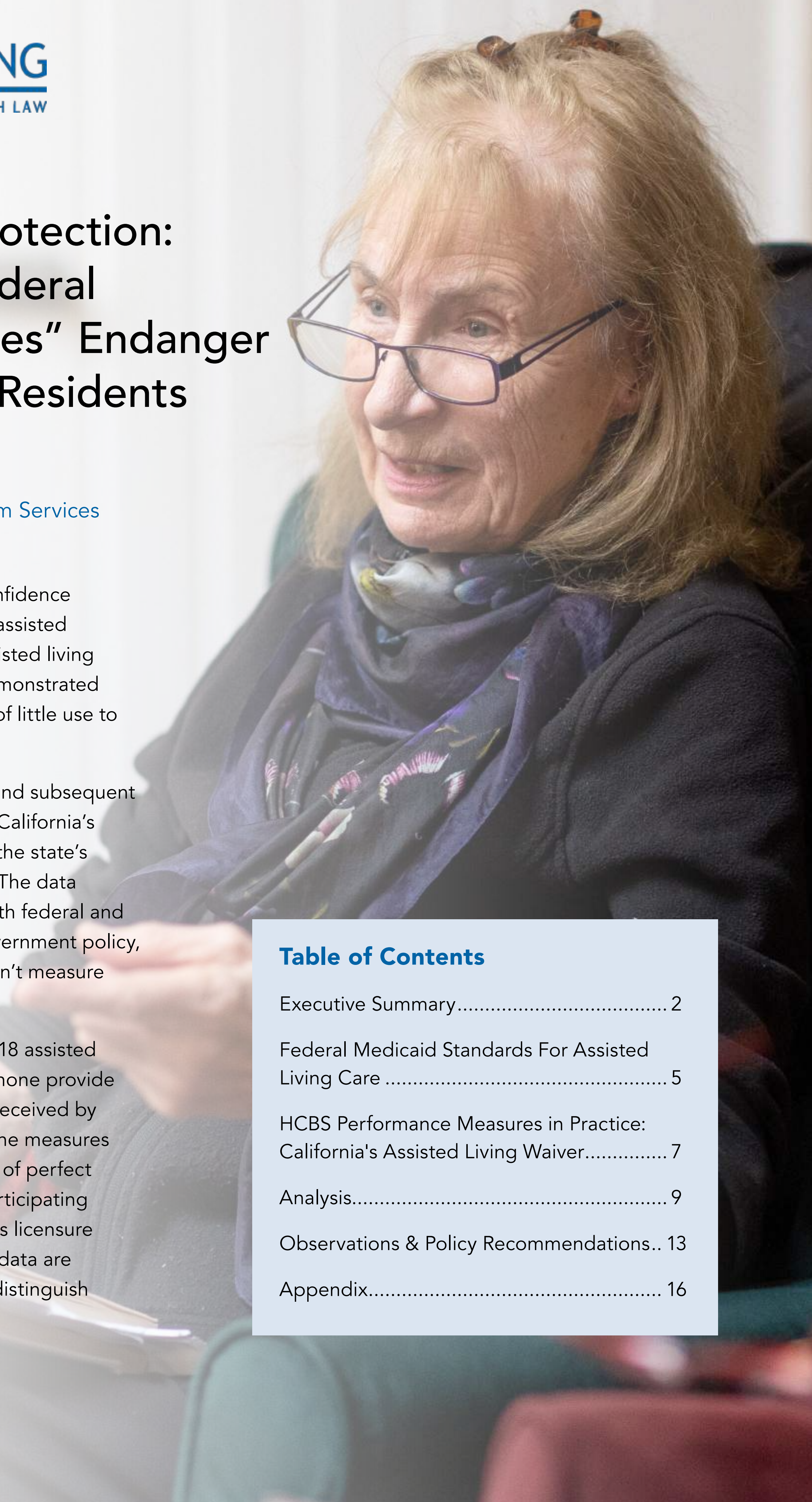

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SPECIAL REPORT

An Illusion of Protection: Meaningless Federal "Quality Measures" Endanger Assisted Living Residents

FEBRUARY 2024

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How can older Americans have confidence in the quality of Medicaid-funded assisted living? Federal policy points to assisted living performance measures, but, as demonstrated in this report, those measures are of little use to consumers or anyone else.

Through a public records request and subsequent lawsuit, Justice in Aging obtained California's "performance measure" data from the state's Medicaid assisted living program. The data demonstrate deep problems in both federal and state Medicaid policies. Under government policy, assisted living quality measures don't measure assisted living or quality.

Specifically, California administers 18 assisted living performance measures, but none provide useful information about the care received by assisted living residents. Many of the measures are trivial — for example, a finding of perfect performance based on the one participating home health agency maintaining its licensure each year. Also, because all of the data are aggregate, none of the measures distinguish between individual facilities.

Table of Contents

Executive Summary.................................... 2

Federal Medicaid Standards For Assisted Living Care 5

HCBS Performance Measures in Practice: California's Assisted Living Waiver.............. 7

Analysis... 9

Observations & Policy Recommendations.. 13

Appendix.. 16

EXECUTIVE SUMMARY

As demonstrated by California's Assisted Living Waiver (ALW), federal assisted living quality measures are largely ineffectual.

Under federal law, a state Medicaid program can use a home and community-based services (HCBS) waiver to cover at-home personal care and certain facility-based care, including assisted living. HCBS coverage is open only to those persons with significant care needs — specifically, persons who need the equivalent of nursing facility care.

Federal HCBS protocols require the state to monitor HCBS waiver program quality through performance measures. These performance measures focus primarily on the actions of agencies administering the waiver, and are not designed to measure quality of care or identify the better service providers.

Under the federal protocols, performance scores are expressed through percentages; a score of 85% or less requires a state to conduct appropriate remediation activities. States choose their own performance measures and may see easy-to-meet performance measures as the path of least resistance.

Using the HCBS waiver authority, California operates an Assisted Living Waiver (ALW) that covers care provided in assisted living facilities and, less commonly, certain other settings. The ALW currently funds assisted living services for roughly 12,000 participants, with another 3,000 persons (approx.) on a waitlist.

As detailed in this report, California's ALW provides a striking example of the inherent flaws in the federal performance measures system. In general, the performance measures provide little value to anyone — not federal or state governments, not assisted living facilities and other service providers, not facility residents, and not the general public.

ALW performance measures are kept from the public.

Across the country, assisted living waiver performance measures generally are not available to the public. In California, the California Department of Health Care Services (DHCS) does not post its ALW performance measure information on its website, or otherwise make the information available to the public. Accordingly, in December 2021, Justice in Aging submitted a public records act request to DHCS for information related to ALW performance measures. DHCS failed to comply with the request for over a year, finally turning over documents only after Justice in Aging filed a lawsuit in December 2022.

ALW performance measures are virtually worthless.

The information eventually turned over by DHCS covers the three-year period from March 2019 through February 2022. The information indicates that DHCS administers 18 performance measures within the ALW. These 18 measures are comprised of:

- **Seven** easy-to-satisfy measures with purported 100% compliance;
- **Six** case-file-review measures with suspiciously identical results;
- **Two** measures based on facilities meeting basic licensure and in-service training requirements;
- **One** faulty measure; and

- **Two** potentially useful measures relating to payment processes.

Overall, the measures provide little to no value. Consistent with federal protocols, as discussed above, the measures focus heavily on agency performance rather than provider quality. Five of the measures supposedly evaluate quality in some fashion: three of those look only at qualifications, i.e., licensure, while another merely records whether the provider offered in-service training. The fifth measure purportedly documents whether services were delivered in accordance with the service plan, but the results from that measure are drawn from a dubious case review process discussed below.

In general, few of the measures seem to offer any insight as to how DHCS might improve the ALW. Many of the measures are designed to be easy, with perfect or near-perfect performance virtually guaranteed. For example, one measure records whether participating home health agencies retained provider qualifications, i.e., licensure, during the year. Because only one home health agency participates in the ALW, and that agency was licensed for all three years, this measure yielded a 100% score for each year.

Similarly, a related measure considers whether facilities held licenses when they were accepted for participation during the year. Again, not surprisingly, the measure recorded a 100% score for each year, since licensure is a minimal threshold requirement for provider enrollment.

Six measures involve case review, and for each of these six measures the case review produced the exact same result: compliance in 26 of 27 reviewed files in the first year, compliance in all 75 reviewed files in the second year, and compliance in 478 of 483 reviewed files in the third year. Such lockstep results suggest strongly that review was cursory, compliance was virtually automatic, and noncompliance was found only when a file was unavailable or compromised in some way.

Finally, none of the performance measures are useful in distinguishing between providers. For many other types of health care providers, Medicare's Care Compare website provides data that allow for comparison of one provider to others. Such provider-specific information can be extremely useful — for example, for a consumer choosing a provider, or an inspector looking for potential quality of care problems. The ALW's performance measures, however — like all HCBS performance measures, under federal protocols — aggregate data across the entire state.

Federal and state governments should reorient HCBS performance measures towards usefulness and transparency.

Current federal procedures prescribe HCBS performance measures largely as a means of tracking a state's performance, rather than the performance of individual providers. As described in this report, California's ALW performance measures fall short in their current state-procedure-focused objective. Also, of course, they provide no information whatsoever regarding individual providers.

California is not an outlier. Many performance measure problems stem from federal procedures, and many states' performance measures have problems similar to California's.

The federal government should reorient HCBS performance measures to focus on quality of care rather than administrative processes. When possible, measures should distinguish between individual providers; this is particularly true for assisted living facilities and other residential facilities, since they are more likely to be larger. Similarly, measures as appropriate should be stratified based on participant characteristics including care needs, race, and

gender, in order to facilitate identification and reduction of care disparities.

Also, federal standards should require true transparency. All performance measure information must be made available in a timely fashion on the internet, in a format reasonably accessible to consumers.

Most importantly, the federal government should reset the approach to performance measures to focus on real-world usefulness. Mediocre performance measures represent both a poor use of resources and a lost opportunity to improve care.

California should make similar changes, i.e, evaluate performance of individual providers (including assisted living facilities), make information public and accessible, and reorient performance measures towards real-world usefulness. California has stated its intent to reevaluate the entire ALW in the near future, making this a particularly favorable time in which to consider performance measure revisions.

FEDERAL MEDICAID STANDARDS FOR ASSISTED LIVING CARE

Medicaid can pay for assisted living care through Home and Community-Based Services waivers.

Federal Medicaid law does not provide an "assisted living" benefit comparable to Medicaid's coverage of (for example) hospital care or nursing facility care. Instead, if a state Medicaid program wishes to cover assisted living care, the state in most cases proceeds through a federal waiver – most commonly, a Home and Community-Based Services (HCBS) waiver. HCBS waivers are frequently used to cover personal care assistance provided in a participant's house or apartment, but they also can be used to cover care in certain residential facilities, including assisted living. The waiver pays for care services while the participant retains financial responsibility for room and board expenses. Provision of the Medicaid-funded services is guided by a service plan developed with the participant's involvement.[1]

An HCBS waiver is intended to provide an alternative to nursing facility care; accordingly, each participant must have care needs significant enough to qualify them for nursing facility care. On the financial side, a state HCBS program at a minimum must demonstrate cost neutrality, i.e., that the cost of waiver services does not exceed the cost that would have been incurred had the participant received nursing facility care rather than HCBS. Notably, HCBS waivers allow a state to limit the number of participants and, when a program is at full capacity, place applicants on waitlists for potentially months or years.[2]

A state applies for an HCBS waiver through a form application developed by the Centers for Medicare & Medicaid Services (CMS). Original approval is granted for up to three years, while renewals may extend for five years.[3]

States must report "performance measure" percentage data to support assurances made to federal government.

As a condition of an HCBS waiver, a state Medicaid program must provide CMS with formal assurances that "necessary safeguards" (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services."[4] In implementing this requirement, CMS requires specific assurances of state compliance in six specified areas. In addition, for each of these six assurances, CMS requires one or more specific subassurances to better flesh out compliance realities, with a total of 16 subassurances:

1. Administrative authority (1 subassurance);
2. Level of care determinations (2 subassurances);
3. Provider qualifications (3 subassurances);
4. Waiver service plans (4 subassurances);
5. Health and welfare (4 subassurances); and
6. Financial accountability (2 subassurances).[5]

To document compliance with subassurances, the state devises and administers "performance measures" (subject to CMS approval) to measure

whether the waiver program is meeting assurances. The performance measures are expressed in a percentage, with a percentage score of 86% or above considered satisfactory. If a performance measure yields a score below 86%, the state must implement a remediation plan to address the situation.[6] For this reason, a state has an incentive to use performance measures that will produce scores above 85%, in order to avoid the additional work of developing, implementing, and documenting a remediation plan.

As an example of the HCBS performance measure system, consider the Level of Care assurance, in which the state assures the federal government that the state implements waiver-designated processes and instruments for evaluating whether participants' care needs would qualify them for nursing facility services. In the two associated subassurances, a state must assure CMS that 1) all applicants receive a level of care evaluation; and 2) waiver-designated processes and instruments are appropriate to determine participant level of care needs. In California's assisted living waiver (as discussed below), these subassurances are monitored through two corresponding performance measures: 1) the percent of new participants whose initial level-of-care determination was performed by a registered nurse from a care coordination agency; and 2) the percent of determinations in which specified processes and instruments were used appropriately in determining participants' level of care needs.

As demonstrated in these examples, current performance measures focus primarily on the actions of agencies administering the waiver, and are not designed to distinguish between individual providers or identify disparities in care. The measures do little or nothing to help a consumer choose a provider, direct inspectors to potential instances of substandard care, or support quality improvement projects by individual providers.

CMS IS PROPOSING FUTURE CHANGES TO HCBS PERFORMANCE MEASURES

In July 2022, CMS released a new HCBS Quality Measure Set. Although use of the Quality Measure Set (QMS) is voluntary at this time, CMS stated its intention to incorporate the QMS into HCBS reporting requirements.[7]

The QMS includes 97 separate performance measures. Almost half of these measures relate to current HCBS waiver assurances, either Waiver Service Plans (29 measures), or Health and Welfare (14 measures). The remaining measures address access (15 measures), rebalancing state programs away from institutional care (6 measures), and community integration (including compliance with the recently-implemented federal regulations to promote non-institutional practices and environments) (33 measures).[8]

HCBS PERFORMANCE MEASURES IN PRACTICE: CALIFORNIA'S ASSISTED LIVING WAIVER

California utilizes HCBS waiver authority to cover assisted living care.

California offers coverage of assisted living care through a Medicaid HCBS waiver called the Assisted Living Waiver (ALW).[9] The vast majority of ALW participants live in Residential Care Facilities for the Elderly (RCFEs), which is California's licensing term for assisted living facilities. Many fewer ALW participants live in Adult Residential Facilities (ARFs), which are licensed to care for persons under age 65. ALW participants may also reside in publicly subsidized housing, with services provided by home health agencies, but this slice of the ALW participant population is extremely small: ALW approval has been extended only to eight publicly subsidized housing sites and one home health agency.[10]

The ALW operates in only 15 counties, mostly in urban areas.[11] Within these counties, 686 individual facilities are approved for ALW participation, with an aggregate capacity of approximately 27,000.[12] The ALW, however, due largely to the state-set enrollment cap, had an August 2023 enrollment of only 11,657, with a waitlist of 3,032 applicants.[13]

California monitors Assisted Living Waiver with eighteen performance measures.

As discussed above, federal performance measure protocols focus on waiver program operations, rather than care quality. CMS requires state Medicaid programs to issue assurances and subassurances, and then to use corresponding performance measures to document compliance. California's Department of Health Care Services (DHCS) monitors the ALW with eighteen separate performance measures. Most of the performance measures relate to service plans (five measures), provider qualifications (four), or health and welfare (four). Two measures relate to level of care determinations, and another two measures relate to financial accountability. A final measure relates to administrative authority.

Not surprisingly, the ALW's subassurances and 18 performance measures track the 16 subassurances required by CMS. The "extra" two performance measures are attributable to DHCS using three separate performance measures for the providers-are-qualified subassurance (+two) and two separate performance measures for the service-plan-revision subassurance (+one), while not using a performance measure for an unlicensed provider subassurance (-one) (because the ALW does not utilize unlicensed providers).[14]

Details about the ALW performance measures, including three years of data, are set forth in a table in the Appendix. The table includes assurances, subassurances, performance measures, and the data related to those measures. The data were obtained from DHCS pursuant to a public records act request.

CALIFORNIA'S PERFORMANCE MEASURES FOR ASSISTED LIVING WAIVER

1. Percent of applications from care coordination agencies that resulted in agency being enrolled into program.
2. Percent of level-of-care determinations performed by registered nurse.
3. Percent of level-of-care determinations conducted appropriately.
4. Percent of enrolled home health agencies that maintained provider qualifications.
5. Percent of enrolled facilities qualified to provide waiver services.
6. Percent of enrolled facilities that did not allow licensure or certification to lapse.
7. Percent of enrolled providers that held mandatory in-service training for staff.
8. Percent of waiver service plans that reflect participant's needs.
9. Percent of waiver service plans submitted within ten days of assessment's completion.
10. Percent of participants with reassessments whose services plans were revised to address changed needs.
11. Percent of participants with services delivered in accordance with waiver service plan.
12. Percent of participants offered choice between waiver services and nursing facility care.
13. Percent of Serious Incident Reports involving abuse, neglect or exploitation.
14. Percent of resolved cases among reported cases of abuse, neglect or exploitation.
15. Percent of waiver service plans that do not call for restraints or seclusion.
16. Percent of reviewed cases indicating that state monitored overall health care standards.
17. Percent of participants enrolled prior to claim submission.
18. Percent of claims coded and paid in accordance with reimbursement methodology.

California currently is applying to renew Assisted Living Waiver.

The ALW's current five-year term expires on February 29, 2024, and DHCS currently is preparing an application for another five-year renewal. DHCS circulated a draft waiver application for public comment; the comment period ended on October 5, 2023.

The draft waiver application proposes to retain 12 of the 18 performance measures, but does not mention the other six measures — ## 3, 10, 12, 14, 15 & 16. It is unclear if these omissions are meant to be permanent or, on the other hand, the omissions just reflect the application's draft status.[15]

Most likely, DHCS does not at this point intend to delete the six measures, many of which may be needed to meet CMS-required subassurances. In a bullet-point "Major Changes" introductory section to the draft application, DHCS simply lists "Updated Performance Measures." In accord, a DHCS e-mail to stakeholders stated that it intended only minor changes in this draft application.[16]

ANALYSIS

Performance measures do not measure provider quality.

Few of the 18 performance measures actually relate to the quality of Medicaid-certified providers. And for those few that do relate at least somewhat to quality, the data from the performance measures are generally unimportant or unrevealing.

Specifically, only five of the performance measures purport to evaluate provider quality in some way:

- #4. Percent of enrolled home health agencies that maintained provider qualifications.
- #5. Percent of enrolled facilities that were qualified to provide waiver services.
- #6. Percent of enrolled facilities that did not allow licensure or certification to lapse.
- #7. Percent of enrolled providers that held mandatory in-service training for staff.
- #11. Percent of participants with services delivered in accordance with waiver service plan.

Few ALW performance measures relate to quality, and data from those few measures are generally unimportant or unrevealing.

The first three of these are trivial: in each case, the measure is simply whether the provider met basic prerequisites for participating in the ALW. The data reflect the measure's triviality. For measures #4 and #5, DHCS reports a measure of 100% for each of the three reported waiver years, while measure #6 yields similarly high results: 98.95%, 96.67% and 98.45% for waiver years 1 through 3, respectively.

Performance measure #7 — the percent of providers that conducted mandatory in-service trainings — also has little relationship to care actually provided. Again, DHCS reports high percentages — 99.48%, 96.67% and 98.45% for waiver years 1 through 3 — but those high percentages say more about the measure's triviality than quality of care.

Performance measure #11 theoretically could relate to quality, based on the measure's description, but data and other contextual information indicate that the measure actually has little value. The measure is comprised of the percent of participants with services delivered in accordance with the waiver service plan — notably, results are based solely on facility case file reviews. DHCS reports the following results:

- **Year #1**: 96.30%; 26 of 27 files reviewed (5,643 participants overall).
- **Year #2**: 100%; 75 of 75 files reviewed (6,782 participants overall).
- **Year #3**: 98.96%; 478 of 483 files reviewed (7,811 participants overall).

Although at first glance these high percentages are attractive, further examination reveals these data to be hollow. Review simply was not designed to truly determine whether participants received needed services. Data were drawn merely from reviewing facility case files, and not from any independent inquiry or interview with program participants. Also, review only included a small percentage of participant case files.

Most significantly, the reported data indicate that case review was extremely cursory. The three bullets above list the ***EXACT*** three-year results not only for measure #11, but also for measures ## 8, 9, 12,

15, and 16.* For each of those six measures, in a review of a total of 585 files, reviewers evidently found perfect compliance in Year #2, and one and five instances of noncompliance, respectively, in Years ## 1 and 3. This suspicious data pattern indicates that 1) reviewers accepted almost any level of documentation as proof of compliance for the six performance measures at issue; and 2) six files were either missing or severely compromised, leading to the limited findings of noncompliance in Years ## 1 and 3.

Thus, measure #11 has little to say about whether participants actually received adequate services. Compliance evidently was virtually guaranteed by measure #11's design and implementation, except in the rare instances when a file was unavailable or compromised.

Case review is not meaningful.

As discussed immediately above, the data indicate that ALW case review is perfunctory. A full six measures — measures ## 8, 9, 11, 12, 15, and 16 — produced ***EXACTLY*** the same results: compliance in 26 of 27 reviewed files reviewed in Year #1, in all 75 reviewed files in Year #2, and in 478 of 483 reviewed files in Year #3.

Under CMS procedures, these high percentages — 96.30% to 100% compliance — supposedly indicate strong performance, e.g., that service plans reflected a participant's needs (measure #8), participants were given a choice between waiver services and nursing facility services (#12), and the state monitored overall health care standards (#16). The lockstep nature of the results, however, indicates that neither the case review process nor the data are meaningful. As a practical matter, the data suggest that reviewers found compliance whenever a case file was available and intact. Then, in the rare instances in which a file was unavailable or compromised for some reason, the reviewer found noncompliance for each of the six relevant performance measures, leading to identical percentages for each of the measures.

> "The six measures based on case review had identical results, suggesting that review was cursory, finding compliance whenever a case file was intact.

This conclusion — that purported "case review" is not meaningful — is reinforced by consideration of measure #15, which is the percentage of waiver service plans not calling for restraints or seclusion. In fact, the ALW prohibits restraints or seclusion, making it even more likely that a finding of non-compliance is due to the lack of an intact case file, rather than a service plan calling for an explicitly prohibited intervention.[17] Also, this measure is trivial like many of the "perfect compliance" measures discussed immediately below, since a perfect or near-perfect score is virtually guaranteed.

"Perfect" compliance indicates that measures are not meaningful.

For obvious reasons, trivial performance measures lead to "perfect" or near-perfect scores. DHCS reported three-year 100% compliance for 7 of the 18 performance measures (## 1, 2, 3, 4, 5, 10 & 14). This report already has discussed measures ## 4 (qualified home health agencies) and 5 (qualified

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* Measures ## 8, 9, 12, 15 & 16 are, respectively: "waiver service plans that reflect participant's needs," "waiver service plans submitted within ten days of assessment's completion," "participants offered choice between waiver services and nursing facility care," "waiver service plans not calling for restraints or seclusion," and "reviewed cases indicating that state monitored overall health care standards."

> “
> Supposed "perfect" compliance for over 20,000 level of care determinations and over 1,000 service plans suggests that "in compliance" findings were virtually automatic.

facilities). Here are the other five instances in which DHCS reported 100 percent compliance over the three relevant years:

- **Measure #1**: 15 of 15 applying care coordination agencies enrolled in ALW during relevant years.
- **Measure #2**: 7,541 of 7,541 level-of-care determinations performed by a registered nurse, as required by program standards.
- **Measure #3**: 20,236 of 20,236 level-of-care determinations in which processes and instruments were used appropriately.
- **Measure #10**: 1,020 of 1,020 waiver service plans in which service plans were revised to address changed needs.
- **Measure #14**: 0 of 0 cases in which reports of abuse, neglect or exploitation were resolved.

Measure #1 is trivial, merely reflecting the fact that applications from care coordination agencies were processed. Measure #2 also is relatively trivial, since the ALW requires that all level-of-determinations be performed by a registered nurse. As a measure of performance, this measure makes little more sense than evaluating surgical performance by considering whether the surgeon graduated from medical school.

Measures ## 3 and 10 also are not meaningful. A careful evaluation of level-of-care determinations (measure #3) or service plans (#10) would require time and professional judgment. But clearly, as a practical matter, no such judgment was applied to 20,236 level-of-care determinations and 1,020 waiver service plans. Instead, all evidence suggests that the relevant computer programs generated “in compliance” findings as a matter of course.

The final instance of “perfect” compliance, measure #14, is an odd situation in which DHCS reached 100% compliance by dividing zero by zero. The genesis of the zero was the absence of any substantiated reports of abuse, neglect and/or exploitation in Serious Incident Reports. Measure #14 is described by DHCS in a confusing way (see Appendix), but the desired “performance” seems to be the percentage of relevant cases resolved. The absence of incidents of abuse, neglect and/or exploitation resulted in a numerator and denominator of zero for all three years, which DHCS logged as 100% compliance.

(Also troubling is the absence of any substantiated instances of abuse, neglect or exploitation from over 5,000 Serious Incident Reports during the relevant three-year period.)

The only potentially meaningful performance measures relate to payment processes.

This report thus far has discussed all measures but three: measures ## 13, 17 & 18. Measure #13, relating to Serious Incident Reports, had a faulty design; as a result, DHCS could not collect relevant data.

Measures ## 17 and 18 each relate to payment: the percent of participants who were enrolled prior to submission of claims (#17), and the percent of claims coded and paid for in accordance with reimbursement methodology (#18). Performance

over the three years ranged from 93.7% to 99.7% for each of the measures. It may be that these two measures are of some use to DHCS in evaluating current payment procedures. Notably, however, these two measures have almost nothing to say about quality of care and waiver participants' lives.

SUMMARY OF PERFORMANCE MEASURES

18 Performance Measures:

- **Seven** easy-to-satisfy measures with purported 100% compliance (## 1, 2, 3, 4, 5, 10 & 14)
- **Six** case-file-review measures with suspiciously identical results (## 8, 9, 11, 12, 15 & 16)
- **Two** measures based on facilities meeting basic licensure and in-service training requirements (## 6 & 7).
- **One** faulty measure (#13)
- **Two** potentially useful measures relating to payment processes (## 17-18)

Performance measures are aggregate across California, and do nothing to identify strong or weak providers or disparities in care.

In many health care settings, performance measure data are stratified by provider. Provider-specific data can be used by state agencies to identify problems, and by consumers to choose a provider. Most prominently, Medicare's Care Compare website includes provider-specific data for eight categories of providers, including physicians, hospitals, nursing facilities, and hospice care agencies.[18]

Additionally, health care data often are stratified by patient populations — for example, to distinguish between care needs, gender, race, age, sexual orientation, primary language, and other characteristics. Analysis of these data can identify disparities in care and aid both policymakers and providers in addressing those disparities.

HCBS waiver performance measures, however, are aggregated across an entire state and, as discussed above, focus primarily on waiver program operations themselves. Accordingly, the ALW performance measures do not distinguish between individual providers even though, in some cases, the performance measures themselves are based on actions of RCFEs (performance measures ## 5-7), home health agencies (#4), and care coordination agencies (## 2 & 3). Because of the data's aggregate nature, the measures provide none of the utility that Care Compare offers to policymakers, providers and consumers, and do not allow for comparison of urban and rural settings, large and small facilities, or other provider classifications.

Likewise, aggregate ALW performance measures have little value in identifying participant-to-participant care disparities. Even assuming useful data, aggregation prevents DHCS and CMS from making distinctions between (for example) men and women, and participants of various ethnicities, or with differing care needs. And, of course, the inability to identify disparities makes it impossible to diagnose and then rectify the problems.

Performance measures are kept secret within federal and state government.

DHCS keeps ALW performance measure information entirely private, aside from mandatory reports to CMS. This privacy sharply limits performance measures' potential usefulness. Even if, for example, performance measures included comparative information about individual providers, that information provides little benefit

if participants and other members of the public are kept in the dark.

The current no-disclosure status quo is not accidental, as demonstrated by DHCS's refusal to comply with a relevant public records act request. Through the California Public Records Act, Justice in Aging requested the ALW performance measure information from DHCS on December 14, 2021.[19] In response, over the following year, DHCS did not provide a single document, despite numerous communications from Justice in Aging including, in June 2022, a draft of a public records act complaint that could be filed against DHCS. Never during this period did DHCS claim that the information was exempt from production; instead, aside from sporadic communications, the state simply refused to comply.

Ultimately Justice in Aging filed a public records act case against DHCS on December 8, 2022.[20] Shortly thereafter, on January 3, 2023, DHCS began providing the requested information.

> "
> California **did not provide requested information until being sued** under the state public records act.

OBSERVATIONS & POLICY RECOMMENDATIONS

If not the first, this report represents one of the few investigations into HCBS performance measures as actually implemented by states. For a variety of reasons, HCBS performance measures have flown largely under the radar, outside a small group of government officials and academics.

This lack of attention has not been healthy for public policy, as demonstrated by the performance measures discussed in this report. Simply put, California's ALW performance measures appear to provide little value to anyone. This state of affairs has been allowed to develop and continue in California and across the country because the performance measure mechanism is entirely invisible to anyone outside government.

The status quo represents a tremendous wasted opportunity. DHCS has many strong reasons to monitor ALW performance; also, information about the ALW and its service providers could be useful to consumers and other stakeholders, and stratification by participant population would assist DHCS in identifying and addressing care disparities. But the current ALW performance measure system does not appear to meet the needs of government, consumers or anyone else. Instead, performance measures are calculated solely to fulfill bureaucratic requirements, with negligible interest in using performance measures as they are intended — to identify problems and improve public policy.

Notably, this critique applies not only to California, but also to CMS and to the other states operating assisted living waivers and other HCBS waivers. Across the country, the reality of performance measures falls far short of their potential.

Federal Policy Recommendations

In fairness to DHCS, it should be noted that the overall approach to HCBS performance measures is largely set by the federal government. As described above, federal guidance requires that performance measures focus on six specific areas: administrative authority, level of care determinations, provider qualifications, waiver service plans, health and welfare, and financial accountability. Overall, the federal guidance calls for a system that monitors

waiver programs themselves, rather than (for example) waiver service providers.

As a result, many of the shortcomings in ALW performance measures are largely attributable to federal policy. This report criticizes the ALW for not measuring provider quality and, by using only aggregate data, not distinguishing between individual providers. Each of these criticisms is best laid at the feet of CMS: the federal HCBS performance measure system is not designed to evaluate individual providers and, by focusing on aggregate agency-level measures within ALW operations, DHCS has merely implemented federal policy.

As discussed above (see page 5), CMS recently announced a new Quality Measure Set that includes 97 separate performance measures.[21] Critique of those 97 measures is beyond the scope of this report, but review of the CMS-related guidance indicates that it largely does not address the issues identified in this report.

Five overarching recommendations address many issues raised in this report:

1. Monitor individual provider performance.

First, CMS should consider how to monitor performance of individual HCBS providers, including assisted living facilities. Such monitoring, accompanied by extensive data sharing on the Care Compare website, is an accepted and prominent part of CMS policy towards hospitals, physicians, nursing facilities, and other federally-certified providers. Implementation of this recommendation should take into account the relatively small size of many HCBS providers.

2. Improve quality monitoring of residential facilities.

Second, and relatedly, CMS should consider how to best monitor HCBS-funded residential facilities (e.g. assisted living facilities). Overall, most HCBS waiver participants receive services in their own houses and apartments; the residential facility waivers are relative outliers. Many performance measures may be relevant for at-home care but not for facility-based care, or vice versa.

CMS review of this issue also should consider strategies beyond performance measures. Currently, both CMS and state Medicaid agencies have little control over assisted living standards and quality. CMS routinely accepts a state Medicaid agency's assurances that residents' health and welfare is safeguarded, and then treats the matter as settled. Furthermore, the state Medicaid agency likewise may have little control over assisted living, since state assisted living licensing standards generally will be developed and enforced by a different state agency. Particularly given the recent federal regulations to promote non-institutional practices and environments in HCBS-funded settings (see p. 6), CMS can no longer maintain what has largely been a hands-off posture towards monitoring and maintaining quality in federally-certified assisted living facilities. CMS should take a more proactive approach, which will require CMS to both set and enforce standards, and to build up the policy infrastructure to make those efforts possible.

3. Use performance measures to address health care disparities.

Third, CMS should expand the scope of performance measures as appropriate to capture resident-specific information including care needs, gender, race, age, sexual orientation, primary language, and other characteristics. CMS and states can use these data to identify disparities in care and then develop strategies to address those disparities.

4. Make performance measure information available to public.

Fourth, states must be required to make up-to-date performance measure information readily available

to the general public, in an accessible format. CMS generally touts transparency as an essential piece in data-driven improvement strategies.[22] Particularly compared to the extensive public-facing data available on Care Compare, current HCBS performance measures are strikingly non-transparent, to the extent in this case that litigation was necessary to extricate performance measure information from the state.

5. Reorient performance measures towards actual policy improvements.

Fifth, CMS should change the orientation of HCBS performance measures to focus more on actual policy improvements. CMS purportedly utilizes a continuous quality improvement cycle in which discovery leads to remediation, which leads to improvement, which leads to design, which leads again to discovery, whereupon the process continues.[23] Needless to say, data from the California ALW give little indication of any such a quality improvement orientation, and CMS complacency is suggested both by the ALW performance measures themselves, and by the process-over-content nature of the relevant DHCS-CMS communications.[24]

California Policy Recommendations

As noted, the current five-year ALW approval will end on February 29, 2024, and DHCS currently is preparing an application for another five-year renewal. In an e-mail to stakeholders, DHCS announced a two-phased approach: an initial renewal application with only minor changes, followed by "a subsequent amendment that will comprehensively address the suggestions raised by stakeholders."[25]

All of the federal recommendations above apply also to California: use performance measures to distinguish between individual providers including assisted living facilities, monitor assisted living quality, use performance measures to address disparities, make performance measure information easily accessible, and change the orientation of performance measure programs to focus on actual policy improvements.

The most needed change is an organizational attitude adjustment towards the performance measure process. The current performance measures seem to be of little use to anyone, and the public measure information is unavailable to the public.

Now is the time for a reset on ALW performance measures, given both the new federal Quality Measure Set and DHCS's stated intention to "comprehensively address" stakeholder suggestions in the ALW Renewal's second phrase. As an initial, necessary step in that reset, CMS should convene a stakeholder session for an honest discussion of the current system and the possibilities for reform.

APPENDIX

The performance measure data from the table below are taken largely from the DHCS report entitled "California State Medicaid Agency Oversight of the Assisted Living Waiver," which is part of a document that DCHS in the footer identifies as CA-0431.R06. The "Oversight" report begins on page 5 of the larger document, which begins on the first page with the California Home and Community-Based Assisted Living Waiver: Waiver Fact Sheet. Citations within the table refer to this report as the "Oversight Report."

In the case of performance measures ## 1, 5, 6, 7, 14, 17 & 18, data from the Oversight report subsequently were modified by CMS's Final Report, Home and Community-Based Services Review, California Assisted Living Waiver, Control #CA-0431.R06, dated February 28, 2023. Citations within the table refer to this report as the "Final Report."

The Final Report includes redacted material on pages 23, 24 and 27. DHCS made those redactions prior to turning over the Final Report, on the grounds that the redacted information pertains to technical details of the State's computer systems, and disclosure of that information could jeopardize system security.

Performance Measures for California's Assisted Living Waiver

March 2019 through February 2022

- **Year 1**: March 2019 – February 2020
- **Year 2**: March 2020 – February 2021
- **Year 3**: March 2221 – February 2022

ADMINISTRATIVE AUTHORITY

ASSURANCE

State retains ultimate administrative authority over waiver program, and administration of waiver program is consistent with waiver application.

SUBASSURANCE

Medicaid agency retains ultimate administrative authority by exercising oversight of other governmental and contracted agencies.

PERFORMANCE MEASURE #1

Percent of complete applications from care coordination agencies that resulted in DHCS enrolling the agency in the waiver program within the waiver year.

PERFORMANCE MEASURE #1 RESULT: 100%

- **Year 1:** 5 of 5 applying agencies enrolled.
- **Year 2:** 9 of 9 applying agencies enrolled.
- **Year 3:** 1 of 1 applying agencies enrolled.

Data from Final Report, p. 7.

LEVEL OF CARE DETERMINATIONS

ASSURANCE

State implements waiver-designated processes and instruments for evaluating whether participants' care needs would qualify them for nursing facility services.

SUBASSURANCE

All applicants receive level of care evaluation, if there is reasonable indication that applicant may need waiver services in the future.

PERFORMANCE MEASURE #2

Percent of new participants whose initial level-of-care determination was performed by a registered nurse from a care coordination agency. (The waiver requires that these initial determinations be performed by registered nurses.)

PERFORMANCE MEASURE #2 RESULT: 100%

- **Year 1:** 2,078 of 2,078 participants.
- **Year 2:** 2,475 of 2,475 participants.
- **Year 3:** 2,988 of 2,988 participants.

Data from Oversight Report, p. 11.

SUBASSURANCE

Waiver-designated processes and instruments are appropriate to determine participant level of care needs.

PERFORMANCE MEASURE #3

In determining participant's level-of-care needs, percent of determinations in which specified processes and instruments were used appropriately.

PERFORMANCE MEASURE #3 RESULT: 100%

- **Year 1:** 5,643 of 5,643 participants.
- **Year 2:** 6,782 of 6,782 participants.
- **Year 3:** 7,811 of 7,811 participants.

Data from Oversight Report, p. 14.

PROVIDER QUALIFICATIONS

ASSURANCE

State has designed and implemented an adequate system to ensure that waiver service providers are qualified.

SUBASSURANCE

Providers initially and continually meet licensure/certification standards and other state standards.

PERFORMANCE MEASURE #4

Percent of enrolled home health agencies that maintained provider qualifications.

PERFORMANCE MEASURE #4 RESULT: 100%

- **Year 1:** 1 of 1 home health agencies.
- **Year 2:** 1 of 1 home health agencies.
- **Year 3:** 1 of 1 home health agencies.

Data from Oversight Report, p. 16.

PROVIDER QUALIFICATIONS—CONTINUED

PERFORMANCE MEASURE #5

Percent of facility providers qualified to provide waiver services, of providers enrolled during the waiver year.

PERFORMANCE MEASURE #5 RESULT: 100%

- **Year 1:** 74 of 74 enrolled facility providers.
- **Year 2:** 110 of 110 enrolled facility providers.
- **Year 3:** 176 of 176 enrolled facility providers.

Data from Final Report, p. 14.

PERFORMANCE MEASURE #6

Percent of enrolled facility providers that did not allow licensure and/or certification to lapse, of providers that received onsite monitoring reviews during the year.

PERFORMANCE MEASURE #6 RESULT: 96.67% TO 98.95%

- **Year 1:** 98.95%; 189 of 191 facilities with onsite reviews.
- **Year 2:** 96.67%; 29 of 30 facilities with onsite reviews.
- **Year 3:** 98.45%; 190 of 193 monitoring reviews.

Data from Final Report, p. 15.

SUBASSURANCE

Provider training is conducted in accordance with waiver requirements.

PERFORMANCE MEASURE #7

Percent of enrolled providers that held mandatory in-service training for staff.

While reporting data, DHCS announced its intention going forward to modify the performance measure to the following: Percent of enrolled facility providers that held mandatory in-service training for staff, of providers that received onsite monitoring reviews during the year.

PERFORMANCE MEASURE #7 RESULT: 96.67% TO 99.48%

- **Year 1:** 99.48%; 190 of 191 providers.
- **Year 2:** 96.67%; 29 of 30 providers.
- **Year 3:** 98.45%; 190 of 193 providers.

Data from Oversight Report, p. 22, as modified by Final Report, p. 16.

WAIVER SERVICE PLANS

ASSURANCE

State has adequate system for viewing service plan adequacy.

SUBASSURANCE

Service plans address all participants' assessed needs and personal goals.

PERFORMANCE MEASURE #8

Percent of participants with a waiver service plan that reflected the participant's needs, based on the assessment, clinical records, and participant's personal preferences, as determined through review of a subset of participant case files.

PERFORMANCE MEASURE #8 RESULT: 96.30% TO 100%

- **Year 1**: 96.30%; 26 of 27 files reviewed (5,643 participants overall).
- **Year 2**: 100%; 75 of 75 files reviewed (6,782 participants overall).
- **Year 3**: 98.96%; 478 of 483 files reviewed (7,811 participants overall).

Data from Oversight Report, pp. 25-26.

WAIVER SERVICE PLANS—CONTINUED

SUBASSURANCE

Service plans are revised at least annually and when warranted by changes in participant's needs.

PERFORMANCE MEASURE #9

Percent of waiver service plans submitted within ten days of completing participant's assessment.

PERFORMANCE MEASURE #9 RESULT: 96.30% TO 100%

- **Year 1:** 96.30%; 26 of 27 files reviewed (5,643 participants overall).
- **Year 2:** 100%; 75 of 75 files reviewed (6,782 participants overall).
- **Year 3:** 98.96%; 478 of 483 files reviewed (7,811 participants overall).

Data from Oversight Report, p. 29.

PERFORMANCE MEASURE #10

Percent of participants with reassessments whose waiver service plans were revised to address changed needs.

PERFORMANCE MEASURE #10 RESULT: 100%

- **Year 1:** 116 of 116 participants with reassessments.
- **Year 2:** 322 of 322 participants with reassessments.
- **Year 3:** 582 of 582 participants with reassessments.

Data from Oversight Report, p. 31.

SUBASSURANCE

Services are delivered in accordance with service plan.

PERFORMANCE MEASURE #11

Percent of participants with services delivered in accordance with waiver service plan.

PERFORMANCE MEASURE #11 RESULT: 96.30% TO 100%

- **Year 1:** 96.30%; 26 of 27 files reviewed (5,643 participants overall).
- **Year 2:** 100%; 75 of 75 files reviewed (6,782 participants overall).
- **Year 3:** 98.96%; 478 of 483 files reviewed (7,811 participants overall).

Data from Oversight Report, pp. 33-34.

SUBASSURANCE

"Participants are afforded choice between/among waiver services and providers."

PERFORMANCE MEASURE #12

Percent of participants offered choice between waiver services and nursing facility care.

PERFORMANCE MEASURE #12 RESULT: 96.30% TO 100%

- **Year 1:** 96.30%; 26 of 27 files reviewed (5,643 participants overall).
- **Year 2:** 100%; 75 of 75 files reviewed (6,782 participants overall).
- **Year 3:** 98.96%; 478 of 483 files reviewed (7,811 participants overall).

Data from Oversight Report, pp. 35-36.

HEALTH AND WELFARE

ASSURANCE

State has an effective system for ensuring participant health and welfare.

SUBASSURANCE

State "identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation and unexplained death."

PERFORMANCE MEASURE #13

Percent of Serious Incident Reports involving abuse, neglect or exploitation.

(While reporting data, DHCS announced its intention going forward to modify the performance measure so that it would measure the percent of Serious Incident Reports resolved during a waiver year.)

PERFORMANCE MEASURE #13 RESULT: 0%

DHCS did not have the necessary data to calculate this performance measure.

Data from Oversight Report, pp. 37-38.

SUBASSURANCE

Incident management system effectively resolves incidents of abuse, neglect and exploitation, and prevents further similar incidents to the extent possible.

PERFORMANCE MEASURE #14

"Percent of cases [from Serious Incident Reports] reviewed with documentation [care coordination agency] has recognizing instances of abuse, neglect or exploitation with the participant/other responsible person reflecting resolution."

This performance measure evidently documents the percentage of resolved cases among cases of abuse, neglect or exploitation.

(While reporting data, DHCS announced its intention to develop a statewide system that allows for inter-departmental information sharing on critical incidents.)

PERFORMANCE MEASURE #14 RESULT: 100%

100% reported, but based on no relevant incidents. A state data report states: "For Waiver Years 1 & 2, there were about 3,000 incident reports submitted to DHCS. However, none of the reported incidents yielded substantiated claims for abuse, neglect, and/or exploitation."

» **Year 1**: 100% reported; 0 of 0 cases (1671 cases overall).

» **Year 2**: 100% reported; 0 of 0 cases (1,336 cases overall).

» **Year 3**: 100% reported; 0 of 0 cases (2,108 cases overall).

Data from Oversight Report, pp. 39-40, as modified by Final Report, pp. 22-23, 26-27.

HEALTH AND WELFARE—CONTINUED

▸ SUBASSURANCE
State policies and procedures for use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

PERFORMANCE MEASURE #15
Percent of waiver service plans that do not call for restraints or seclusion.

PERFORMANCE MEASURE #15 RESULT: 96.30% TO 100%
- **Year 1:** 96.30%; 26 of 27 files reviewed (5,643 participants overall).
- **Year 2:** 100%; 75 of 75 files reviewed (6,782 participants overall).
- **Year 3:** 98.96%; 478 of 483 files reviewed (7,811 participants overall).

Data from Oversight Report, p. 42.

▸ SUBASSURANCE
State establishes overall health care standards and monitors those standards based on service providers' responsibility under waiver.

PERFORMANCE MEASURE #16
Percent of reviewed cases indicating that state monitored overall health care standards.

PERFORMANCE MEASURE #16 RESULT: 96.30% TO 100%
- **Year 1:** 96.30%; 26 of 27 files reviewed (5,643 participants overall).
- **Year 2:** 100%; 75 of 75 files reviewed (6,782 participants overall).
- **Year 3:** 98.96%; 478 of 483 files reviewed (7,811 participants overall).

Data from Oversight Report, p. 44.

FINANCIAL ACCOUNTABILITY

ASSURANCE
State has designed and implemented adequate system for insuring financial accountability.

▸ SUBASSURANCE
Claims are paid for services rendered in accordance with waiver's reimbursement methodology.

PERFORMANCE MEASURE #17
Percent of participants who were enrolled prior to submission of claims.

PERFORMANCE MEASURE #17 RESULT: 91.9% TO 99.7%
- **Year 1**: 93.7%; 5,239 of 5,594 participants.
- **Year 2**: 91.9%; 6,151 of 6,686 participants.
- **Year 3**: 99.7%; 7,727 of 7,749 participants.

Data from Final Report, p. 31.

FINANCIAL ACCOUNTABILITY—CONTINUED

▸ SUBASSURANCE

Payment rates follow approved rate methodology.

PERFORMANCE MEASURE #18

Percent of claims coded and paid for in accordance with reimbursement methodology.

PERFORMANCE MEASURE #18 RESULT: 93.7% TO 99.7%

- **Year 1:** 93.7%; 138,892 of 139,342 claims.
- **Year 2:** 93.7%; 159,337 of 159,878 claims.
- **Year 3:** 99.7%; 210,807 of 211,446 claims.

Data from Final Report, p. 31.

ENDNOTES

1 *See 42 U.S.C.* § 1396n(c) (federal statutory authority for HCBS waivers); 42 C.F.R. § 441.301(c)(2) (person-centered service plans).

2 *See 42 U.S.C.* § 1396n(c).

3 42 C.F.R. § 441.304(a), (b); CMS, Application for a § 1915(c) Home and Community-Based Waiver, Instructions, Technical Guide and Review Criteria (Version 3.6, January 2019).

4 42 U.S.C. § 1396n(c)(2)(A).

5 CMS, Application for a § 1915(c) Home and Community-Based Waiver, Instructions, Technical Guide and Review Criteria, at 10-11 (Version 3.6, January 2019).

6 CMS, Application for a § 1915(c) Home and Community-Based Waiver, Instructions, Technical Guide and Review Criteria (Version 3.6, January 2019); CMS, Modifications to Quality Measures and Reporting in § 1915(c) Home and Community-Based Waivers (March 12, 2014).

7 CMS, Home and Community-Based Services Quality Measure Set, SMD #22-003 (July 21, 2022).

8 42 C.F.R. § 441.301(c)(4) (non-institutional practices and environments); CMS, Home and Community-Based Services Quality Measure Set, SMD #22-003 (July 21, 2022).

9 Approved Application for Assisted Living Waiver (effective March 1, 2019 through Feb. 29, 2024).

10 Cal. Health & Safety Code §§ 1569- 1569.889 (RCFEs); Cal. Welf. & Inst. Code § 14132.36 (ALW); 22 Cal. Code Regs. §§ 85000- 85187 (ARFs), 87100- 87795 (RCFEs); DHCS, Assisted Living Waiver Program Public Subsidized Housing Facilities (accessed Oct. 16, 2023).

11 Department of Health Care Services, Assisted Living Waiver (accessed Oct. 8, 2023).

12 DHCS, Assisted Living Waiver (ALW) Program Participating Facilities (aggregate numbers calculated by Justice in Aging based on DHCS information current as of March 10, 2023).

13 California Dep't of Health Care Services, Integrated Systems of Care Division, Assisted Living Waiver (ALW) Year to Date Enrollment and Waitlist January 2019 through August 2023.

14 CMS, Application for a § 1915(c) Home and Community-Based Waiver, Instructions, Technical Guide and Review Criteria, at 10-11 (Version 3.6, January 2019); *see also Appendix.*

15 The draft waiver was available on the DHCS website while the comment period was open. A copy is on file with Justice in Aging.

16 DHCS e-mail to stakeholders, Home and Community Based Services Waiver Update (Sept. 22, 2023) (on file with Justice in Aging).

17 Approved Application for Assisted Living Waiver, at Appendix G-2.

18 Care Compare, https://www.medicare.gov/care-compare/.

19 *See Cal. Public Records Act, Cal. Gov't Code,* §§ 7920.000- 7931.000.

20 *Justice in Aging v. California Department of Health Care Services*, 22STCV38340 (Superior Ct., Los Angeles County).

21 CMS, Home and Community-Based Services Quality Measure Set, SMD #22-003 (July 21, 2022).

22 *See, e.g., CMS Newsroom website,* Data (accessed October 9, 2023).

23 *See, e.g., CMS,* Modifications to Quality Measures and Reporting in § 1915(c) Home and Community-Based Waivers, at 2 (March 12, 2014).

24 *See CMS, Final Report, Home and Community-Based Services Review, California Assisted Living Waiver, Control* #CA-0431.R06, dated February 28, 2023.

25 DHCS e-mail to stakeholders, Home and Community Based Services Waiver Update (Sept. 22, 2023) (on file with Justice in Aging).