National Council on Aging

January 9, 2017

Acting Administrator Andy Slavitt
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2404-NC
P.O. Box 8013
Baltimore, MD 21244-8013

Submitted electronically to: http://www.regulations.gov

Re: Medicaid Program; Request for Information (RFI): Federal Government Interventions to Ensure the Provision of Timely and Quality Home and Community Based Services

Dear Acting Administrator Slavitt:

Thank you for the opportunity to comment on this request for information concerning Medicaid Home and Community-Based Services (HCBS). The National Council on Aging (NCOA) is one of the nation's leading nonprofit service and advocacy organization representing older adults and the community organizations that serve them. Our goal is to improve the health and economic security of 10 million older adults by 2020. Our comments primarily focus on two major questions posed by CMS concerning access to HCBS and quality.

What are additional reforms that CMS can take to accelerate the progress of access to HCBS and achieve an appropriate balance of HCBS and institutional services in the Medicaid LTSS system to meet the needs and preferences of beneficiaries?

Financial and Functional Eligibility

Financial eligibility varies considerably across states, different populations/HCBS programs, and HCBS authorities. To the extent possibly within CMS authority, streamlining financial eligibility rules among the various HCBS eligibility pathways could significantly reduce administrative burden for states and confusion for beneficiaries using HCBS.

As noted in the RFI, FY 2016 and 2017 President's Budgets contained some specific proposals that could eliminate some administrative burdens for states in regard to eligibility pathways for 1915(i) and 1915(k) that require states to maintain HCBS waiver programs in order for some individuals to meet eligibility. These proposals would decrease administrative burdens and expand access to HCBS.

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CMS might also consider eliminating institutional biases within eligibility pathways when considering approval and re-approval of HCBS authorities. For example, while most states use the same financial eligibility limit for 1915(c) HCBS waivers as for nursing facility and other institutional services, 25% of HCBS waiver programs in 2014 used more restrictive financial eligibility limits than the limit used for nursing facilities. Similar to financial eligibility, functional eligibility rules to qualify for HCBS can be more restrictive than for institutional services. In 2014, ten 1915(c) waivers in eight states used stricter eligibility criteria for HCBS.

Caregiver Assessment and Supports

Family and other unpaid caregivers provide critical supports that often assist individuals with disabilities and seniors with maintaining community living, independence, health and well-being. However, historically Medicaid has focused solely on the beneficiary and rarely considered the support needs of unpaid caregivers providing supports. A significant precedent was set in 2014 when CMS issued final regulations for the 1915(i) HCBS State Plan Option. For the first time, CMS required a caregiver assessment whenever unpaid caregivers are "relied upon to implement any elements of the person-centered service plan." While there a variety of approaches and tools can be used, a caregiver assessment asks questions of family and unpaid caregivers in order to assess their health and well-being, levels of stress and being overwhelmed, and determine service and supports needs that they may have.

Few states have implemented this new requirement due to lack of CMS guidance. Furthermore, the requirement currently only applies to 1915(i) and not other important HCBS authorities (i.e. 1915(c), 1915(k), and 1115). Similar to the extension of guidance on person-centered planning across all HHS, CMS and ACL should utilize the authority of Section 2402(a) of the Affordable Care Act to extend guidance on caregiver assessment across all HCBS authorities. Guidance should clarify expectations and provides resources for implementation of caregiver assessment. This would provide greater consistency across populations as states design their HCBS systems.
In collaboration with ACL, other federal partners, and aging and disability stakeholders, CMS should also launch a technical assistance initiative to assists states and MLTSS health plans with designing HCBS programs that supports unpaid family caregivers and natural supports, including promotion of evidence-based family caregiver supports.

What actions can CMS take, independently, or in partnership with states and stakeholders, to ensure quality of HCBS and beneficiary health and safety?

Improved HCBS Data Collection

We recommend that CMS explore ways to streamline and improve data collection on HCBS. There are currently several major data sources for Medicaid HCBS. However, data that are available: 1) lack sufficient detail; 2) data collected are not uniform and often vary from one state to the next, making clear comparisons very difficult; 3) access to data is poor; and 4) data are often old and outdated. Concerns exist about the significant lag time on HCBS data which makes it difficult to track progress on such

issues as rebalancing in a timely manner. We also have significant concerns about lack of available HCBS data as states move towards managed care.

We also recommend that CMS implement a minimum data set on the direct care workforce providing HCBS that includes: 1) numbers of direct service workers (full time and part time), (2) stability of workforce (turnover and vacancies), and (3) average compensation of workers (wages and benefits). Currently, there is a lack of baseline and ongoing, reliable state-based data on the direct care workforce. States are not required to report this information to CMS. Without this minimum data, it is very difficult to assess access, measure quality, and set benchmarks for improvement. CMS commissioned a paper in 2009 entitled "The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection." The paper was prepared by the National Direct Service Workforce Resource Center, PHI, University of Minnesota Research and Training Center on Community Living, The Lewin Group, and Westchester Consulting. We believe the recommendations in this paper are a starting point to improving data collection that will enable assessing access to HCBS.

Waiting lists for HCBS are a major indicator of inadequate access. Data reported by states on waiting lists for 1915(c) HCBS waivers is unreliable. Some state do not report, many underreported, and there are no standards on maintaining the fidelity of waiting list data. We recommend that CMS institute new standards and reporting requirements on waiting lists for 1915(c) HCBS waivers.

HCBS Quality and Performance Measures

HCBS quality and performance measures are essential, particularly as states move towards delivery systems reforms such as Managed LTSS and integrated care for individuals dually eligible for Medicaid and Medicare under capitated arrangements. Performance measures help ensure consumer protections, provide information so individuals and their families can choose health plans, assist health plans to improve outcomes, and assist states with aligning payments, incentives, and penalties to drive desired goals –such as promoting options for self-direction, rebalancing, community employment, or strengthening the direct support professional workforce. However, there is currently very little federal guidance to states on HCBS quality, which has resulted is lack of consistence across states. Moreover, greater investments are needed in HCBS measure development.

We recommend that CMS utilize the 2016 report from the National Quality Forum (NQF) Committee on HCBS Quality to provide greater federal guidance to states on HCBS quality and target additional investments in HCBS measure development. The NQF report outlines an overarching HCBS quality framework that consists of 11 domains and 40 subdomains. It provides example promising measures for subdomains based on environmental scans of MLTSS programs and individual measures from existing consumer surveys. The report also provides domain specific and global recommendations for investments in measure development.

Specifically, CMS in partnership with ACL should undertake a process to select and initial core set of domains and subdomains for which to provide additional guidance to states. Consistent with recommendations from the NQF committee, this should consist of standard measures, as well as a menu of supplemental measures and promising measure concepts from which states could choose from that are tailorable to the population, setting, and program. The selection of an initial core set should be driven by stakeholder input from consumers, health plans, and states. The RRTC on HCBS Outcome Measures at the University of Minnesota (funded by National Institute on Disability Independent Living and Rehabilitation Research) is compiling a database of measures from consumer surveys organized by the NQF framework that could assist with informing this guidance.

Based on the recent CMS managed care regulations, a manageable first step forward might be to prioritize subdomains that correlate with areas of quality emphasized in the rule (i.e. quality of life, rebalancing, community integration, and person-centered planning and coordination). In prioritizing "quality of life" we believe it is essential to focus on measures that assess consumer and family caregiver experiences. The recent NQF endorsement and CAHPS approval of the HCBS Experience survey is a major step forward. In addition, ACL and states have significantly invested in the development of the National Core Indicators (NCI) and National Core Indicators for Aging and Disability (NCI-AD). We believe these and other measures hold great promise for the future. Additional guidance would assist states and plans with meeting these requirements in the managed care regulations and promote greater consistency across states. An initial core set of HCBS measures could also be implemented within the MMCO financial alignment demonstrations to further develop and test measures.

CMS should also make additional investments in HCBS measure development. While progress is being made, there remain significant gaps in HCBS measure development. The NQF committee recommended investments across all areas of the framework. Currently, there is very little measure development being undertaken in domains such as workforce, caregiver supports, and consumer leadership in system design. We recommend CMS and ACL consider these areas in the future.

Thank you again for this opportunity to share our comments. We look forward to ongoing dialogue with the CMS on these issues. If you have any questions or if we can be of any further assistance, please contact Joe Caldwell at Joe.Caldwell@ncoa.org.

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