinction for Health Plans[37] A credential for health plans coordinating LTSS. To earn the LTSS distinction, plans must work with NCQA to implement a quality improvement framework for LTSS, with a focus on delivery of efficient, person-centered care that supports people living optimally in their preferred setting.	**Structures** ▸ Qualifications and Assistance for LTSS Providers **Processes** ▸ Person-Centered Care Planning ▸ Care Transitions ▸ Coordination of Services ▸ Critical Incident Management	Administrative data from health plans; gap analysis to compare accreditation standards with current processes	Organizations that have earned NCQA LTSS distinction can be found in the NCQA Report Card.

* HEDIS measure.

Note: *AHRQ* is Agency for Healthcare Research and Quality; *CAHPS* is Consumer Assessment of Healthcare Providers and Systems; *CMS* is Centers for Medicare & Medicaid Services; *HCBS* is home and community-based services; *HEDIS* is Healthcare Effectiveness Data and Information Set; *LTSS* is long-term services and supports; *MLTSS* is managed long-term services and supports; *NCQA* is National Committee for Quality Assurance.

Assessment of the Quality of In-Home Supportive Services

Though many of the same considerations for HCBS quality assessment apply to IHSS, some of its aspects are unique, resulting in different considerations for assessment of access to services, adequacy of services, and consumer experience. First, IHSS is covered by California's Medicaid State Plan. Unlike HCBS provided though waiver programs, there is no waiting list for IHSS (though some recipients may have service delays if they have difficulty connecting to an IHSS provider), and no one needs to qualify for an institutional level of care to receive IHSS. However, IHSS service hours are capped at 283 per month, regardless of consumer need. In addition, IHSS are self-directed, with most consumers responsible for hiring and firing their own workers.[38] Notably, over 70% of IHSS care providers receive compensation to provide care for a family member.[39] Consumer experiences with IHSS are likely very different for those with family/friend caregivers versus those who hire outside care providers. Therefore, different quality metrics or stratified evaluation of quality metrics for these two groups may be warranted. IHSS consumers without family caregivers may have difficulty finding care providers who can meet their needs, and some may have difficulty self-directing care due to issues such as cognitive impairment/dementia, mental illness, substance use disorders, or housing instability.

The Master Plan for Aging identifies goals to improve delivery of IHSS, which include increasing stability for IHSS consumers through backup provider systems and registries, as well as expanding opportunities for dementia training for IHSS family caregivers. Given the self-directed nature of IHSS, structural measures of its quality may include measures to assess training for care providers, support for family caregivers, and availability of registries or other services to assist IHSS consumers in finding care providers. Process measures relevant to IHSS may include timely delivery of participant-directed services following authorization and the proportion of authorized service hours actually provided. Other important quality metrics for IHSS may include person-reported outcome measures to assess consumer choice and decisionmaking, community participation, and adequacy of service hours and type of services. Systems to link IHSS to other HCBS and social services may be necessary to better understand whether consumers are receiving adequate service hours and the right type of services to meet their needs.

Approaches to Measuring Equity in HCBS

Measuring equity in access to, use of, and outcomes of HCBS is an important step toward improving equitable delivery of HCBS in California. However, this will require more consistent collection of demographic data for Medi-Cal enrollees, including age, disability status, sexual orientation and gender identity, and race, ethnicity, and language (REaL) data. Other relevant data may include income and family structure. Because individual experiences vary across multiple intersecting characteristics, collection and reporting of intersectional data may allow identification of gaps in HCBS access or quality for specific groups of Medi-Cal enrollees. Given challenges to accessing HCBS programs and providers in California, enrollees' county and zip code are also important to track geographic variation in HCBS enrollment and utilization.[40]

DHCS, Medi-Cal managed care plans, and other health plans in California have begun to take steps to measure and improve equity, including better collection of REaL data and stratified reporting of utilization and quality data to identify targets for improvement.[41] DHCS recently began publicly reporting data on access and quality in Medi-Cal managed care by race and ethnicity.[42] Covered California, the state health insurance marketplace, now requires plans to collect self-reported patient

identity data from at least 80% of enrollees and use these data to show yearly reductions in disparities by race, ethnicity, and gender for certain chronic conditions and for behavioral health, with future efforts planned for LGBTQ enrollees and enrollees with limited English proficiency.[43]

Delivery of culturally and linguistically appropriate services in health care settings is recognized as a modifiable factor that can reduce inequities in care for populations who face language, literacy, or cultural barriers.[44] Over 70% of Medi-Cal enrollees are members of racial and ethnic minority groups, and nearly 40% identify their primary language as other than English.[45] Existing tools and guidelines can help organizations improve delivery of person-centered services in the area of language and culture. One such tool, the **National Standards for Culturally and Linguistically Appropriate Services (CLAS)** (PDF),[46] provides guidelines to assist health care organizations in delivering culturally and linguistically appropriate services, including strategies to identify gaps, implement interventions for quality improvement, and track improvements over time. Efforts to increase concordance between HCBS consumers and care providers in race, ethnicity, and language may also play an important role in providing person-centered care. Greater flexibility in hiring requirements for care managers and other staff (e.g., substituting years of experience or language capacity for educational requirements) may facilitate efforts to hire staff that reflect the population of those served in terms of language, culture, and lived experience.

Over 70% of Medi-Cal enrollees are members of racial and ethnic minority groups, and nearly 40% identify their primary language as other than English.

Finally, community engagement at the local level with HCBS consumers, families, and advocacy groups may be useful to identify community needs to improve access to HCBS and ensure the relevancy of measures to consumers. Solutions to address lack of providers or barriers to enrollment will likely vary across different regions of the state.

Learning from Other State Approaches to HCBS Quality Assessment and Improvement

Approaches to HCBS quality assessment and improvement implemented in other states may inform best practices in California and vice versa. Many states have proposed investments in HCBS quality initiatives as part of their HCBS spending plans supported by the American Rescue Plan Act (ARPA), including improvements in data infrastructure and quality reporting, implementation of new quality metrics and pay-for-performance initiatives, and investments in HCBS workforce capacity to drive improvements in quality of care.[47] In the following sections, a few examples are provided for how California can address quality measurement of its HCBS structures, processes, and outcomes. Also highlighted are approaches from other states for which certain components could be applied to California.

Structures for Workforce Capacity and Training

An adequate workforce of HCBS care providers is critical to meet consumer needs for HCBS. However, the direct care workforce faces some of the lowest recruitment and retention rates[48] due to low pay, demanding workloads, and little opportunity for advancement. States such as Tennessee and New York are trying to address chronic HCBS workforce shortages and provide workers with better training and skill development (see "Measuring Workforce Capacity: Tennessee and New York"). One of the goals of California's Master Plan for Aging is creation of one million high-quality direct care jobs.

Incorporating structural measures of HCBS workforce capacity (e.g., availability of providers, training for providers) into quality reporting efforts and value-based payment models may incentivize investments in HCBS workforce development. California's HCBS Spending Plan includes funding to support development of career pathways for the direct care workforce, funds to recruit and train direct care workers to build provider capacity, and grants to expand training for home-based clinical care.

Processes for Referral, Assessment, and Enrollment

Process measures may be useful to incentivize streamlined pathways for enrollment in HCBS programs and referral to services. Multiple state HCBS spending plans include plans to improve processes for enrollment and referral. Several states (see "Measuring HCBS Uptake: New Mexico and North Carolina" on page 16), including California, have proposed implementing or enhancing person-centered "no wrong door" systems that provide navigation assistance at the local level to streamline access to LTSS.

Measuring Workforce Capacity: Tennessee and New York

Through the Quality Improvement in LTSS (QuILTSS) initiative, Tennessee's Medicaid program is establishing a process for collecting workforce-related data at the provider and system levels to address workforce issues and track efforts to improve recruitment and retention.* To incentivize better training for HCBS providers, the state created a comprehensive competency-based workforce development program and credentialing registry for those paid to deliver LTSS. Providers receive value-based incentives to employ better-trained and qualified staff to promote delivery of high-quality care. Workers have the opportunity to acquire short-term credentials portable across providers and settings, earn college credit to apply toward a degree program, and build competencies to access higher wages and more advanced jobs.†

New York has made similar investments through the Workforce Investment Program,‡ which requires MLTSS plans to contract with local workforce training centers to recruit and train direct care workers in the areas they serve. Plans are required to analyze local workers' training and employment needs and to develop strategies to address health disparities through placement of workers in underserved communities. The program is intended to expand availability of home care and respite care to enable more people in need of long-term care to remain in their homes and communities.

* "**Value Based Purchasing**," TennCare, accessed September 7, 2021.

† ***Advancing Value-Based Payment in Medicaid Managed Long-Term Services and Supports: Opportunities for Community-Based Care*** (PDF), Center for Health Care Strategies, September 18, 2018.

‡ ***MRT Waiver Amendment: Managed Long Term Care Workforce Investment Program*** (PDF), New York State Dept. of Health.

Measuring HCBS Uptake: New Mexico and North Carolina

New Mexico has proposed implementation of a technology-enabled "closed loop" referral system for HCBS that provides a real-time view of people's referral status, allows data exchange among care providers, assigns tasks, and reports on outcomes of referrals.*

North Carolina has proposed implementation of needs assessments for HCBS consumers to address social determinants of health (SDOH), including food, housing, transportation, and safety needs. This would leverage the state's coordinated care network, NCCARE360, which electronically connects those with SDOH needs to community resources and provides a feedback loop on the outcomes of referrals. Medicaid plans can use this system to perform SDOH needs assessment for enrollees, track time from referral to receipt of services, monitor community demands and service needs, and identify gaps in community programs.†

* ***Spending Plan for the Implementation of the American Rescue Plan Act of 2021, Section 9817*** (PDF), New Mexico Human Services Dept., 2021.

† ***North Carolina Spending Plan for the Implementation of the American Rescue Plan Act of 2021, Section 9817*** (PDF), North Carolina Dept. of Health and Human Services, 2021.

Consumer Health and Safety Outcomes

Outcome measures are useful to ensure accountability by managed care plans and HCBS providers for achieving objective outcomes related to health and safety of HCBS consumers. In California, with the intent to move toward alignment of Medicare and Medi-Cal incentives, such measures may be applicable for Dual Eligible Special Needs Plans (D-SNPs), a type of Medicare Advantage plan that coordinates Medicare and Medi-Cal benefits for dually eligible enrollees.

Consumer Experience Surveys to Drive Quality Improvement

Many states are using consumer-reported data to drive quality improvement in HCBS. Pennsylvania and other states are using consumer experience data from the HCBS CAHPS Survey to inform quality improvement efforts (see "Measuring Consumer Experience Outcomes: Pennsylvania" on page 17). One funding approach that 12 states have proposed is implementing or expanding consumer surveys for HCBS through ARPA funds. Colorado's HCBS Spending Plan includes establishing a Colorado Providers of Distinction network designation to identify providers who deliver higher quality care and better care experience outcomes to HCBS members.[49] Arizona has proposed to expand its National Core Indicators survey to additional populations, create a data repository to track performance of managed care organizations, and make comparisons at the national level with similar populations.[50] Indiana has proposed to survey family caregivers of HCBS consumers to better understand gaps in the continuum of supports and to create a plan to address identified gaps.[51]

Measuring Consumer Experience Outcomes: Pennsylvania

Pennsylvania is one of several states that currently use consumer experience data from the HCBS CAHPS Survey to inform quality improvement efforts. Medicaid managed care organizations participating in Pennsylvania's Community HealthChoices Program are required to administer the survey annually to gather feedback on consumer experiences with HCBS. Plans must examine current composite measure scores and trends over time and submit a narrative report to the state Medicaid agency describing plans for quality improvement.* Aggregate results from the 2019 HCBS CAHPS Survey indicated that plans were performing well in areas such as listening and communication, personal safety, allowing consumers to decide daily schedules, and helpfulness of service coordinators. Areas for improvement included choice of services that matter to consumers, assistance with being active in the community, and increasing consumers' awareness of employment assistance and housing services.†

* "**Appendix H: Quality Improvement Strategy**" (PDF) in *2019 Community HealthChoices (CHC) Waiver Renewal*, Pennsylvania Dept. of Human Services, August 17, 2019.

† ***Community HealthChoices 2019 HCBS CAHPS Survey Results*** (PDF), Pennsylvania Dept. of Human Services, May 12, 2020.

Data Infrastructure and Reporting

With the increased funding for HCBS provided through ARPA, multiple states have proposed implementing universal assessment systems for standardized electronic data collection across HCBS providers, such as New York's Uniform Assessment System for Long-Term Care (see "Universal Assessment Systems: New York"). In California, challenges to implementation of a universal assessment system for HCBS have included difficulty aligning a common assessment tool across all HCBS programs, as well as pushback from HCBS providers due to the expense and effort required for implementation of a universal assessment. However, California's **HCBS Gap Analysis and Roadmap**[52] proposal includes plans to explore a universal baseline assessment, and implementation of **Electronic Visit Verification**[53] for Medicaid-funded personal care and home health care services will enable more consistent data collection on HCBS consumers and the types of services they use.

Some states plan to create public-facing LTSS dashboards to report utilization, cost, and quality data for HCBS providers and long-term care facilities.

Universal Assessment Systems: New York

New York's Uniform Assessment System for Long-Term Care (NY-UAS) is a standardized tool for documentation of HCBS needs assessments across various Medicaid MLTSS programs. Data are used to inform eligibility for MLTSS, assist health care providers in care planning and outcome monitoring, and evaluate plan performance.* The New York State Department of Health publishes performance data on MLTSS plans using data collected electronically through the NY-UAS and through an enrollee satisfaction survey. Regional consumer guides are published online to help consumers choose a plan that meets their needs. Plans receive performance ratings for outcomes such as patient safety, quality of life, satisfaction with care, and stability or improvement in functional status.†

* ***2019 Managed Long-Term Care Report*** (PDF), New York State Dept. of Health.

† "**MLTC Consumer Guides**," New York State Dept. of Health, accessed September 7, 2021.

Arizona has proposed creation of a public-facing dashboard to report HCBS utilization and cost data, licensing data, and quality metrics.[54] The dashboard is intended to assist consumers and families in choosing HCBS providers, drive systemwide quality improvement, and provide more comprehensive oversight and monitoring of providers. Similarly, California's HCBS Spending Plan includes an LTSS data transparency initiative, with plans to create an LTSS dashboard to report statewide nursing home, long-term care, and HCBS utilization and cost data, as well as other quality and demographic data. The dashboard is intended to provide greater transparency for regulators, policymakers, and the public; identify gaps and disparities in LTSS quality and access; and strengthen the provision of Medi-Cal HCBS.[55]

Approaches to Value-Based Payment in HCBS

Across health care delivery systems, value-based payment (VBP) models link provider payments to the cost and/or quality of care delivered. Yet many HCBS providers have limited capacity to take on financial risk, and many lack the necessary infrastructure for data collection and reporting.[56] In addition, there is limited opportunity to achieve Medicaid savings for dually eligible enrollees not enrolled in an integrated program to align Medicare and Medicaid incentives. With some exceptions (see "Value-Based Payment: New York"), very few VBP initiatives exist that include HCBS. However, with increasing adoption of state models to shift delivery of LTSS to managed care plans (MLTSS), either as a stand-alone benefit or as part of a comprehensive package of physical and behavioral health services and LTSS, many states are seeking to implement or expand VBP models for MLTSS.[57] States such as Minnesota, New York, Tennessee, and Texas have implemented MLTSS VBP models to link payment to performance. In HCBS spending plans for ARPA, 15 states have proposed implementation

Value-Based Payment: New York

Each year, the New York State Department of Health evaluates a set of quality measures for use in value-based payment (VBP) arrangements for its Managed Long Term Care program, including measures to assess enrollee health and safety outcomes.* Candidate measures are reviewed by the state's VBP Workgroup and Managed Long Term Care Clinical Advisory Group, a group of subject matter experts including clinicians, managed care plans, advocacy groups, and consumers.

Criteria for measure selection include clinical relevance, reliability and validity, and feasibility for use by managed care plans. Candidate measures are sorted into three categories: approved measures that are reliable, valid, and clinically relevant (category 1); measures that are reliable, valid, and clinically relevant but require further investigation of feasibility before implementation in VBP arrangements (category 2); and measures that are not recommended for VBP because they are not reliable, not valid, and/or not feasible (category 3). Measure sets and classifications are reviewed and updated annually. The current set includes measures to assess outcomes such as acute care utilization, falls, stability or improvement in functional status, and symptom management, as well as some process and consumer experience measures (see the appendix).

* ***Managed Long Term Care Partial Subpopulation: Value Based Payment Quality Measure Set, Measurement Year 2020*** (PDF), New York State Dept. of Health, February 2020.

of pay-for-performance or other VBP initiatives for HCBS.[58] In California, many HCBS are carved out of MLTSS, limiting options for VBP arrangements that include HCBS. However, CalAIM reforms may provide new opportunities for development of VBP models for HCBS. For example, with implementation of Enhanced Care Management and Community Supports, there are opportunities for developing VBP arrangements targeting high-cost, high-need managed care enrollees. Developing such arrangements will require building networks of HCBS providers that can enter into performance-based agreements with Medi-Cal managed care plans. Ensuring that providers have clear targets with a corresponding revenue stream that aim to mitigate disparities and support all consumers will be essential to incentivizing both equitable and value-based care.

Summary of Lessons Learned

Though state approaches to HCBS quality assessment and improvement vary, some themes are common across states. First, states have recognized that improving HCBS quality for consumers will require structural investments in workforce development and improvements in working conditions for HCBS care providers. Second, in recognition of the challenges consumers face in navigating fragmented systems, many states plan to implement streamlined processes for HCBS assessment, enrollment, and referrals. Third, though there is currently a dearth of HCBS outcome measures, many states are implementing consumer experience measures to drive quality improvement. As part of these efforts, states are investing in HCBS data infrastructure and reporting to increase transparency and to identify opportunities for improvement.

Conclusion

In the context of CalAIM reforms and planned transitions to MLTSS, California has an opportunity to invest in HCBS quality monitoring and data infrastructure in accordance with the state's Master Plan for Aging, planned HCBS Gap Analysis and Roadmap work, and HCBS Spending Plan related to ARPA. Through these efforts, California can address systems challenges to HCBS delivery such as access inequities and gaps, workforce shortages, and variation in service availability. Increasing equity in HCBS quality requires identifying and mitigating disparities in the structures, processes, and outcomes of the HCBS delivery system, and in consumer experiences of care. Incorporating measures of equity into quality measurement efforts and setting benchmarks to reduce disparities may facilitate improvements in quality of HCBS for populations that have historically faced barriers to accessing these services, potentially reducing disparities in outcomes across age, race/ethnicity, language, geography, and other dimensions. Given the complexity and current fragmented administration and oversight of HCBS, a coordinated effort will require budget investments and policy development, as well as collaboration between the state government, state and local agencies, and the private sector. Together, these stakeholders can accelerate efforts to improve the quality of California's HCBS delivery system, ensuring this system is prepared to serve the growing number of Californians of all backgrounds who will rely on it in coming decades.

Appendix. New York State Value-Based Payment Measures for Managed Long-Term Care

CATEGORY 1 MEASURES	STEWARD / DATA SOURCE
Percentage of members who did not have an emergency room visit in the last 90 days*	New York State / NY-UAS
Percentage of members who did not have falls resulting in medical intervention in the last 90 days*	New York State / NY-UAS
Percentage of members who did not experience falls that resulted in major or minor injury in the last 90 days*	New York State / NY-UAS
Percentage of members who received an influenza vaccination in the last year*	New York State / NY-UAS
Percentage of members who remained stable or demonstrated improvement in pain intensity†	New York State / NY-UAS
Percentage of members who remained stable or demonstrated improvement in Nursing Facility Level of Care score†	New York State / NY-UAS
Percentage of members who remained stable or demonstrated improvement in urinary continence†	New York State / NY-UAS
Percentage of members who remained stable or demonstrated improvement in shortness of breath†	New York State / NY-UAS
Percentage of members who did not experience uncontrolled pain*	New York State / NY-UAS
Percentage of members who were not lonely or not distressed*	New York State / NY-UAS
Potentially avoidable hospitalizations for a primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection per 10,000 days enrolled in the plan*	New York State / NYS-UAS with linkage to Statewide Planning and Research Cooperative System
CATEGORY 2 MEASURES	**STEWARD / DATA SOURCE**
Care for Older Adults — Medication Review: Percentage of adults age 66 and older who had a medication review by a clinical pharmacist or prescribing practitioner*	NCQA
Use of High-Risk Medications in the Elderly: Percentage of patients age 67 and older who were ordered high-risk medications*	NCQA
Percentage of members who rated the quality of home health aide or personal care aide services within the last six months as good or excellent*	New York State / MLTC Survey
Percentage of members who responded that they were usually or always involved in making decisions about their plan of care*	New York State / MLTC Survey
Percentage of members who reported that within the last six months the home health aide or personal care aide services were always or usually on time*	New York State / MLTC Survey

* Prevalence (point-in-time) rates, which reflect one measurement period.

† Performance over time, which reflects changes in the MLTC population over a 6- to 12-month period.

Notes: *MLTC* is managed long-term care. *NCQA* is National Committee for Quality Assurance; for details on measures visit "**Care for Older Adults (COA)**" and "**Medication Management in Older Adults (DAE/DDE),**" HEDIS Measures and Technical Resources, NCQA. *NY-UAS* is **New York Uniform Assessment System**. Examples provided are limited to quality measures relevant to HCBS.

Source: ***Managed Long Term Care Partial Subpopulation Value Based Payment Quality Measure Set, Measurement Year 2020*** (PDF), New York State Dept. of Health, February 2020.

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