College of Public Health – N232A
105 River Street
Iowa City, IA 52242
(319)-384-3832
http://www.rupri.org/panelandnetworkviewer.php?id=9
Keith-mueller@uiowa.edu

January 9th, 2017

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2404-NC
P.O. Box 8013
Baltimore, MD 21244-8013
By electronic submission at http://www.regulations.gov

RE: 42 CFR Part 440 – Medicaid Program; Request for Information (RFI): Federal Government Interventions To Ensure the Provision of Timely and Quality Home and Community Based Services.

To Whom It May Concern:

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal policy makers. The Panel is pleased to offer comments in response to the request for information sought by CMS regarding additional reforms and policy options to help accelerate the provision of home and community-based services (HCBS) to Medicaid beneficiaries. Our comments are limited to rural-specific issues and are structured to parallel general questions posed, or issues stated, by CMS (not technical comments regarding specific sections of the proposed rule). Our comments focus on the rural Medicaid older adult population, largely because more is known about their long-term services and support (LTSS) needs and use than other Medicaid sub-populations.

By way of background, the Panel notes that there is evidence that rural older adult Medicaid beneficiaries disproportionately rely on nursing home care rather than HCBS to meet their LTSS needs compared with those living in urban areas.[1] Although the reasons for this pattern or rural LTSS use are complex, some of the variation in HCBS use is likely the result of a combination of larger nursing home bed supplies in rural areas and more limited availability of and access to HCBS services in many rural communities. The following comments are designed to bring an evidence-informed rural perspective to the questions posed in the RFI.

Question: *What are additional reforms that CMS can take to increase the progress of access to HCBS and achieve a balance of HCBS and institutional services in the Medicaid LTSS system to satisfy the needs and preferences of beneficiaries?*

Medicaid plays a critical role in meeting the LTSS needs of rural elderly beneficiaries in part because of the higher percentage of lower income, older adults in rural versus urban areas of the country.[2] The Maine Rural Health Research Center recently used 2008 Medicaid claims data to show that the proportion of

expenditures for personal care, home health, hospice, adult day care, and rehabilitation were all significantly lower for rural than urban Medicaid LTSS users. Compared with urban Medicaid LTSS users, rural users were more likely to receive nursing facility care, and the proportion of LTSS spending for nursing facility services was greater among rural than urban LTSS users.[3]

Rural-urban differences in the use of HCBS versus nursing home care are likely driven by HCBS capacity and the market for home care versus nursing home services in rural areas. It is not clear how state policies have affected these disparities. For example, states currently have the option of limiting their HCBS waiver programs to specific geographic areas, potentially reflecting variations in the capacity to deliver personal care and/or other HCBS services in some rural areas of the state.

The RFI asks whether restrictions on eligibility for nursing home care should be used to encourage greater use of HCBS. The Panel is concerned that in the absence of greater rural HCBS capacity in some areas, such policies could create undue barriers to rural Medicaid beneficiaries accessing needed LTSS.

Some of the specific capacity needed in rural areas includes:

- An organized system of care: the capacity to deliver HCBS in rural areas depends on an organized system of care involving multiple public and private health and social service agencies and organizations. Rural areas with limited HCBS often lack organized, inter-agency collaboration to manage the complex functions of eligibility determination, service development and coordination, care management, quality improvement and so forth.
- Care management: the Panel has discussed the problems of care management capacity in rural areas in previous work, noting the lack of capacity for effective care management in smaller, under-resources rural health and social service organizations.[4]
- Related to the capacity for effective care management, many rural agencies lack adequate IT infrastructure to support these critical functions.
- Workforce, a problem noted later in this RFI, is a known problem in rural areas and will need specific attention in any effort to build rural HCBS capacity.

A number of states, such as Minnesota, Maine and others, have demonstrated effective models for ensuring that rural Medicaid beneficiaries have access to a more balanced LTSS system that emphasizes access to HCBS services.[5] As CMS considers options for expanding access to Medicaid HCBS, the Panel recommends that states be asked to assess their capacity to deliver HCBS in underserved rural parts of their state. In states with limited HCBS capacity and infrastructure in rural areas, a combination of incentives, financial support, and technical assistance will be needed to help communities and regions build and sustain capacity and services.

Question: *What actions and how best can CMS ensure high-quality HCBS that promote the health and well-being of beneficiaries, and what other quality measurement activities could CMS undertake to strengthen the provision of HCBS?*

The Panel commends CMS for emphasizing quality measurements to track progress and ensure that HCBS are affordable, accessible, and are providing high-quality care to beneficiaries. We would like to comment on two main issues:

1) Organizational barriers that rural HCBS providers may have in collecting and reporting data due to limited resources and staff expertise, and
2) Measurement specification problems that result from low rural service volume and/or lack of rural relevancy in the measures and their specifications.

With regard to organizational barriers, some rural providers may have difficulty collecting data, accessing health IT and other financial and skill sets necessary to effectively report quality measures, and ultimately, to improve care. Therefore, rural HCBS providers, which typically have limited resources, staff, and expertise, can especially benefit from a quality focus that includes both financial help and technical assistance for measurement and improvement.

The range of services offered and the volume of services provided tend to be substantially smaller in rural versus urban health and social service organizations complicating the problem of selecting appropriate quality measures to improve quality. Rural-relevant measures should assess performance based on the scope, volume, and types of services appropriately delivered in rural communities. While benchmarks and performance standards should be rigorous, measures, which validly and reliably assess quality in rural places, need to be designed to address or account for low volumes of patients/clients or services within the scope of care provided. Rural providers should not be disadvantaged by measurement systems that, by their specifications, make it difficult or impossible for a rural provider to perform well.

The Health Panel encourages CMS to promote and develop technical assistance and other resources to foster training and dialogue among providers and service participants, specifically, in rural communities. Consistent with CMS' emphasis on community integration, we think that care coordination and management is integral to high quality HCBS and should be a critical focus of quality measurement and improvement. The Panel suggests that CMS encourage the use of patient experience surveys as well as patient-reported outcome measures such as functional status/activities of daily living. In addition, we encourage CMS to promote the integration of these measures in quality reporting in healthcare and other systems. Since many Medicaid HCBS recipients are dually Medicare and Medicaid eligible, CMS should consider options to align Medicare and Medicaid quality measures and use existing quality improvement infrastructure and programs to support HCBS, such as the Medicare QIN-QIO (Quality Innovation Network Quality Improvement Organization) program, to offer technical assistance to rural organizations and providers.[6]

The Testing Experience and Functional Tools (TEFT) program is currently being implemented in nine states and is showing promise in testing quality measurement tools and demonstrating e-health in Medicaid community-based long term services and supports. TEFT should be expanded, particularly, to rural areas to help test quality measurement tools and enable electronic exchange of information germane to the care of LTSS beneficiaries. In addition, providing financial incentives to HCBS providers will be helpful in encouraging a focus on the quality of services provided in rural areas. The Panel proposes that CMS encourage states to consider an add-on for HCBS provider payments for quality improvement; for example, in Minnesota, this is in the form of a percentage rate increase that is be applied to reimbursement rates.

Question: What particular steps could CMS take to improve the HCBS home care workforce?

Rural areas face unique struggles with providing quality LTSS to help seniors and people living with disabilities live at home and in the community and still receive necessary services. The Panel encourages CMS to be flexible with any requirements that may be established regarding improving HCBS home care workforce. The Panel agrees that expanded training options are needed in rural areas to build an effective HCBS workforce, additional disadvantages such as travel and training costs may undermine efforts to strengthen the workforce. Additionally, recognizing the challenges of recruitment and retention for HCB

staff is critical when considering improvements to the HCBS home care workforce. The Panel supports the option cited in the RFI for state-administered worker registries, which could be very helpful for families and could help facilitate access to personal care services.

Sincerely,

The Rural Policy Research Institute Health Panel

Keith J. Mueller, PhD – Chair
Andrew F. Coburn, PhD
Jennifer P. Lundblad, PhD, MBA
A. Clinton MacKinney, MD, MS
Timothy D. McBride, PhD
Charlie Alfero

---

[1] Phillips CD et al. *Nursing Homes in Rural and Urban Areas, 2000.* Bryan, TX: Texas A&M University System Health Science Center;2003.

[2] Coburn, AF et al. *Are Rural Older Adults Benefiting from Increased State Spending on Medicaid Home and Community-Based Services?* Maine Rural Health Research Center Research and Policy Brief, PB-65, June 2016.

[3] Li H. *Rural Older Adults' Access Barriers to in-Home and Community-Based Services*. *Soc Work Res*. 2006;30(2):109-118.

[4] RUPRI panel document on care management

[5] Lenardson JD, et al. *Profile of Rural Residential Care Facilities: A Chartbook*. Portland, ME: Maine Rural Health Research Center, University of Southern Maine;2014.

[6] Bennett KJ et al. *Characteristics, Utilization Patterns, and Expenditures of Rural Dual Eligible Medicare Beneficiaries*. Columbia, SC: South Carolina Rural Health Research Center;2014.