JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

January 4, 2016

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2328-NC
P.O. Box 8016
Baltimore, Maryland 21244

Submitted electronically

Re: CMS-2328-NC – Medicaid Program; Request for Information (RFI)-Data Metrics and Alternative Processes for Access to Care in the Medicaid Program

Justice in Aging is pleased to submit comments in response to the above referenced Request for Information, published at 80 Fed. Reg. 67377 (Nov. 2, 2015).

Justice in Aging, formerly the National Senior Citizens Law Center, uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources.

Our submission is limited to comments on four questions raised in the RFI concerning access to long term services and supports (LTSS), including home and community based services (HCBS). The comments are informed by our work with advocates across the country on issues related to the provision of HCBS to low income older adults, both in fee-for-service Medicaid and through Medicaid managed care.

An increasing share of LTSS is being provided at home and in the community, shifting the balance of public spending and services away from institutional care.[1] In fact, HCBS accounted for a majority of Medicaid long-term services and supports expenditures for the first time in FY 2013,[2] which reflects the growing demand for high-quality services provided in more integrated settings. With the increased demand for HCBS and growing Medicaid expenditures paying for care in the community, it is important to establish strong measures to evaluate access to HCBS care.

Our comments regarding specific questions in the RFI are below.

Specific to long-term services and supports, including home and community based services, what factors do you believe we should consider in measuring access to care? (80 Fed. Reg. at 67379)

[1] NQF HCBS study, available at http://www.qualityforum.org/Measuring_HCBS_Quality.aspx.
[2] Truven Medicaid LTSS Spending Report, available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf.

WASHINGTON
1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES
3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND
1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

Access to care for long-term services and supports, including home and community-based services, must be considered as part of a broader effort to measure outcomes for Medicaid-funded LTSS[3]. As part of this broader effort, three core principles that must be considered are:

1. The measurement process is person-centered;
2. Measurement examines quality of life outcomes; and
3. Measurement outcomes inform improvement.[4]

Situating consideration of access to LTSS as part of the broader evaluation of LTSS outcomes will enable states and the Centers for Medicare and Medicaid Services to have a more complete view of access to care for LTSS and specifically HCBS.

While the need to measure access to LTSS is great, there are significant gaps in current measurements. The National Quality Forum recently released its second draft report for comment, *Addressing Performance Measure Gaps in Home and Community-Based Services to Support Community Living*.[5] The report profiles 11 key domains of HCBS quality measurement. Of these 11 domains, the most relevant for measuring access to HCBS are: choice and control and workforce.

At this time, the authors found too few measures currently exist for evaluating: Consumer Voice, Equity, Community Inclusion, and Caregiver support. We believe it is critical for an HCBS quality plan to evaluate measurement in these areas, however, we recognize these measure domains are outside the scope of the information sought in this RFI. The access domains of Choice and Control and Workforce, in contrast, are more robust, with 17 and 10 measures currently available for each domain, respectively.

Under the Choice and Control domain, NQF explains that one critical area is access to participant-directed personal care services. We agree with this assessment. Access to participant-directed personal care services is a domain that should be measured in both fee-for-service (FFS) Medicaid, as well as managed Medicaid.

Other areas we recommend CMS exploring while measuring access to Medicaid LTSS are:

- Total HCBS and institutional expenditures monthly, quarterly, and annually as a percentage of total LTSS;[6]
- Average per person expenditures in HCBS and Nursing Facility (NF) settings;
- Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services versus institutional care;[7]
- Percent of waiver individuals who experienced a decrease/increase in the authorization of personal care hours;[8]
- Beneficiary satisfaction including identification of unmet need;
- Snapshots, changes over time, and long-term trends in number of enrollees in different LTSS settings;

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[3] Disability Rights Education & Defense Fund & Nat'l Senior Citizens Law Cntr., Identifying and Selecting Long-Term Services and Supports Outcome Measures (2013)) [hereinafter LTSS Outcome Measures Report] (discussing potential measures and their limitations), available at http://dredf.org/2013-documents/Guide-LTSS-Outcome-Measures.pdf.

[4] Id. at 13.

[5] NQF Draft report (December 18, 2015), available at http://www.qualityforum.or.g/Measuring_HCBS_Quality.asp x

[6] See KanCare Program, Medicaid State Quality Strategy, pg. 112, available at http://www.kancare.ks.gov/download/Attachment_J_State_Quality_Strategy.pdf(September 2014).

[7] KanCare Quality Strategy, pg. 47

[8] See Virginia Memorandum of Understanding, pg. 95, available at.: https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/downloads/vamou.pdf.

- Average length of residence in HCBS settings;
- Number of new admissions to NFs over 12 months and average length of stay;
- Number of LTSS enrollees transitioned from NFs to HCBS settings over 12 months and, conversely, the number of enrollees admitted to NFs from HCBS settings; and
- Summaries and trends on complaints and appeals, especially those related to access to care.[9]

Further, metrics should be developed to evaluate not only whether LTSS participants have access to prescribed care, but whether providers prescribe all needed care or are merely suggesting treatments based on available services. Metrics should also include whether prescribed hours are actually received, and whether the level of "natural supports" expected from family or friends is truly voluntary. Data collected through all metrics should be stratified to assess whether particular populations, such as older adults, LEP individuals, LBGT individuals, or persons of color have particular problems with access to care.

Do you believe we should incorporate into reviews of access to care for these services economic factors and significant policy factors such as: Minimum wage and overtime requirements, direct service worker shortages, training and professional development costs, or other factors? (80 Fed. Reg. at 67379)

To set a baseline for workforce-related questions, we suggest adopting the data collection recommendations of the CMS-funded National Direct Service Workforce Resource Center report, The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection, issued in February 2009.[10] Such data should include:

- Workforce volume
  - Number of full-time workers
  - Number of part-time workers
- Workforce stability
  - Turnover rate
  - Vacancy rate
- Workforce compensation
  - Average hourly wage
  - Benefits (health insurance and paid time off)

This information is critical for states and the federal government to understand workforce challenges, develop policy solutions, and assess the impact of policy changes and trends over time. Collecting such data will enable more appropriate consideration of economic factors into the review of access to care for HCBS services.

Much more data is needed on these issues, which affect the overall health delivery system, not just Medicaid. Data will assist policy makers at both the federal and state level in developing policies addressing workforce issues in health care. However, we have concerns about how such data will be incorporated into reviews of access to HCBS. Whether Medicaid beneficiaries have access to high quality HCBS must be kept distinct from the underlying structural problems that affect that access. If data is

[9] See LTSS Outcome Measures Report at 15-16.
[10] The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection, February 2009, available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/workforce/downloads/monitoring-dsw.pdf.

misused, it could mask or otherwise impede absolute comparisons of HCBS access among plans and states. Importantly, such data should not be used in any way, for example in quality ratings or state comparisons, to adjust access ratings or affect quality-based payments so as to excuse lack of access to HCBS services.

Do you believe access to HCBS should be tracked in FFS and in managed care delivery systems? Do you perceive any differences between tracking HCBS in each system? (80 Fed. Reg. at 67380)

Yes, in both the FFS and managed care delivery system, it is critical to have a clear understanding of access to HCBS. Currently, in both FFS and managed care, there is little data shared about Medicaid expenditures and access. In recent years, we've seen early progress in states rebalancing public spending on LTSS by increasing access to HCBS. We believe this progress reflects both the preference of individuals who require LTSS and the cost-effective nature of delivering care through HCBS. Unfortunately, Medicaid policies continue to give preference to the provision of LTSS in institutional settings instead of at home and in the community. As a result, people who could receive care at home are unnecessarily moved to institutions. To make significant progress and truly address the current imbalance, CMS and states must measure and evaluate access to home and community-based services in both the FFS and managed care system. Further, access must be measured for both state plan and waiver services.

Initial Medicaid LTSS expenditure data exist at the national and state level,[11] however, this only tells part of the access story. As mentioned above, CMS must also track access to participant-directed services, choice in HCBS waiver services, and availability of an HCBS workforce.

There are differences in tracking HCBS in each system, but the elements measured are the same. Whether a state used FFS to deliver HCBS, uses managed care, or offers both approaches, tracking access provides core information on whether a state's Medicaid system is working effectively to provide quality HCBS at the level needed by its Medicaid beneficiaries. This tracking is particularly important given the large-scale transitions to managed LTSS taking place across the country. Tracking also provides useful information for policy makers to compare the effectiveness of different delivery system designs in delivering HCBS both within a state and across states.

Much of the tracking would be the same across systems, although some differences or additions may be required to fully capture Medicaid managed care performance. For example, HCBS determinations reversed at State Fair Hearing is a measure that can be used for both FFS Medicaid and Medicaid managed care. For Medicaid managed care, however, there should be an additional measure that captures results of internal appeals within the plan.

Do you believe there are additional metrics that need to be tracked related to HCBS? (80 Fed. Reg. at 67380)

Waiting lists should be considered a metric of HCBS access. Medicaid HCBS programs are primarily funded through waivers, with Section 1915(c) waivers accounting for nearly 3 out of 4 dollars spent on LTSS provided in community settings.[12] According to the Kaiser Family Foundation, "[i]n 2014, more than

[11] Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2013, available at https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf.

[12] http://kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2012-data-update/

582,000 people were on § 1915(c) waiver waiting lists, and the average waiting time exceeded two years."[13] Average time spent on waiting lists varied widely, from three months for HIV/AIDS waivers to 47 months for I/DD waivers. Some states do not keep or report waiting lists, or have moved to "interest lists," which simply obfuscates the problem. Without consideration of waiting lists, HCBS access cannot be measured. We suggest improving and standardizing data regarding waiting lists for HCBS waivers to promote greater accuracy in tracking such metrics.[14]

Further, state laws or regulations that impact service delivery capacity should be monitored, particularly as states comply with the new Department of Labor rules regarding overtime. For example, overtime caps or restrictions on paying for travel time should be considered in the assessment of access to HCBS.

Thank you for the opportunity to comment. If there are questions concerning this submission, please contact Jennifer Goldberg, Directing Attorney, jgoldberg@justiceinaging.org.

Sincerely,

Kevin Prindiville
Executive Director

[13] See http://kff.org/medicaid/report/medicaid-home-and-community-based-services-programs-2012-data-update.
[14] See http://kff.org/health-reform/state-indicator/waiting-lists-for-hcbs-waivers/ for a compilation of currently available data.