An Updated Policy Roadmap

CARING FOR THOSE WITH COMPLEX NEEDS

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HEALTH PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., the Bipartisan Policy Center's Health Project develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The project focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

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Glossary of Terms

ACL – Administration for Community Living

ACO – Accountable Care Organization

ADLs – Activities of Daily Living

APM – Alternative Payment Model

CAPABLE – Community Aging in Place—Advancing Better Living for Elders

CCM – Chronic Care Management

CMS – Centers for Medicare & Medicaid Services

D-SNP – Dual Eligible Special Needs Plan

EPSDT – Early and Periodic Screening, Diagnostic and Treatment

EVV – Electronic Visit Verification

FAI – Financial Alignment Initiative

FIDE SNP – Fully Integrated Dual Eligible Special Needs Plan

FLEC – Financial Literacy and Education Commission

FMAP – Federal Medical Assistance Percentage

FPL – Federal Poverty Level

HCBS – Home and Community-Based Services

HHS – Department of Health and Human Services

HIDE SNP – Highly Integrated Dual Eligible Special Needs Plan

HIPAA – Health Insurance Portability and Accountability Act of 1996

IADLs – Instrumental Activities of Daily Living

IDD – Intellectual and Developmental Disabilities

LTSS – Long-Term Services and Supports

MA – Medicare Advantage

MFP – Money Follows the Person

MMCO – Medicare-Medicaid Coordination Office

NAIC – National Association of Insurance Commissioners

PACE – Program of All-Inclusive Care for the Elderly

SHIP – State Health Insurance Assistance Program

SNF – Skilled Nursing Facility

SPA – State Plan Amendment

SSBCI – Special Supplemental Benefits for the Chronically Ill

SSI – Supplemental Security Income

T-MSIS – Transformed Medicaid Statistical Information System

TWWIIA - Ticket to Work and Work Incentives Improvement Act of 1999

Executive Summary

Beginning in 2013, four of BPC's health leaders—former Senate Majority Leaders Tom Daschle and Bill Frist, former Health and Human Services Secretary and Gov. Tommy Thompson, and former Congressional Budget Office Director Alice Rivlin—began working on bipartisan policy solutions to improve care and financing for those with complex health care needs. Since then, BPC has issued more than a dozen reports with recommendations addressing complex care, some of which have been enacted into law or incorporated into regulations or other agency guidance. For example, the Bipartisan Budget Act of 2018 included policies that BPC has long recommended, such as permanently authorizing dual eligible special needs plans (D-SNPs); establishing new integration standards for D-SNPs; unifying grievances and appeals procedures for certain D-SNPs; and allowing Medicare Advantage plans to provide Special Supplemental Benefits for the Chronically Ill (SSBCI) that address social needs for select Medicare beneficiaries. Today, about 3 million dual eligible beneficiaries are enrolled in D-SNPs[i], and the number of plans offering SSBCI stood at 947 (15.1%) in 2021.[ii]

Despite this progress, policymakers should take additional action if both equity in access to care and quality of service are to continue advancing in public and private insurance programs. In Medicaid, the use of multiple home and community-based services (HCBS) waivers or a combination of waivers and state plan amendments (SPAs) creates an enormously complex system for states to manage and beneficiaries to navigate. Additionally, confusion surrounding Medicaid buy-in programs for working individuals with disabilities, as well as the lack of federal guidance, is a barrier to state adoption of those programs, which are often critical to allowing individuals with disabilities to live independently and to work.

Congress and the U.S. Department of Health and Human Services (HHS) have expanded access to integrated care models, such as fully integrated D-SNPs and programs of all-inclusive care for the elderly (PACE). However, individuals eligible for both Medicaid and Medicare are not guaranteed access to fully integrated care and must often navigate separate programs to receive primary care, behavioral health, long-term services and supports, and other Medicare and Medicaid services.

Because Medicare does not cover comprehensive long-term services and supports (LTSS), individuals with functional limitations who do not qualify for Medicaid must pay out-of-pocket for LTSS, often until they spend down their savings to qualify for Medicaid, and many also rely on unpaid caregivers to deliver LTSS. For those enrolled in Medicare fee-for-service, either by

choice or because Medicare Advantage plans offering SSBCI are not available, policymakers could improve equity by making similar evidence-based, non-medical benefits available to individuals with chronic conditions who are served in risk-based or care management models. Public- and private-sector reforms that address these and other challenges discussed in this report would help remove barriers to quality, person-centered care for individuals with complex health care needs.

This report draws on recommendations from 12 previous reports to lay out a roadmap of policy solutions that Congress and federal agencies should still consider.[1] Some of the recommendations here are reflected in pending legislation, described in the Policy Landscape section below, although the outlook for those measures was uncertain at the time BPC drafted this report. To the extent that any of these recommendations become law, BPC hopes the Biden administration will work closely with states and stakeholders to implement the policies effectively and expeditiously.

This report presents the recommendations in two parts. Part I focuses on proposals that improve health and long-term services and supports for low-income individuals through the Medicaid program. Part II includes recommendations to provide support for middle- and higher-income individuals who may also face catastrophic long-term care costs, often causing them to exhaust their financial resources until they must rely on Medicaid. While Congress passed legislation to expand Medicaid home and community-based services (HCBS) through enhanced funding for states in the American Rescue Plan Act,[2] we hope this report will be useful to policymakers as they seek additional ways to improve care for those with complex needs.

To keep this report at a manageable length, we have included basic background information and policy rationales. Where we believe additional information would be useful, we have provided links to previous reports.

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1 *Guaranteeing Integrated Care for Dual Eligible Individuals*, November 2021; *Streamlining and Simplifying Medicaid HCBS Authorities*, October 2021; *Bipartisan Solutions to Improve the Availability of Long-term Care*, September 2021; *Bridging Health and Health Care*, September 2021; *Improving Opportunities for Workers with Disabilities*, January 2021; *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries*, July 2020; *Integrating Care for Beneficiaries Eligible for Medicare and Medicaid: An Update*, April 2020, white paper; *Policy Options for Integrating Care for Individuals with Both Medicare and Medicaid*, April 2020, white paper; *Next Steps in Chronic Care*, July 2019; *Improving Care for Patients with Serious Illness: Part 2*; November 2018; *Improving Care for Patients with Serious Illness: Part 1*, October 2018; *A Policy Roadmap for Individuals with Complex Care Needs*, January 2018.

2 The American Rescue Plan Act, passed in March 2021, increases the federal match rate by 10% for state spending on certain HCBS from April 1, 2021, through March 31, 2022. States must use the funding to supplement, not supplant, their current HCBS spending. All 50 states and the District of Columbia have taken up the option to receive enhanced funding.

Recommendations

Part I – Improving Medicaid Coverage for Those with Complex Needs

A. Simplifying and Streamlining Medicaid HCBS Authorities

1. **Congress should establish a new, consolidated SPA, combining existing state plan options and waivers. Current enrollees should be grandfathered to prevent a disruption in services.[3]**

2. **The Centers for Medicare & Medicaid Services (CMS) should clarify that under 1915(i) SPAs, states are permitted to phase in benefits, but they must provide coverage statewide when the SPA is fully implemented.**

3. **CMS should provide comprehensive technical assistance to states as they transition to the new, consolidated HCBS state plan authority.**

4. **Congress should direct the secretary of HHS to collect data and issue an annual report on disparities in access to HCBS and make recommendations to Congress to address inequities.**

B. Integrating Medicare and Medicaid Services for Dual Eligible Beneficiaries

1. **Congress should establish a framework for integrating Medicare and Medicaid services for dual eligible individuals.**

    a. Congress should create a "full integration" standard of coverage and care for dual eligible beneficiaries.

    b. Congress should require the HHS secretary, in partnership with states, to provide access to fully integrated Medicare and Medicaid services for all dual eligible individuals, like the approach taken under the Financial Alignment Initiative (FAI) demonstration. The secretary would make integrated care available under a federal fallback program in states that decide not to integrate.

    c. Congress should provide the Medicare-Medicaid Coordination Office with funding and regulatory authority to establish and oversee full integration in all programs serving dual eligible individuals, including integrated care models implemented by states and the federal fallback program.

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3 See Appendix I for a table outlining all the required changes to current law and authorities that would be consolidated into the single state plan amendment.

d. Congress should provide waiver authority to the secretary of HHS to align administrative differences between the Medicare and Medicaid programs, excluding issues related to eligibility, benefits, access to care, Medicare freedom-of-choice protections, and beneficiary due process rights.

e. Congress should direct the HHS secretary to adopt best practices from the Financial Alignment Initiative demonstration and apply them to Fully Integrated Dual Eligible Special Needs Plans. The secretary should also convene a working group to identify best practices where they have yet to be identified.

2. **Congress should improve enrollment and eligibility.**

   a. Congress should limit enrollment in fully integrated models to full-benefit dual eligible individuals. The secretary of HHS should also consider limiting beneficiary enrollment to fully integrated Medicare Advantage (MA) plans, if such an approach does not limit access to supplemental benefits or adequate access to providers.

   b. Congress should allow auto-enrollment in state-implemented or federal fallback integration models with a beneficiary opt-out available at any time in the case of Medicare-covered services.

   c. Congress should permit and encourage states to implement 12-month, continuous Medicaid eligibility for dual eligible individuals; it should also encourage states to reduce administrative burdens on beneficiaries.

3. **Congress should provide incentives for state-administered integrated care programs.**

   a. Congress should define and develop full integration models for states that choose to integrate care.

   b. Congress should provide financial and technical assistance to states, through HHS, to support state implementation of full integration in states that notify the secretary of their intention to integrate care. This support should include funding to plan, develop, and implement these models.

   c. Congress should provide the secretary of HHS with authority to develop a guaranteed shared savings program for full integration models.

4. **Congress should establish a federal fallback program.**

   a. Congress should direct the HHS secretary to fully integrate Medicare and Medicaid services for full-benefit dual eligible individuals. The federal government should recoup payments for enrolled individuals that would have otherwise been made to the state, like the approach taken in Medicare Part D for prescription drugs.

b. Congress should permit state participation in all aspects of policy development for integration programs.

c. To ensure options for beneficiaries in all counties, Congress should direct the secretary of HHS to require MA plans to offer at least one fully integrated plan in each service area in which they offer coverage.

5. **Congress should improve the beneficiary experience.**

   a. Congress should direct the HHS secretary to require collaboration between CMS, the Administration for Community Living, and states to implement model standards for outreach and education. It should also increase funding to the State Health Insurance Assistance Program so it can expand and improve information and counseling for dual eligible individuals.

   b. Congress should provide resources and technical assistance to states for consumer, provider, and plan engagement and education, and should encourage states to prioritize partnerships with community-based organizations and local governments.

   c. The HHS secretary should use their authority to improve and expand training for insurance brokers by including a training module on fully integrated models.

C. Addressing Barriers to Medicaid Buy-In Programs for Workers with Disabilities

1. **The administration should issue an executive order that clarifies and simplifies the current Medicaid Buy-In programs for workers with disabilities.**

   a. The administration should direct CMS to issue agency guidance identifying the full range of authority available to states to design, improve, and expand Medicaid Buy-In (MBI) programs for workers with disabilities.

   b. The administration should instruct CMS to change the name “Medicaid Buy-In” to “Medicaid for Workers with Disabilities.”

2. **HHS/CMS should issue regulations on Medicaid Buy-In programs.**

   a. HHS/CMS should issue a Notice of Proposed Rulemaking (NPRM) to give CMS the opportunity to address topics not addressed through informal guidance.

3. **Congress should consolidate Medicaid Buy-In authorities.**

   a. Congress should update, consolidate, and streamline existing authorities into a single state option.

b. Congress should reauthorize TWWIIA-funded Medicaid Infrastructure Grants and appropriate funding to help states develop programs and study best practices in other states that have successfully promoted MBI options.

Part II – Options to Improve LTSS for Individuals Not Qualifying for Medicaid

A. Establishing an HCBS Buy-In Through Integrated Models of Care

1. **Congress should allow Medicare beneficiaries who are ineligible for Medicaid to purchase LTSS coverage through fully integrated care models, including improved FIDE-SNPs, PACE, or other models approved by the secretary of HHS.**

B. Improving Chronic Care

1. **Congress should expand non-medical benefits in Medicare fee-for-service.**

   a. Congress should give the HHS secretary authority to identify and authorize coverage of and payment for evidence-based, non-medical benefits for patients with chronic conditions under the following conditions:

      - Peer-reviewed evidence demonstrates that the benefit improves or maintains health or function for a specific subset of patients with certain chronic conditions and/or functional limitations.
      - The CMS Office of the Actuary certifies that coverage of the defined benefit for the defined population results in no net increase in Medicare spending.
      - The chronic condition is being managed by an ACO, a comprehensive primary care model, through Chronic Care Management (CCM), or through other payment or delivery models that include a care management component.

   b. In establishing eligibility for non-medical services, the HHS secretary will need to make coverage decisions based on both chronic conditions and functional status. To facilitate this, Congress should direct the secretary to develop a uniform functional assessment tool and define the conditions under which providers would perform the assessment.

   c. Congress should direct the secretary to establish criteria for organizations that would be eligible to provide non-medical services identified by the secretary in traditional Medicaid fee-for-service (FFS). The secretary should also establish monitoring programs to minimize fraud, waste, and abuse.

d. For any new evidence-based benefits for the chronically ill, the HHS secretary should make available to Medicare providers a list of suppliers in the geographic area in which they provide services.

e. Congress should direct the secretary to examine potential modifications to the risk-adjustment model to ensure more accurate predictions of medical expenses for Medicare beneficiaries with functional limitations. The secretary should consider the appropriateness of developing a tool that can determine eligibility and assess risk.

2. **Congress should improve the chronic care management benefit.**

   a. Congress should eliminate the beneficiary co-pay for CCM services covered under Medicare for calendar years 2024, 2025, and 2026, because the benefit covers provider-to-provider communications outside an office visit and are not obvious to the beneficiary.

   b. Congress should expand the list of qualified health providers who can bill for CCM services to include licensed clinical social workers working within the scope of practice in such a way as to maximize cost-effective care and minimize program costs.

   c. Congress should direct the HHS secretary to eliminate beneficiary co-payments for advance-care planning for calendar years 2024, 2025, and 2026.

3. **The HHS secretary should improve the availability of non-medical health-related services and supports in the home and community.**

   a. The HHS secretary should direct CMS and the Administration for Community Living to develop a model contract that could be used to facilitate referrals, coordination, and reimbursement for non-medical, health-related services.

C. Creating a Caregiver Tax Credit

1. **Congress should establish a refundable tax credit to help caregivers with out-of-pocket costs for paid LTSS-related care.**

D. Improving the Availability and Affordability of Private Long-Term Care Insurance

1. **Congress should standardize and simplify private long-term care insurance to achieve an appropriate balance between coverage and affordability, by making "retirement long-term care insurance" (LTCI) available.**

2. **Congress should incentivize employers to offer retirement LTCI and to auto-enroll certain employees (age 45 and older with minimum retirement savings), with an opt-out similar to many employer-sponsored retirement savings accounts.**

3. **Congress should permit early penalty-free withdrawal from retirement savings accounts to cover retirement LTCI premiums.**
4. **Congress should ask the National Association of Insurance Commissioners (NAIC) to modify model laws and regulations to accommodate products that convert from life insurance to long-term care insurance.**

E. Strengthen Public Education on Long-Term Care

1. **The Financial Literacy and Education Commission and partnering federal agencies should coordinate to strengthen educational resources on LTC and incorporate LTC planning into retirement education topics.**

Introduction

Policymakers have long sought ways to improve care and to lower its costs for Americans of all ages with complex medical and non-medical care needs. Despite meaningful progress, policymakers should take additional action if both equity in access to care and quality of service are to continue advancing in public and private insurance programs. This report draws on recommendations from 12 previous BPC reports to identify policy solutions that Congress and federal agencies should still consider.[4]

Adults with complex needs, despite some similarities, are a diverse population with disparate medical and social service requirements. They include frail older adults, adults under age 65 with disabilities, and people of all ages with chronic conditions. This population can also have serious behavioral health issues or be terminally ill. Some may require significant medical care, while others may be relatively healthy but have functional needs requiring long-term services and supports (LTSS). Some require both health care and long-term services and supports.

Half of all adults in the United States have at least one chronic condition, while more than a quarter have two or more. Dual eligible beneficiaries are the most likely to have multiple chronic conditions, with more than 75% of that population having two or more chronic conditions in 2020.[iii] Chronic conditions constitute the majority of health care spending in the nation: in 2016, chronic diseases accounted for $1.1 trillion in direct health care costs.[iv] Both the prevalence, and cost, of caring for adults with chronic conditions are projected to grow as the U.S. population ages rapidly over the next decade.

For those ages 65 and over, and for those under 65 with disabilities who have met a two-year waiting period requirement, Medicare covers hospitalizations, provider office visits, prescription drugs, and other health care services. For low-income individuals under age 65 who do not qualify for Medicare, Medicaid covers health care services, provided they meet Medicaid eligibility requirements.

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4 *Guaranteeing Integrated Care for Dual Eligible Individuals*, November 2021; *Streamlining and Simplifying Medicaid HCBS Authorities*, October 2021; *Bipartisan Solutions to Improve the Availability of Long-term Care*, September 2021; *Bridging Health and Health Care*, September 2021; *Improving Opportunities for Workers with Disabilities*, January 2021; *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries*, July 2020; *Integrating Care for Beneficiaries Eligible for Medicare and Medicaid: An Update*, April 2020, white paper; *Policy Options for Integrating Care for Individuals with Both Medicare and Medicaid*, April 2020, white paper; *Next Steps in Chronic Care*, July 2019; *Improving Care for Patients with Serious Illness: Part 2*; November 2018; *Improving Care for Patients with Serious Illness: Part 1*, October 2018; *A Policy Roadmap for Individuals with Complex Care Needs*, January 2018.

Low-income Medicare beneficiaries who qualify for Medicaid, commonly referred to as dual eligible individuals, rely on Medicare for most medical services. Medicaid, as the secondary payer, covers those medical items and services that Medicare does not cover. For example, Medicaid may cover certain types of durable medical equipment and supplies when Medicare coverage is limited.

For those who need long-term services and supports, Medicaid covers LTSS for the lowest-income individuals, while middle- and higher-income individuals rely on a combination of savings, unpaid care delivered by friends or family members, and private long-term care insurance. Once their savings and assets are exhausted, they may qualify for Medicaid LTSS coverage.

Policy Landscape

RELEVANT PROPOSED LEGISLATION

Many policymakers support legislation that advances BPC's goal of improving care for those with complex needs in a manner that is fiscally sustainable.

Members of Congress have introduced legislation that addresses some of the issues outlined in this report, with some garnering bipartisan support. For example, Sens. Joni Ernst (R-IA), Michael Bennet (D-CO), Shelley Moore Capito (R-WV), and Elizabeth Warren (D-MA) have introduced the Credit for Caring Act of 2021 (S.1670). This bill would give working family caregivers of those requiring long-term care up to a $5,000 nonrefundable tax credit for out-of-pocket caregiving expenses. Rep. Linda Sánchez (D-CA) has introduced the companion bill (H.R.3321) in the House.

Another bill, the Cures 2.0 Act, introduced in November 2021 by Rep. Diana DeGette (D-CO), has support from 78 Democrats and 13 Republicans. The bill would fund educational programs and training for caregivers; incorporate Reps. Lisa Blunt Rochester (D-DE) and Dr. Michael C. Burgess' (R-TX) Telehealth Improvement for Kids' Essential Services (TIKES) Act to increase access to telehealth under Medicaid and the Children's Health Insurance Program; extend Medicare telehealth flexibilities; prohibit the use of GPS tracking and biometrics in Medicaid Electronic Visit Verification systems; and establish other changes.

The Build Back Better Act (BBB), introduced as a part of the reconciliation process for fiscal year 2022, is a partisan bill that would significantly increase federal spending on Medicaid HCBS. Although BPC has recommendations for advancing care for individuals with complex needs that are not included in the BBB plan, there is some overlap, as several of BBB's more targeted HCBS provisions, which were aimed at improving how the current program works, have also appeared in previous BPC reports. In particular, the BBB has changes that address, although in somewhat different ways, the same issues that have been the focus of BPC's efforts. BPC's goals include simplifying and streamlining Medicaid HCBS authorities into a consolidated state plan amendment and reducing disruptions in coverage for dual eligible beneficiaries. BPC's recommendations include:

- New quality reporting on Medicaid HCBS;[5]
- A maintenance-of-effort requirement for HCBS spending to ensure that additional federal funding supplements, not supplants, current spending levels;
- Enhanced match for administrative activities related to Medicaid HCBS;
- Resources for technical assistance and guidance to states that wish to improve their Medicaid HCBS programs;
- Permanent reauthorization for the Money Follows the Person demonstration;[6]
- A permanent state option to extend protections against impoverishment for spouses of individuals receiving Medicaid HCBS; and
- A state option for continuous 12-month eligibility for certain Medicaid beneficiaries.[7]

BBB's prospects in this Congress are uncertain, as is true for other legislation affecting policies related to complex care needs. However, it is possible that Congress will pass legislation this year that makes some of BPC's recommendations redundant.

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5 Under BPC's recommendation, HCBS quality reporting would be optional with a 1% enhanced FMAP available. Under the House and Senate versions of BBB, states would be required to report on a set of HCBS quality measures but would receive an enhanced administrative federal match of 80%.

6 This appears in the House and Senate versions of BBB.

7 BPC recommends allowing 12-month continuous Medicaid eligibility for dually eligible individuals, which is more restrictive than the provision included in the House version of BBB. This provision was included in the version of BBB that passed the House, but has not been included in the Senate version.

LOOKING AHEAD

Throughout the COVID-19 pandemic, Congress and federal agencies have created additional flexibilities and approved a variety of temporary waivers within the Medicare and Medicaid programs to support access to care during the public health emergency. These flexibilities include a wide range of actions, such as expanding the use of telehealth; relaxing provider enrollment requirements; expanding the scope of practice for many nonphysician groups; and temporarily pausing Medicaid eligibility redeterminations to ensure continuous coverage for beneficiaries. The Biden administration has extended the public health emergency several times, and it is currently set to expire on April 16, 2022. Many stakeholders urge further extension of the public health emergency, but whether the administration will agree is uncertain.

Although this report provides a policy roadmap to improve coverage for individuals with complex needs, opportunities remain to address a range of challenges experienced by this population. For example, policymakers will need to consider which flexibilities should continue after the public health emergency ends. Many groups, including BPC, have begun to explore that question and identify which flexibilities have improved the financing or delivery of services.[8] Other flexibilities that will expire, such as the Medicaid continuous coverage requirement, must be carefully unraveled by the HHS secretary to minimize burdens to states and beneficiaries. Accordingly, CMS released guidance to help states prepare to address the large volume of pending eligibility and enrollment actions.[V] Concerns continue, however, around the Medicaid eligibility redetermination process and the risk that many Medicaid beneficiaries could lose coverage or experience churn in and out of the Medicaid program due to income fluctuations common among the Medicaid population. This highlights one example of a policy issue that will become particularly important after the public health emergency, such as the need to ensure seamless enrollment and transitions between Medicaid, marketplace coverage, and employer-sponsored insurance to reduce disruptions in coverage. BPC hopes to address this and other policy gaps in future reports.

8 BPC released a request for information in 2021 to inform its forthcoming report in September 2022 on Medicare coverage of telehealth services beyond the public health emergency. To read more about the Medicare and Medicaid flexibilities used throughout the pandemic and opportunities to retain them, see The SCAN Foundation's webpage, *Sustaining Flexibilities in Medicare and Medicaid*, for reports and resources from other groups focused on these issues.

Part I – Improving Medicaid Coverage for Those with Complex Needs

This report's recommendations on how to improve care for lower-income individuals are drawn from two recent BPC reports, *Streamlining and Simplifying Medicaid HCBS Authorities* and *Guaranteeing Integrated Care for Dual Eligible Individuals*, released in October and November of 2021, respectively. Although this report discusses the goals of these policy recommendations, please see the full reports for details on current law and policy as well as a broader rationale for these recommendations.

A. SIMPLIFYING AND STREAMLINING MEDICAID HCBS AUTHORITIES

These recommendations seek to increase accessibility to HCBS in Medicaid and to advance equity in access to HCBS by streamlining and simplifying administrative requirements. This goal could be achieved by replacing the complex patchwork of state plan amendments (SPAs) and waivers with a single, consolidated state plan amendment that draws from authorities that exist under current law. Streamlining and simplifying HCBS waivers and state plan options could be addressed independently, or as part of other efforts to reform Medicaid HCBS. The SPA should provide necessary services to those in need, while giving states budget predictability.

The patchwork of waivers and SPAs that states use to deliver home and community-based services has created challenges for states and beneficiaries alike and has resulted in divergent levels of access to services both within and between states. Historically, states have relied on 1915(c) waivers to provide HCBS, as these waivers allow states to target services to certain subpopulations and provide states with budget certainty. In 2020, of the 254 active 1915(c) waivers, most targeted individuals with intellectual disabilities (91 waivers), those with physical disabilities (86 waivers), and seniors ages 65 and older (64 waivers).[vi] Multiple 1915(c) waivers have enabled states to target different populations or provide different services, with some states relying on up to 11 waivers at once.[vii]

The use of multiple waivers or a combination of waivers and state plan amendments creates an enormously complex system for states to manage and beneficiaries to navigate. States often must administer multiple programs and benefit packages with different eligibility requirements. Beneficiaries must

navigate the different sets of requirements to identify the pathway most likely to meet their needs. Additionally, the current structure encourages states to rely heavily on multiple waivers, which can lead to inequitable access to services within a state. For example, two residents of a state may have similar diagnoses and HCBS needs but may not be eligible to receive the same services due to targeting allowed under 1915(c) waivers.

Although most of the national conversation on expanding home and community-based services focuses on increasing the number of people served and strengthening the infrastructure and workforce that care for them, simplifying and streamlining Medicaid HCBS authorities by creating a single SPA would reduce complexity in the current system. This streamlining would enable states to better design and administer their HCBS programs around the needs of the beneficiary, while also improving the beneficiary experience. As described in greater detail in BPC's report, many states rely on waivers to control costs and cite this reliance as a challenge to effective administration of their programs. The U.S. Government Accountability Office (GAO) released a report in April 2020 acknowledging that many state officials GAO interviewed suggested allowing states to limit HCBS enrollment through their state plans and allowing more flexibility in their ability to target LTSS to certain beneficiaries. BPC's recommendation for a consolidated state plan amendment would address these challenges by increasing flexibility under state plan authority while preserving budget predictability for HCBS.

Recommendations

1. **Congress should establish a new, consolidated SPA, combining existing state plan options and waivers. Current enrollees should be grandfathered to prevent a disruption in services.**

This section describes characteristics of the new consolidated SPA. For a comparison of current law and the legislative or administrative action required to establish the consolidated SPA, *see Appendix I (page 58)**. For an overview of existing waivers and SPAs,* *see Appendix IV (page 91)**.*

Eligibility: Similar to rules governing Section 1915(i), states would be permitted to cover individuals with incomes up to 300% of SSI, or about 221% of the federal poverty level (FPL). States would establish functional needs criteria based on activities of daily living (ADLs), instrumental activities of daily living (IADLs), need for mental health services, or other criteria established by the state and approved by the HHS secretary. States would provide an estimate of the number of eligible individuals based on state-established criteria. States could modify the needs-based criteria without obtaining prior approval by the secretary if enrollment exceeds projections, and if it is clear that they are providing such benefits through criteria that is nondiscriminatory to certain populations. However, to ensure transparency when adopting the consolidated

state plan, states should be required to describe the process they will use to modify eligibility criteria once the enrollment projection is met.

Under the consolidated SPA, as under 1915(i), individuals would not have to meet criteria for an institutional level of care. This would permit states to offer services to individuals before their conditions require significant and more costly interventions. To advance efforts to rebalance HCBS and institutional services, states would be required to establish a more stringent needs-based criteria for individuals requiring an institutional level of care. In establishing minimum needs-based eligibility criteria for HCBS under the consolidated SPA and for services in an institution, states should ensure that standards do not harm access to care, particularly those appropriately requiring care in an institution; the intent is to delay or avoid institutional care by providing earlier access to HCBS.

Benefits: The new consolidated SPA would allow states to cover the full range of HCBS currently authorized under state plan benefits and sections 1915 and 1115 of the SSA.

Individualized Care Plan: Under the consolidated SPA, states should conduct independent assessments; develop individualized care plans in consultation with providers, caregivers, family, or representatives; and identify services to be provided. States must allow individuals to choose self-directed services. States would not be required to meet Medicaid requirements for comparability, or amount, scope, and duration of services standards; states, however, must continue to comply with federal nondiscrimination rules. In implementing the consolidated SPA, the HHS secretary should establish and enforce protections against discrimination.

Maintenance of Effort: As discussed in more detail below, to receive an enhanced administrative match under the consolidated SPA, states must comply with a maintenance-of-effort requirement for HCBS eligibility and benefit standards. This would ensure that federal funding supplements, not supplants, existing state funds expended on Medicaid HCBS, as of the date Congress passes legislation establishing the consolidated SPA.

Spousal Impoverishment Protections: When simplifying and streamlining HCBS authorities into a single SPA, Congress should permanently authorize the state option to extend protection against impoverishment for spouses of individuals receiving Medicaid HCBS.

Enhanced Match and Payment for Services

Enhanced Administrative Match: States would be eligible for an enhanced administrative match for activities related to streamlined eligibility and enrollment functions, such as those typically performed by states' "No Wrong Door" system, as well as for ombudsman activities. An enhanced match would allow states to establish administrative structures that ensure individuals

know how to access Medicaid HCBS, furthering efforts to rebalance the LTSS system and promote person-centered care in the community. To help states transition to the consolidated SPA, BPC recommends an enhanced match rate for the administrative services related to streamlined eligibility and enrollment functions, including infrastructure development. To receive the enhanced match, states must comply with a maintenance-of-effort requirement for HCBS eligibility and benefit standards to ensure federal funding supplements, not supplants, existing state funds expended on Medicaid HCBS, as of the date Congress passes legislation establishing the consolidated SPA.

Additional Enhanced Administrative Match for HCBS Quality Reporting: Existing national quality measures are clinically oriented and leave gaps for those individuals receiving services in non-clinical, home and community-based settings. Many of the quality measures in widely used measurement sets, such as the Healthcare Effectiveness Data and Information Set (HEDIS), were never designed for people with complex health needs. As users of HCBS, these patients often are excluded from many measures. While some HEDIS measures are relevant, they are often directed at measuring undesirable outcomes in clinical settings, such as readmissions, rather than the delivery or quality of care provided to patients with complex needs in home and community-based settings. They are also not designed to measure HCBS recipients' experiences while receiving care or how well services meet individuals' goals and improve quality of life.

Congress should direct the secretary of HHS to develop recommended core and supplemental sets to measure HCBS quality.[9] States that choose to measure and report on an approved set of HCBS quality measures would be eligible to receive an additional 1% Federal Medical Assistance Percentage (FMAP) increase beyond the enhanced administrative match. To promote person-centered, high-quality care, the HCBS quality measurement set should include outcome measures that reflect whether care is aligned with patient and caregiver goals.[10] In developing the recommended core set, the HHS secretary should also prioritize measures that capture beneficiary and caregiver experiences. In developing these quality measures, HHS should collaborate with the administrator of CMS, the administrator of the Administration for Community Living, the director of the Agency for Healthcare Research and Quality, and the administrator of the Substance Abuse and Mental Health Services Administration. HHS should also solicit feedback from stakeholders and incorporate their suggestions into their recommendations. States would have the option of adopting the core set

9 CMS is considering establishing a nationally available set of recommended Medicaid HCBS quality measures; in September 2020, CMS sought public feedback on a draft for a voluntary set of HCBS quality measures. Congressional action would ensure continued progress toward a nationally available set of quality measures for HCBS care delivery.

10 Existing efforts, such as the National Committee for Quality Assurance's (NCQA's) person-driven outcome measures, could inform these measures. They were developed in coordination with stakeholders and with support from the John A. Hartford Foundation and The SCAN Foundation. The National Quality Forum's (NQF's) recommendations to develop standardized HCBS quality measurements could also inform these measures.

of HCBS quality measures or another set of HCBS quality measures approved by the HHS secretary. As states adopt the proposed HCBS quality measurement set, researchers could make comparisons across states and track changes in HCBS care delivery quality over time. Establishing an HCBS quality measurement set might also encourage more health plans and HCBS providers to seek accreditation distinctions for LTSS.[11]

Maintaining Existing Initiatives: The 6% enhanced FMAP for 1915(k) and the enhanced FMAP available for the Money Follows the Person (MFP) demonstration would extend to the consolidated SPA. The MFP demonstration would be permanently reauthorized.

Under current law, states can also receive a 90% enhanced FMAP for integration and coordination of services for eight quarters through the Medicaid Health Homes model. This should continue under the consolidated SPA.

2. **CMS should clarify that under 1915(i) SPAs, states are permitted to phase in benefits, but they must provide coverage statewide when the SPA is fully implemented.**

Under 1915(i) SPAs, states must offer benefits statewide; however, there is an option to phase in and target benefits to certain populations, or phase in enrollment during the first five-year period after SPA approval.[viii] The phase-in can be dependent on the needs of a population, the availability of infrastructure to provide services, or both.[ix] States must submit a plan to CMS for approval that outlines the criteria used for the benefit phase-in. By the end of the five-year approval period, the services must be available to all eligible individuals statewide.[x]

The HHS Office of the Assistant Secretary for Planning and Evaluation has recommended that CMS clarify that a state can use the phase-in option to test new HCBS approaches in a specific geographic location before it makes these approaches available statewide.[xi] The ability to phase in enrollment and services should apply to the new, consolidated SPA as well.

3. **CMS should provide comprehensive technical assistance to states as they transition to the new, consolidated HCBS state plan authority.**

Transitioning from waivers to a state plan option would require both technical assistance and guidance from CMS, including the Disabled and Elderly Health Programs Group. CMS should work closely with states as they implement the new streamlined SPA and help states transition from current authorities to the new SPA. During this transition, CMS should also collaborate with the HHS's Administration of Community Living.

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11 For example, NCQA offers Accreditation of Case Management for LTSS.

4. **Congress should direct the secretary of HHS to collect data and issue an annual report on disparities in access to HCBS and make recommendations to Congress to address inequities.**

Currently, data on disparities in the delivery of HCBS are lacking. Disparities in access by racial and ethnic groups, disability category, and age, as well as by populations both within and across states, exist but are not well understood. Leveraging the data collected by existing systems, such as the Electronic Visit Verification (EVV) system, and combining them with demographic, disability, and waiver data reported in the Transformed Medicaid Statistical Information System (T-MSIS), can help close the gap.

As required under current law, EVV systems must collect and report data on the type of service provided, the individual who is receiving the service, the date of service, the location, the provider, and the time the service began and ended.[xii] The system's purpose is to prevent fraud by ensuring beneficiaries are receiving proper care. However, the system could also be used for other purposes. For example, some providers use their EVV systems to improve quality by sending out alerts of missed appointments so that a backup plan can be implemented quickly.[xiii] The system can also ensure timely payment to direct care workers by verifying visits on a real-time basis.[xiv]

Improving interoperability between the various systems should be explored. Ideally, the entire process—from functional assessment to verification that the approved services were delivered—should go through a single stream. Adding functional assessment data to the EVV system or linking EVV systems to care management systems that contain functional assessment data, would provide a more holistic view of an individual's care plan.

States and plans can use this information to determine whether the services are adequate to meet beneficiaries' needs. States and plans could use the information to track how beneficiaries' needs and service utilization change over time, and could draw on this knowledge to update care plans more frequently. Additionally, because EVV systems are linked to the individual's electronic health records and T-MSIS, functional assessment data could appear in those data sets as well; currently, they are not. Because T-MSIS includes demographic data, states could use the expanded metrics to study disparities in the delivery of HCBS between racial, ethnic, age, and diagnostic groups.

Although expanding the use of EVV data holds clear benefits, various consumer advocacy groups have raised privacy concerns. The most common concern is that some states could use GPS-based EVV systems to track beneficiaries and providers as they move through the community. Additionally, some EVV phone applications may continue to track location even when the individual is not logged into the app; many consumers believe this further infringes on their privacy and freedom.[xv] Notably, as discussed above in the Policy Landscape section, some legislation that has been introduced in Congress would address

the major privacy concerns by prohibiting the use of GPS and biometrics in EVV systems.[xvi]

B. INTEGRATING MEDICARE AND MEDICAID SERVICES FOR DUAL ELIGIBLE BENEFICIARIES

BPC believes that all dual eligible individuals should have the ability to access integrated care. Although states are in the best position to integrate Medicare benefits through their state Medicaid programs, not all states have the resources to achieve this outcome. BPC also recognizes that some states will choose not to integrate care. To advance integration of Medicare and Medicaid and provide equitable access to integrated care nationwide, BPC's recommendations include incentives to encourage states to integrate care themselves, as well as proposals for a federal fallback program for states that do not to integrate care.

> **All dual eligible individuals should have the ability to access integrated care.**

When Medicare and Medicaid services are not integrated, dual eligible individuals must navigate separate programs to receive health care, long-term services and supports, or other services. In states that contract with managed care plans to deliver Medicaid services, some of which may separately provide, or "carve out," certain benefits—such as behavioral health—a dual eligible individual must navigate not only separate programs but also multiple Medicaid plans. Individuals may choose to receive Medicare benefits through managed care or fee-for-service. They may obtain some Medicaid services on a fee-for-service basis but may be required to enroll in one or more Medicaid managed care plans for other services.

BPC's definition of fully integrated care requires the alignment of the financing and delivery of Medicare and Medicaid benefits through a single plan or program (see recommendation 1.a. in this section for BPC's full definition of integrated care). Existing models that meet that definition include Medicare Advantage Dual Eligible Special Needs Plans (FIDE SNPs), the Program of All Inclusive Care for the Elderly (PACE), and a managed fee-for-service model, based on a program developed in Washington state as part of the Financial Alignment Initiative demonstration.

States should take the lead in integrating care for dual eligible individuals. However, the secretary of HHS should have authority to implement a federally administered integration model—essentially a federal fallback program—that would operate in states that choose not to integrate services or do not notify the

secretary of their decision within two years after enactment of the policy; the federal fallback would be functional five years after enactment. In these states, the secretary should contract directly with FIDE SNPs or PACE organizations to provide integrated Medicare and Medicaid services. States should provide notice to the HHS secretary of their intent to either integrate care themselves or request the secretary to implement the federal fallback program.

This structure would be similar to the framework established under the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, states may establish laws governing health care information privacy, as long as those laws meet or exceed federal standards. Similarly, states would always retain the right under this approach to fully integrate care for dual eligible beneficiaries independent of a federal fallback, as long as states meet the minimum federal standard for "full integration" of coverage and care through full integration models (described below in recommendations 1.a. and 3.a). BPC encourages states to take the lead in fully integrating care by including incentives for state-led integration in the recommendations below.

Recommendations

1. Congress should establish a framework for integrating Medicare and Medicaid services for dual eligible individuals.

a. Congress should create a "full integration" standard of coverage and care for dual eligible beneficiaries.

Although 36 states operate at least one model of fully integrated care,[12] many continue to offer fragmented services by carving out benefits, such as behavioral health and long-term services and supports. As a result, in some states, dual eligible individuals remain in Medicare fee-for-service but receive Medicaid benefits through one or more managed care plans; or, they may have signed up for Medicare Advantage and receive Medicaid services through fee-for-service. Dual eligible individuals can enroll in Medicare and Medicaid managed care plans offered by the same carrier, only to find that the two plans operate independently and do not coordinate with each other. Although CMS and states have made some progress in integrating care, much of that care is not truly integrated. Dual eligible beneficiaries frequently experience fragmented care and poor health outcomes when their Medicaid and Medicare benefits are not coordinated. Integration of care will streamline and simplify services and, when done well, will improve health outcomes and patient experience.

Based on discussions with a broad range of stakeholders, BPC defines "full integration" as:

1. Fully aligned benefits and financing with a single plan or provider organization that is responsible for providing all covered Medicare and

12 The Health Management Associates issue brief defines an integrated program as including the Financial Alignment Initiative demonstrations, PACE, or a FIDE SNP.

Medicaid services to dual eligible individuals within a service area.

2. One benefit package that includes all Medicare- and Medicaid-covered services, including medical benefits, behavioral health, dental, and long-term services and supports.

3. A single enrollment period, a single set of member materials, a single point of access for enrollees to direct questions and coverage decisions, and a single grievance and appeals process.

4. A process that ensures that beneficiaries are informed of and understand their options and rights within an integrated program, and one that provides sufficient time to allow them to make decisions regarding enrollment, with strong safeguards to protect beneficiaries.[13]

5. A process that allows plans and providers to identify high-risk enrollees and provide for prompt assessments. This process would also include an interdisciplinary care team. The team would rely on a standard assessment to develop an individualized, person-centered care plan that is designed to meet the unique needs of high-risk enrollees and that is updated as needed to address beneficiaries' changing needs over time and across settings.

6. A single and streamlined set of measures across the two programs, including quality and performance measures developed for complex populations, to be used for quality improvement and to help beneficiary decision-making.

   b. **Congress should require the secretary of HHS, in partnership with states, to provide access to fully integrated Medicare and Medicaid services for all dual eligible individuals, like the approach taken under the Financial Alignment Initiative demonstration. The secretary would make integrated care available under a federal fallback program in states that decide not to integrate.**

Once this proposal is enacted, states may either choose to integrate care themselves or allow HHS to integrate care through the federal fallback program. The secretary should develop a process for states to provide notice of intent to fully integrate care, meeting the definition outlined above (which has been taken from BPC's July 2020 report, *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries*). For states that choose to integrate care themselves, services should be integrated within eight years of enactment, with mutually agreed-upon milestones between states and the secretary. The secretary should have the authority to extend the deadline by two years for states that request an extension and have demonstrated meaningful progress

13 Examples of safeguards would include preserving Medicare freedom of choice, including the right to disenroll from a fully integrated model at any time for Medicare-covered services; requiring that training for insurance brokers includes fully integrated models to improve beneficiaries' access to information on the range of models available to them; and other protections identified by the HHS secretary for dual eligible beneficiaries.

toward meeting the milestones. For states that have not indicated their intentions within two years, the secretary would implement a federal fallback to be operational within ideally five years of enactment. The shorter time frame is a recognition that the secretary should proceed with the implementation of the federal fallback, rather than waiting eight years.

Timeline

In the July 2020 final report, BPC recommended full integration of care within eight years. BPC had initially proposed a five-year timeline in the April 2020 white paper, but revised the timeline in response to stakeholder feedback. BPC received comments from states and other experts indicating that it would be difficult for some states to integrate care within five years, especially in light of the challenges they are facing during the COVID-19 pandemic. Experts recommended providing resources to states that choose to fully integrate care, creating agreed-upon milestones to measure progress, and establishing a goal of full integration within 10 years. The revised timeline of up to 10 years seeks to provide additional time to states if mutually agreed-upon milestones are met. Others raised concerns that without a federal deadline, integration would

Figure 1: Timeline for the Full Integration of Care

Year 1	States notify HHS secretary of intent to integrate services.
Year 2	**State-Led Integration:** MMCO works with states to develop timeline and milestones for state integration.
	Fallback Program: HHS secretary determines which states do not intend to integrate services.
Year 5	MMCO implements fallback program, which goes into effect for states that request the HHS secretary to integrate care or for states that do not pursue state integration.
Year 8	States pursuing their own integration must offer fully integrated models; states may request two additional years if needed, provided they demonstrate progress on milestones.

not occur. BPC adopted a hybrid approach to provide ample time and resources to states that choose to move forward, along with a five-year timeline for the federal fallback program (see Figure 1). Also see "Federal Fallback for States That Request the HHS Secretary Integrate Care" below for a detailed description of BPC's federal fallback model.

c. **Congress should provide the Medicare-Medicaid Coordination Office with funding and regulatory authority to establish and oversee full integration in all programs serving dual eligible individuals, including integrated care models implemented by states and the federal fallback program.**

For certain programs for dual eligible individuals, Congress under the 2018 Bipartisan Budget Act directed the secretary of HHS to provide regulatory authority to the Medicare-Medicaid Coordination Office (MMCO).[xvii] Although the Centers for Medicare & Medicaid Services has provided additional regulatory authority to MMCO, it did not include all programs affecting dual eligible individuals, one example being PACE. Lack of staffing and resources requires MMCO to rely on other offices within CMS for many functions. Without full authority to establish and oversee integration in all programs serving dual eligible individuals, these offices can hinder the full integration of services and create differing requirements for the various models, potentially with unintended consequences.

BPC recommends providing authority for the alignment of policies affecting dual eligible populations.

Congress should direct CMS to provide full regulatory authority to MMCO, subject to the final approval of the secretary, for all dual eligible programs, including the improved FIDE SNPs and PACE; to serve as a full partner with states seeking to integrate care; and to implement the federal fallback program. MMCO should also have the authority to issue regulations and guidance for all dual eligible programs. This transfer of authority will require a strong commitment from the HHS secretary and the CMS administrator. MMCO will need increased staffing and funding. Until a single agency within CMS has full authority to regulate all aspects of programs serving dual eligible individuals, subject to the final approval of the secretary, these programs will remain separate, with different interests and priorities.

d. Congress should provide waiver authority to the secretary of HHS to align administrative differences between the Medicare and Medicaid programs, excluding issues related to eligibility, benefits, access to care, Medicare freedom-of-choice protections, or beneficiary due process rights.

Under the Financial Alignment Initiative demonstrations, CMS used the waiver authority provided to the Center for Medicare & Medicaid Innovation to ensure full administrative alignment between programs. When, under the Bipartisan Budget Act of 2018, CMS sought to align Medicare and Medicaid for Fully Integrated Dual Eligible Special Needs Plans, HHS Secretary Alex Azar concluded that the agency lacked the authority to do so.[xviii] Moreover, some stakeholders have voiced concern that unlimited waiver authority could harm beneficiaries. As such, BPC is recommending providing authority for the alignment of policies affecting dual eligible populations. We are also recommending that such an approach should preclude the waiver of any provision that limits eligibility, benefits, access to care, Medicare freedom-of-choice protections, and due-process rights.

e. Congress should direct the HHS secretary to adopt best practices from the Financial Alignment Initiative demonstration and apply them to Fully Integrated Dual Eligible Special Needs Plans. The secretary should also convene a working group to identify best practices where they have yet to be identified.

The variation permitted under the current regulatory structure distinguishing between fully integrated and highly integrated D-SNPs has its uses during the transitional phase to full integration. However, over time the distinction between the two should be eliminated and all states should be required to meet the definition of integration outlined in recommendation 1.a. of this section.

The HHS secretary should convene a working group composed of state agency officials; representatives of consumer advocacy organizations; private health insurance plan providers; health care and non-health care providers with experience in serving complex populations, including those who have expertise in identifying and developing programs for dual eligible individuals; and other experts. The secretary should implement standards agreed upon by the working group, with the goal of adopting best practices from the FAI demonstration and applying them to FIDE SNPs.[14] The group should develop uniform standards in the following areas:

- Care management standards for integrated clinical health services, behavioral health, and LTSS, consistent with the home and community-based settings rule for non-elderly persons with disabilities.
- Network adequacy standards, including flexible, data-driven standards for Medicaid long-term services and supports, as well as the resources needed to address social determinants and risk factors, appropriate for dual eligible individuals.
- Standard materials for marketing, plan notices, and other member materials, including templates where appropriate.
- A process for a single open enrollment period.
- A process for joint oversight of plans by CMS and states.
- Alignment of Medicare and Medicaid measures, including measures of access to care, beneficiary experience, clinical quality, care coordination,

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14 CMS has begun taking steps to apply best practices from the Financial Alignment Initiative demonstration to D-SNPs including FIDE SNPs, and should continue these efforts going forward. CMS released a proposed rule in January 2022 that would apply certain FAI demonstration requirements to D-SNPs, such as a new requirement that any Medicare Advantage organization offering a D–SNP must establish one or more enrollee advisory committees in each state to solicit direct input on enrollee experiences. Finalizing and successfully implementing such provisions of the rule will be an important step toward BPC's effort to improve FIDE SNPs.

person-centeredness, and appropriateness of financial incentives among plans, providers, states, and the federal government.[15]

- A model outreach and engagement plan to help inform and educate enrollees and providers on the requirements and benefits of fully integrated care models (see recommendation to improve the enrollee experience below).

In developing standards, the secretary should ensure they are consistent with the current home and community-based services settings rule for non-elderly persons with disabilities. The secretary should also consider incorporating the National Quality Forum's work on establishing performance measures for care provided to dual eligible individuals.

2. Congress should improve enrollment and eligibility.

a. Congress should limit enrollment in fully integrated models to full-benefit dual eligible individuals. The secretary of HHS should also consider limiting beneficiary enrollment to fully integrated Medicare Advantage plans, if such an approach does not limit beneficiary access to supplemental benefits or adequate access to providers.

Full-benefit dual eligible individuals are eligible for the full range of Medicare- and Medicaid-covered services. Partial-benefit dual eligible individuals are not eligible for Medicaid benefits and receive only assistance with Medicare premiums, co-pays, and deductibles, based on income. This bifurcation of benefits has prevented the development of uniform materials. Limiting enrollment to full-benefit dual eligible individuals should have little impact on enrollees. The Medicare Payment Advisory Commission found that relatively few partial-benefit dual eligible individuals later qualified for full Medicaid benefits, and those with partial Medicaid benefits fared equally well in MA plans.[xix] States that have implemented FIDE SNPs have recognized this, and every state with a FIDE SNP limits enrollment in those plans to full-benefit dual eligible individuals.[xx]

To encourage fully integrated care for dual eligible individuals, the HHS secretary should also consider limiting enrollment to fully integrated Medicare Advantage plans, if such an approach does not limit beneficiaries' access to supplemental benefits or adequate access to providers.

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15 Efforts are underway to develop standard quality measures for complex care programs beyond cost and utilization. For more information, see Heidi Bossley and Keziah Imbeah, "Measuring complexity: Moving toward standardized quality measures for the field of complex care," May 21, 2020. Available at: https://www.nationalcomplex.care/wp-content/uploads/2020/05/Quality-measures-report_final.pdf.

b. Congress should allow auto-enrollment in state-implemented or federal fallback integration models with a beneficiary opt-out available at any time in the case of Medicare-covered services.

The FAI demonstration states were permitted to implement a system of "passive enrollment" in which dual eligible beneficiaries were auto-enrolled in a managed care plan and allowed to opt out at any time. Patient surveys found high rates of satisfaction with the care they received.[xxi] Focus groups conducted by the University of California show high satisfaction with California's financial alignment demonstration. On a scale of one to 10, the average satisfaction score for those enrolled in Cal MediConnect was eight, with beneficiaries reporting that expanded coordination services helped them navigate their managed care plan and access necessary services.[xxii] However, as discussed in an analysis prepared by Ananya Health Innovations for BPC's report, *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries* (2020), some beneficiaries choose to opt out of integrated models for a variety of reasons, including concerns about loss of established provider relationships. Individuals who opt out of the program will remain in Medicare fee-for-service or other integrated model of their choice. For those dual eligible individuals who opt out, the state will continue to provide Medicaid services.

One benefit of auto-enrollment would be to identify and enroll individuals who are eligible but not enrolled in Medicaid or are in other low-income assistance programs. This is especially important in ensuring that beneficiaries are not charged for Medicare premiums, co-pays, and cost sharing, or balance billed when Medicaid does not cover the entire cost-sharing amount. At the same time, both plans and insurance experts have indicated that passive enrollment with a beneficiary opt-out would ensure greater plan participation, avoid risk selection concerns, and provide greater choice in both the state and federal fallback programs. Auto-enrollment should also be coupled with consumer education (see recommendation B in section 5 below) about integrated care models.

Individuals who opt out of integrated programs will remain in Medicare FFS or other integrated model of their choice.

c. Congress should permit and encourage states to implement 12-month, continuous Medicaid eligibility for dual eligible individuals; it should also encourage states to reduce administrative burdens on beneficiaries.

States have the option to provide children with 12 months of continuous coverage through Medicaid and CHIP;[xxiii] and evidence demonstrates the policy is effective.[xxiv] However, states do not have

the option of offering continuous enrollment to adults in Medicaid unless they seek a waiver.[xxv] The Medicaid and CHIP Payment and Access Commission has recommended that Congress extend a statutory option for 12 months of continuous eligibility for adults in Medicaid, similar to the state option for children.[xxvi] That recommendation should be implemented to promote continuity of care for dual eligible individuals.

Because of federal eligibility requirements, almost one-third of dual eligible individuals temporarily lose their Medicaid coverage—usually for at least one month—within a year of receiving full benefits.[xxvii] Within that population, most lost their coverage for three months or longer. The most common reason is the failure to comply with administrative requirements, such as failing to complete paperwork on time.[xxviii] Transitioning in and out of Medicaid disrupts continuity of care. Loss of coverage also causes individuals to forgo primary and preventive care that can head off more costly health care. Disenrolling and re-enrolling individuals also is costly to states.[xxix]

State and federal policymakers should work to reduce administrative burdens on enrollees and ease stringent eligibility requirements by shortening and simplifying applications and lengthening the time between eligibility redeterminations, especially since this population's coverage loss is often not due to monthly income fluctuation. Policymakers should also consider eliminating or raising asset and income limits to help dual eligible individuals enroll in integrated care models and stay enrolled.

3. **Congress should provide incentives for state-administered integrated care programs.**

    a. **Congress should define and develop full integration models for states that choose to integrate care.**

These recommendations are designed to create strong incentives for states to integrate care. The report identifies three care models from which states can choose to achieve full integration:

- Improved FIDE SNPs that reflect lessons learned from the FAI demonstration's Medicare-Medicaid plans;
- The Program of All-Inclusive Care for the Elderly (PACE); and
- A flexible model negotiated between the HHS secretary and a state, building off the model used by the state of Washington.

Building on the best practices of the past 40 years, all models must cover all Medicare and Medicaid benefits and meet all integration requirements identified in BPC's recommendation B.1.a. on page 24 above.

One concern raised by states is the need for a clear roadmap to achieve integrated care. Establishing three models and clearly defining them in law would help to address this challenge. Under this approach, states would still have the flexibility to design models that meet individual state needs, including unique geographic challenges. The improved FIDE SNP should include auto-enrollment with a beneficiary opt-out. Individuals who opt out of the program will remain in Medicare fee-for-service or other integrated model of their choice. For those dual eligible individuals, the state would continue to provide Medicaid services. To encourage fully integrated care for the dual eligible, the HHS secretary should consider eventually limiting enrollment to fully integrated MA plans, if such an approach does not limit beneficiaries' access to supplemental benefits or to providers.

b. Congress should provide financial and technical assistance to states, through HHS, to support state implementation of full integration in states that notify the secretary of their intention to integrate care. This support should include funding to plan, develop, and implement these models.

Stakeholders and others recognize that states will require both financial and technical assistance to fully integrate Medicare and Medicaid services. For example, when Massachusetts integrated care for their under-65 dual eligible population, the mental health needs of the newly enrolled populations exceeded the state's capacity to provide services. As a result, Massachusetts had to spend more to bring additional outpatient mental health centers online.

At the beginning of the FAI demonstration, states could apply for up to $1 million in grants to cover the costs of designing programs and building the infrastructure necessary to integrate care. Additionally, some stakeholders noted the usefulness of contract management teams utilized in the FAI. These teams created opportunities for states and MMCO staff to work together, which allowed for a more fluid, coordinated response to issues that arose during the demonstration. Congress should encourage states and MMCO to continue these partnerships as additional states move forward.

Integration requires resources to hire staff and cover additional legal costs associated with aligning the programs, revising contracts and plan materials, and paying for other costs associated with rolling out a new program.[16] In its June 2020 report, the Medicaid and CHIP Payment and Access Commission recommended additional federal funding to train state staff in Medicare and to cover upfront costs of designing and implementing new models.[xxx]

16 See "Actions at the Federal Level to Support States Seeking to Achieve Integration" in the data brief in Appendix I of *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries*.

Congress ensuring that financial and technical assistance are available to states will be critical to helping states achieve full integration. For those states that notify HHS of their intent to integrate care, the secretary should make adequate resources and technical assistance available to them. To be eligible for financial assistance, states would be required to make one individual responsible for care integration and would have to demonstrate state- and community-level support for integrating services.[17]

c. Congress should provide the secretary of HHS with authority to develop a guaranteed shared savings program for full integration models.

One issue that states frequently mention is the lack of financial incentives to integrate care. In many cases, integration requires increased state spending under Medicaid. To the extent that savings are achieved, they arise from reduced utilization of emergency departments or inpatient hospitalization. Absent a mechanism for sharing the Medicare savings and program investments, such as those built into the FAI demonstrations, states are reluctant to move forward with integration.

Although the FAI demonstration permitted states to share in some of the Medicare savings, shared savings are not permitted at all outside of the demonstration. In developing each model, the secretary should ensure that states get a portion of the Medicare savings and that those savings are guaranteed. This means that rates to FIDE SNPs, PACE, or an alternative integrated model would be set in such a way that reductions are incorporated in the total cost of care on a per capita basis.

BPC does not recommend a specific shared savings model at this time, but Congress could consider an approach similar to that used in the FAI demonstration. For example, the Centers for Medicare & Medicaid Services could develop a benchmark payment to improved FIDE SNPs that includes 1) the state's per capita Medicaid costs for a dual eligible individual, and 2) the MA

For those states that notify HHS of their intent to integrate care, the secretary should make adequate resources and technical assistance available to them.

17 See "Conduct Environmental Scan and Assessment of State Environment" in Figure 7 in Appendix I of *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries*.

county-level, risk-adjusted benchmark. Although savings are not guaranteed and are difficult to determine, the payment under the combined benchmark would likely be reduced by 1% to 2% in the first year. Going forward, the payment would be indexed to the overall growth in national expenditures for dual eligible individuals. The federal government and the states would then share any savings, with states at a minimum getting 33% of the savings (Figure 2).

Figure 2: Hypothetical Guaranteed Shared Savings Example

Example of a Guaranteed Savings Benchmark Calculation

Year 1: Medicare-Medicaid benchmark representing 1-2% savings from prior year total FFS spending for dual eligible individuals in the state.

Years 2-5: Year 1 calculation indexed to the overall growth in national dual eligible spending.

Guaranteed Savings Benchmark and Distributed Savings Calculation (Year 1):

1. Per capita spending on dual eligible individuals (2012):

Medicare:	$17,847
Medicare:	$12,772
Total:	**$30,619**

2. Calculating Benchmark and Savings:

   Assuming a 2% reduction in the combined benchmark, in Year 1 an improved FIDE SNP would receive $30,006.62 for each dual eligible enrolled, resulting in a guaranteed per capita savings of **$612.38**, excluding additional savings achieved.

$30,619 x .98 =	$30,006.62
$30,619-$30,006.62 =	**$612.38**

3. Distribution of $612.38 in Savings:

Entity	Share of Savings	Savings
Federal Government	67%	$410.30
State	33%	$202.09

Note: This example is used solely to illustrate how a shared savings program could work. BPC does not suggest these will be the actual savings.

4. Congress should establish a federal fallback program.

a. Congress should direct the HHS secretary to fully integrate Medicare and Medicaid services for full-benefit dual eligible individuals. The federal government should recoup payments for enrolled individuals that would have otherwise been made to the state, like the approach taken in Medicare Part D for prescription drugs.

As with the process undertaken as part of the financial alignment demonstration, states and the HHS secretary would enter into a three-way contract to offer Medicare and Medicaid services with improved[18] FIDE SNPs or other fully integrated models described below. The secretary should provide guidance to states on the respective roles and responsibilities of the states and federal government. If the state requests the HHS secretary to integrate care or has not indicated within two years its intent to pursue state integration, the secretary would establish a federal fallback program. Under that program, the secretary would contract for Medicare and Medicaid services, similar to the federal role in Medicare Advantage. Key features of this federal fallback model include:

- **Eligibility:** Under the federal fallback model, states would continue to determine eligibility for Medicaid. The state and the HHS secretary, however, could define the populations eligible for integrated models through a flexible negotiation process that ensures covered populations comply with state law and policy. To ensure beneficiaries do not lose coverage under the federal fallback model, states should meet maintenance-of-eligibility requirements for this population. States would provide the secretary with current beneficiary information for the purposes of enrollment.

  Although this recommendation would not expand Medicaid eligibility, BPC has released a separate recommendation to improve access to HCBS for Medicare beneficiaries who are ineligible for Medicaid, outlined below in Section II.A. of this report.

- **Covered services:** The federal fallback model should include coverage of all Medicare-covered services, including any supplemental services offered by FIDE SNPs. The federal fallback would also cover all Medicaid services offered by the state, as of the date Congress passes legislation. The state and the secretary of HHS, however, could define the covered services through a flexible negotiation process that ensures covered services comply with federal and state law and policy. This process would resemble the negotiation process that states and CMS currently engage in to develop the memorandum of understanding under the FAI demonstration. To ensure a seamless beneficiary experience and full integration of services, no benefits may be carved out.

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18 In *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries*, BPC recommended that Congress direct the secretary of HHS to identify best practices from the FAI demonstration and apply them to FIDE SNPs. BPC refers to these FIDE SNPs that incorporate best practices as "improved FIDE SNPs."

- **Care delivery:** The HHS secretary should contract with improved FIDE SNPs to provide fully integrated care. The secretary may also contract with certain provider organizations, including PACE and other fully integrated provider organizations, that meet the principles for integration established by the MMCO.
- **Financing and benchmarks:** Financing would continue as under current law. The secretary would be authorized to make payments to plans or provider organizations for both Medicare- and Medicaid-covered services under the federal fallback program. In determining the state share, the secretary should calculate state-specific per capita rates. The benchmark itself and the inflation rates could be designed in such a way as to create incentives for states to serve specific groups of people and offer certain benefits to achieve a greater degree of consistency across the country. The federal government would recoup payments for enrolled individuals that would reflect the amount of payments that would otherwise have been made to the states for this population. This process should resemble the recoupment of funding authorized for prescription drugs when Medicare Part D was established.
- **Enrollment:** Each dual eligible individual would have the option of enrolling in a fully integrated model. Those who decline coverage would be passively enrolled in a fully integrated care model through a "smart assignment" process. To ensure continuity of care, eligible individuals would have the ability to disenroll and re-enroll in another fully integrated plan or to disenroll and remain in traditional fee-for-service for Medicare-covered benefits. Congress should direct the HHS secretary to allow individuals to disenroll and re-enroll in another plan monthly to ensure continuity of care with providers. For example, if a Medicare-Medicaid beneficiary enrolls in a new plan that does not cover their usual providers, the individual should be able to disenroll and change plans promptly to avoid care disruptions. Recent regulations permit changes every three months; the intent here is to return to previous policy when a monthly change was allowed.

The secretary of HHS should monitor and enforce regulations prohibiting D-SNP "look-alike" plans, which are non-integrated Medicare Advantage plans with disproportionately high dual eligible enrollment of 80% or more of the plan's total enrollment.[xxxi] These plans are designed to attract dual eligible individuals but are not subject to D-SNP integration requirements, such as the model of care requirement. To better address the enrollment of dual eligible individuals in non-SNP MA plans, the HHS secretary should prohibit non-SNP MA plans from directly targeting dual eligible individuals in their marketing. As discussed above, the secretary should also consider limiting beneficiary

enrollment to fully integrated MA plans, if such an approach does not limit beneficiaries' access to supplemental benefits.

- **Implementation:** The secretary, through the MMCO, should implement the program.

b. Congress should permit state participation in all aspects of policy development for integration programs.

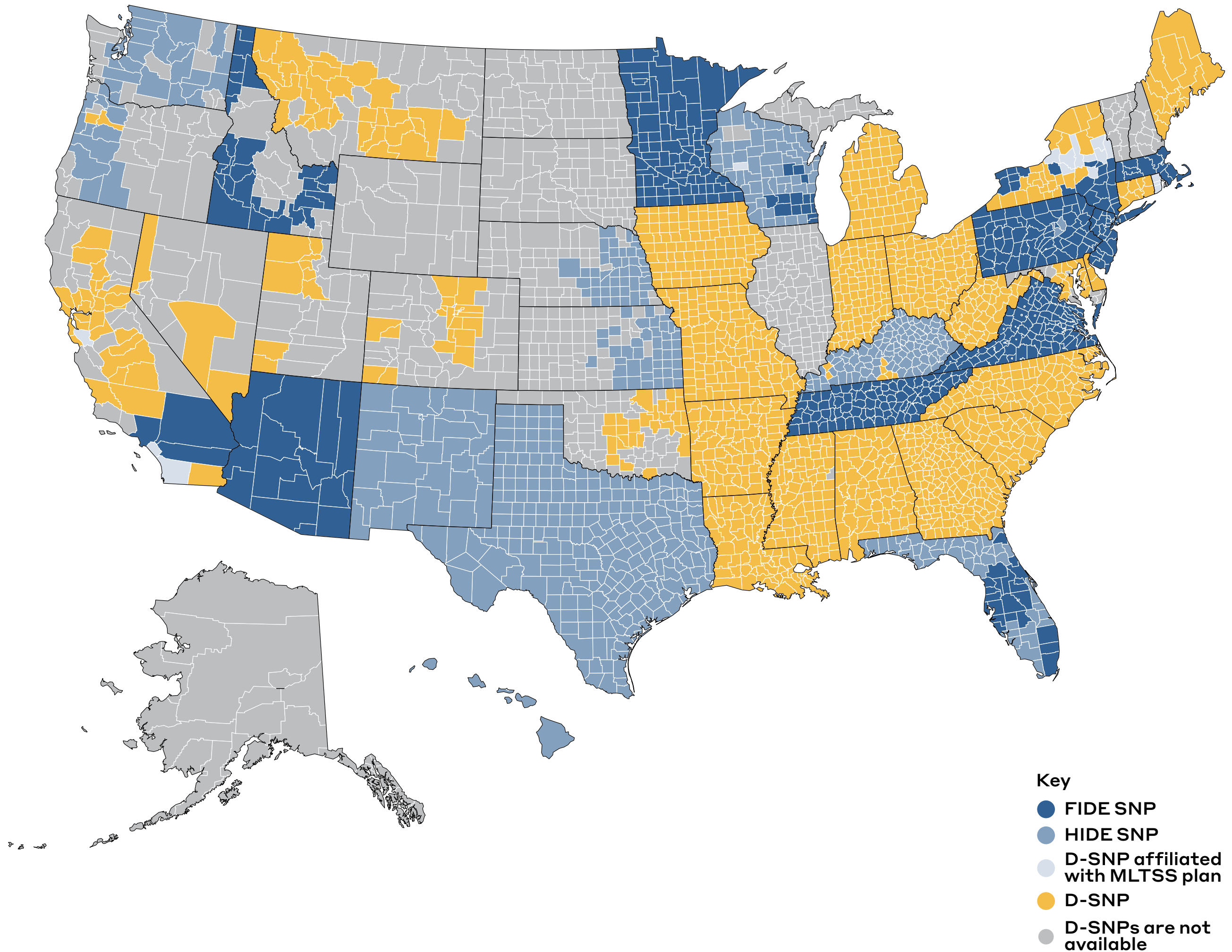
In states that elect to have the HHS secretary integrate care, the secretary should define functions that, at the state's request, the state could perform. For example, the state may choose to have the secretary integrate care, but it would have the opportunity to consult on certain functions, such as determinations of network adequacy, plan readiness reviews, conducting of stakeholder engagement forums, or education and outreach to providers and beneficiaries.

The options for state participation allowed in the federal fallback would resemble state involvement in the establishment of the individual insurance exchanges. When setting up the exchanges, states could allow the federal government to operate the program through a federally facilitated exchange, could establish and operate their own state-based exchange, or could create a hybrid state-based exchange on the federal platform.[xxxii] The state-based exchanges that operate on the federal platform would rely on HHS for certain functions, such as eligibility and enrollment processes, while the state would maintain other functions, such as consumer outreach and assistance.[xxxiii] The shared responsibilities between HHS and the state would be similar under the federal fallback.

c. To ensure options for beneficiaries in all counties, Congress should direct the secretary of HHS to require MA plans to offer at least one fully integrated plan in each service area in which they offer coverage.

States could request that the secretary exercise this authority as part of state-based integration. This option is to address the possibility that carriers do not offer plans in every county. In February 2021, 43 states and the District of Columbia were operating D-SNPs, with about 3 million dual eligible individuals enrolled.[xxxiv] However, D-SNPs were not necessarily available statewide, and the level of integration of the available SNPs varied from county to county in many states (Figure 3). If carriers were required to offer at least one fully integrated plan in each service area they covered, the availability of fully integrated options would expand greatly, both increasing capacity for and improving access to integrated care for individuals who live in states with existing D-SNPs.

Figure 3: Most Integrated Type of Dual Eligible Special Needs Plan Available by County, 2021



Source: MACPAC, 2021

Notes: The map shows the most integrated type of D-SNP available in each county as of February 2021. Muliple types of D-SNPs may be avaiable in the same county. FIDE SNP is fully integrated dual eleigible special needs plan. HIDE SNP is highly intergrated dual eligible spacial needs plan. MLTSS is managed long-term services and supports. D-SNPs are affiliated with MLTSS plans when they are operated by the same parent company. Medicare-Medicade Plans offered under the Financial Alignment Initiative, not shown on this map, are available in 9 states. California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, and Texas.

5. **Congress should improve the beneficiary experience.**

   a. **Congress should direct the HHS secretary to require collaboration between CMS, the Administration for Community Living, and states to implement model standards for outreach and education. It should also increase funding to the State Health Insurance Assistance Program so it can expand and improve information and counseling for dual eligible individuals.**

A fundamental goal of integrating care for dual eligible individuals is to eliminate the administrative complexities of accessing needed care and improving overall health and well-being. The federal government, through the State Health Insurance Assistance Programs (SHIP), assists Medicare-eligible individuals in better understanding coverage options, Medicare premiums, and cost-sharing, and it assists beneficiaries when they are applying for Medicaid.[xxxv] The Administration for Community Living (ACL), within HHS, administers SHIP program grants for free local health coverage counseling and assistance for Medicare-eligible individuals and their families.

As the complexity of coverage options for dual eligible individuals has grown with the addition of new options, the FY2022 budget proposed increasing funding for SHIP by about $3 million.[xxxvi] Funding for this program should be increased to better assist dual eligible individuals in understanding the potential benefits and drawbacks of enrolling in a fully integrated care model.

Experts also suggested that increased funding be used to improve counseling services by providing better education and training. As part of the collaboration between agencies, CMS should revise the Medicare Plan Finder to address the unique challenges associated with providing information to dual eligible beneficiaries. Development and maintenance of Web-based decision support and enrollment tools should be a priority, as well as integrated, person-centered systems designed to inform older individuals and people with disabilities about the full range of benefits for which they are eligible. CMS and ACL can draw from existing tools to address this need,[xxxvii] e.g., My Care, My Choice.

   b. **Congress should provide resources and technical assistance to states for consumer, provider, and plan engagement and education, and should encourage states to prioritize partnerships with community-based organizations and local governments.**

States play a significant role in beneficiary outreach. The lack of education for consumers and health care providers is a major challenge to increasing enrollment in fully integrated programs. In the initial FAI demonstration states, dual eligible individuals were enrolled in integrated health plans with little understanding of the program or the plans.[xxxviii] At the same time, health

care providers who did not want to participate in the plans encouraged their patients to disenroll. Because dual eligible individuals can disenroll at any time—an important beneficiary safeguard— the result was a significant drop in enrollment.[xxxix]

Since the early days of FAI demonstration implementation, states began investing in the education of consumers and providers. However, states with limited resources have been less able to do this. The HHS assistant secretary for planning and evaluation has encouraged states to take a more active role in educating dual eligible individuals on the benefits of these integrated programs, and the results have been positive.[xl] Yet, states need greater resources to support these activities.

Congress should provide increased resources and technical assistance to states for consumer, provider, and plan engagement and education, and should encourage states to prioritize partnerships with community-based organizations and local governments. Solutions include an ombudsman program, as well as special employment initiatives, to encourage plans to hire consumers who can provide insight into beneficiaries' concerns and ways to address those concerns.[19] For example, ongoing education in Arizona "has made beneficiaries more aware of the advantages of being in aligned plans for their Medicaid and Medicare benefits."[xli] The creation of a technical assistance center focusing on consumer education and outreach could support these efforts. This center could also increase state adoption of best practices and ensure more uniform consumer experience across state lines. Existing initiatives, such as funding under the FAI demonstration for ombudsman programs ($24.4 million for 10 states) and one-on-one counseling programs ($8.5 million for eight states), could help to inform the amount needed.[xlii]

c. The HHS secretary should use their authority to improve and expand training for insurance brokers by including a training module on fully integrated models.

A recurring theme in stakeholder comments was the concern that insurance brokers could potentially confuse dual eligible individuals. There seemed to be a consensus that plans and beneficiaries would be better served if brokers were more knowledgeable about fully integrated models and the needs of dual eligible individuals. CMS sets minimum requirements for annual training and testing of insurance brokers authorized to enroll beneficiaries in Medicare Advantage or Part D plans,[xliii] as outlined in 42 CFR § 422.2274, 423.2274. CMS should expand training to include required education on fully integrated models and dual eligible individuals.

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19 See "Lessons Learned and Critical Success Factors" in the data brief in Appendix I of BPC's report, *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries*.

C. ADDRESSING BARRIERS TO MEDICAID BUY-IN PROGRAMS FOR WORKERS WITH DISABILITIES

In the late 1990s, Congress recognized that federal policy not only established low expectations for people with disabilities to live and work independently but also recognized that the Medicaid program created disincentives to work. Congress, along with the Clinton and George W. Bush administrations, enacted laws creating two optional Medicaid eligibility groups through Section 4733 of the Balanced Budget Act (BBA) of 1997 and Section 201 of the Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999.

Although Medicaid is the primary source of health insurance for people with significant disabilities, the program provides much more than health care services. Medicaid allows individuals with disabilities to live independently in the community. It also covers case management services, transportation, specialized medical equipment and supplies, and home and community-based services—including personal care assistant services—among other services not covered by Medicare or private health insurance.

BBA and TWWIIA provided additional flexibility for states to offer Medicaid coverage to higher-income individuals with disabilities who—excluding income—meet the Social Security definition of disability. Together, these programs are referred to as Medicaid Buy-In (MBI) for Workers with Disabilities. Separate and distinct from recently implemented Medicaid Community Engagement Demonstrations with work requirements, the Medicaid Buy-In eligibility option gives workers with disabilities access to Medicaid community-based services not available through other insurers.

Research has shown that promoting employment for workers with disabilities is also cost effective for state Medicaid agencies. MBI participants have better health outcomes and lower Medicaid utilization rates than their nonworking peers with disabilities. Employers also benefit from hiring workers with disabilities—demonstrated by increased profits and cost effectiveness, higher employee retention, increased reliability and punctuality, employee loyalty, and improved company image.

In 2020, BPC reached out to stakeholders and hosted public and private discussions with experts on the topic. Participants included current and former state and federal officials, consumers, and policy experts. Based on those discussions, BPC developed recommendations to improve Medicaid Buy-In programs for working people with disabilities. These recommendations were included in the report, *Improving Opportunities for Working People with Disabilities*, which BPC released in January 2021.

The recommendations that follow include ways to make Medicaid Buy-In programs for working people with disabilities more understandable, more accessible, and more relevant as states seek to ensure pathways to successful employment outcomes for these workers. Strong leadership at the federal and state level is critical to successfully implementing these recommendations.

Recommendations

Improving Medicaid Buy-In programs for workers with disabilities will require both administrative and legislative action. In the near term, providing additional agency guidance on the combined authorities—Section 4733 of BBA of 1997 and Section 201 of TWWIIA—and issuing regulations on the two programs will help clarify the range of flexibility available to states. Over the long term, Congress should pass legislation to combine authorities to streamline and simplify the programs. Recommended actions include:

1. **The administration should issue an executive order that clarifies and simplifies the current Medicaid Buy-In programs for workers with disabilities.**

   a. **The administration should direct CMS to issue agency guidance identifying the full range of authority available to states to design, improve, and expand Medicaid Buy-In programs for workers with disabilities.**

In June 2021, President Biden signed an executive order that included provisions to advance an equitable, accessible, and inclusive environment for federal employees with disabilities.[xliv] The executive order focused on equity in the federal workforce and did not address MBI programs for workers with disabilities. An executive order directing HHS to issue guidance through CMS on MBI programs for workers with disabilities would complement the administration's recent effort to advance equity for federal employees with disabilities.

   b. **The administration should instruct CMS to change the name "Medicaid Buy-In" to "Medicaid for Workers with Disabilities."**

The term "Medicaid Buy-In" has been applied more broadly across the Medicaid program in recent years. This has caused confusion and made apparent the need for more precise language when referring to Medicaid benefits provided to workers with disabilities.

2. **HHS/CMS should issue regulations on Medicaid Buy-In programs.**

Although CMS released informal agency guidance between 1997 and 2000, it has not issued final regulations or provided additional guidance in the past 20 years.

a. **HHS/CMS should issue a Notice of Proposed Rulemaking (NPRM) to give CMS the opportunity to address topics not addressed through informal guidance.**

Examples of issues to examine include retaining Medicaid when a beneficiary takes a medical leave from work and widening the eligibility age for MBI programs beyond age 65 to conform with the Social Security retirement age of 67. HHS and CMS should also look at how assets are treated after enrollment, and the controversial issue of how work is defined. This process would entail soliciting input from consumer organizations, states and other experts, and would require HHS to address relevant comments or questions arising from the NPRM, providing further clarification to help guide states.

3. **Congress should consolidate Medicaid Buy-In authorities.**

Although it is possible to formulate MBI programs for working individuals with disabilities by combining multiple statutory authorities with waivers, it would be easier for states to implement these programs through consolidated authority.

a. **Congress should update, consolidate, and streamline existing authorities into a single state option.**

This option should permit states to offer the full range of Medicaid benefits, a subset of Medicaid benefits designed to supplement employer-sponsored insurance, and other private health insurance coverage.

b. **Congress should reauthorize TWWIIA-funded Medicaid Infrastructure Grants and appropriate funding to help states develop programs and study best practices in other states that have successfully promoted MBI options.**

This would include reauthorizing TWWIIA-funded Medicaid Infrastructure Grants to promote outreach and education about the MBI, as well as to promote successful employment outcomes for people with disabilities. The program should convene stakeholders to address barriers to earnings and employment experienced by people with disabilities who often rely on HCBS to allow them to work. Issues to address include transportation barriers, skills training, and employer outreach.

Part II – Options to Improve LTSS for Individuals Not Qualifying for Medicaid

In this section, the policy options are designed to help middle- and higher-income individuals access LTSS, so the recommendations are generally aimed at those whose incomes and resources are too high to qualify for Medicaid. Many of these individuals are at risk of spending down into the Medicaid program. More than 15 million Americans ages 65 and above are economically insecure—living at or below 200% of the federal poverty level in 2021.[xlv] Two hundred percent of the FPL annually ($25,760 for a single person last year) translates to $2,146 per month— just a few hundred dollars above eligibility caps for several Medicaid programs designed for older adults.[xlvi] Improving access to long-term care outside of the Medicaid program will prevent or slow the process of individuals spending down their resources; it will also lower the inequities experienced by middle- and higher-income populations trying to access LTSS.

A. ESTABLISHING AN HCBS BUY-IN THROUGH INTEGRATED MODELS OF CARE

The Medicaid program is the primary payer for HCBS. However, a significant need for access to these services exists outside Medicaid. As the baby boom generation continues to age, many Medicare beneficiaries who are not eligible for Medicaid will wish to access care that allows them to remain in their home or community. The following recommendation from BPC's report, *Bipartisan Solutions to Improve the Availability of Long-term Care* (2021), would create a pathway for eligible Medicare beneficiaries to buy in to certain integrated models so they can receive some HCBS. Sliding-scale subsidies would be available for individuals with low to moderate incomes. BPC contracted with ATI Advisory to model the federal cost of three potential HCBS service packages and the total number of beneficiaries likely to be served.

Recommendations:

1. **Congress should allow Medicare beneficiaries who are ineligible for Medicaid to purchase LTSS coverage through fully integrated care models, including improved FIDE-SNPs, PACE, or other models approved by the secretary of HHS.**

   Services: Home and community-based services would be available through fully integrated health plans and providers. In a set of recommendations,

BPC suggested Congress require states to integrate Medicare and Medicaid services for dual eligible individuals (Section B in Part I above). If adopted, all Medicare beneficiaries would have access to integrated models, including FIDE SNPs, PACE, or other integrated medical home models.[20] Eligible Medicare beneficiaries could choose one of three benefit packages:

- A set of services with a fixed dollar amount, to be used by beneficiaries to address their individual needs, similar to the Community Aging in Place—Advancing Better Living for Elders (CAPABLE) program.[21]
- Personal care assistance services, totaling up to 10 hours per week.
- Services covered under Section 1915(c) of the Medicaid program.[22] (Note: for the purposes of estimating the federal cost of an HCBS benefit package, BPC is assuming this is the most expensive of the three options, and the package is set at the 90th percentile of per capita state spending for 1915(c) waiver services.)

Eligibility and Federal Subsidies: Eligibility would be limited to Medicare beneficiaries who meet functional eligibility requirements and who are not Medicaid-eligible. The functional eligibility criteria would be defined through a mix of factors, such as an individual's ability to perform activities of daily living or instrumental activities of daily living and clinical criteria related to the diagnosis of an injury, illness, or disability.[xlvii] To determine the potential costs of the three benefit packages, ATI Advisory calculated estimates using both a standard[23] and expanded[24] definition of the

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20 This policy is designed to be consistent with BPC's earlier recommendation to require states to offer fully integrated Medicare and Medicaid services to dual eligible individuals within eight to 10 years. In states that choose not to integrate services, qualifying Medicare beneficiaries would be able to enroll in a fully integrated Medicare Advantage special needs plan or other fully integrated model, established through a federal fallback. These policy proposals for integrating Medicare and Medicaid are outlined in *A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries* (2020).

21 The Community Aging in Place—Advancing Better Living for Elders (CAPABLE) program was developed at the Johns Hopkins School of Nursing. The time-limited program aims to help participants decrease fall risks, improve functional status and independence, and age safely at home. Key components of the program include home-based, one-on-one care from a registered nurse (who provides four visits to each participant), an occupational therapist (who provides six visits to each participant), and a handyperson (who provides up to $1,200 in services, including home modification). See Johns Hopkins School of Nursing, "Community Aging in Place – Advancing Better Living for Elders (CAPABLE)." Available at: *https://nursing.jhu.edu/faculty_research/research/projects/capable/index.html*.

22 1915(c) HCBS include "case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness." § 1915(c)(4)(B) of the Social Security Act.

23 "Standard" eligibility assumes individuals:
- Need help with 3+ ADLs, or
- Have a diagnosis of Alzheimer's disease/dementia/other cognitive impairment, and need help with 2 ADLs, or
- Have a diagnosis of Alzheimer's disease/dementia/ other cognitive impairment, and need help with 0-1 ADLs and 3+ IADLs.

24 "Expanded" eligibility assumes individuals need help with 2+ ADLs and 3+ IADLs.

population that could be eligible to enroll in the package. BPC plans to further explore in detail how functional eligibility criteria would be set; this future work will also examine program administration, among other issues.

- These "qualifying beneficiaries," with incomes at or below 221% of the FPL (300% of SSI)[25] would be eligible for low-income subsidies and would incur no cost for HCBS. In 2021, 300% of SSI is $2,382 per month for an individual.[xlviii]
- A partial subsidy would be available to those whose incomes fall between 221% and 400% of the FPL. In 2021, 400% of the FPL was $4,293 per month for an individual.[xlix]
- Medicare beneficiaries who are ineligible for subsidization could access HCBS through Medicare Advantage or other integrated model by paying the full cost of the services they choose. This may prove to be a valuable option for them, as the plans are likely to secure discounted rates for HCBS, and to provide those services more conveniently than is the case today.

BPC chose the 300% of SSI as a cut off for the full subsidies to help create equity between institutional care and HCBS, as states may provide nursing home care to individuals with incomes up to 300% of SSI.[l] Participating plans and providers would receive a full subsidy for the cost of providing HCBS to qualifying Medicare beneficiaries whose incomes fall below 221% of the FPL and a partial subsidy for qualifying Medicare beneficiaries whose incomes fall between 221% and 400% of the FPL.

Estimated number of newly eligible individuals: BPC contracted with ATI Advisory to estimate the federal cost of the three HCBS packages and the total number of beneficiaries likely served. Based on the ATI analysis, the number of individuals newly eligible for services would be 2.2 million (1.1 million under 221% of the FPL, 587,000 between 221% and 400% of the FPL). For the most expensive benefit package, which is the 90th percentile of state spending on 1915(c) waiver services, BPC assumes 50% of the population eligible for a full subsidy and 5% of the population eligible for a partial subsidy would enroll (since their cost would still be about $1,400 per month). Approximately 587,000 individuals receiving varying amounts of subsidies are estimated to enroll.

Costs for unsubsidized individuals: ATI Advisory estimates that by accessing HCBS through integrated models, eligible Medicare beneficiaries would see savings of 12% to 23%, based on current Medicaid fee schedules

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25 Under current law, states may offer nursing home services to individuals with incomes up to 300% of SSI. This policy would fully and partially subsidize the benefit for eligible individuals who enroll in an integrated plan and have incomes below 300% of SSI or between 221% to 400% of the FPL, respectively.

and the assumption that the savings would be reflected in reduced buy-in amounts. This range is based on the difference between Medicaid and private-sector personal care reimbursement, with an overall difference of 23% between the two payers, and an average that results in a 12% decrease on private payer reimbursement.

To determine potential savings for unsubsidized individuals, ATI Advisory analyzed personal care services reimbursement from 14 states with geographic, demographic, and programmatic diversity: California, Colorado, Connecticut, Florida, Idaho, Maine, Mississippi, Montana, Nevada, North Carolina, Oklahoma, South Carolina, Washington, and Wisconsin. Calculated hourly rates for Medicaid in the sample ranged from $14 to $30.48, with an average across the states of $18.45. A 2020 survey of private home health aides found the hourly rate ranged from $17 in Louisiana to $33 in Minnesota, with a national average of $24 per hour.[li] The national average cost for private homemaker services in 2020 was $23.50.[lii]

Cost of Federal Subsidies: For the purpose of determining the cost of this proposal, BPC assumes the most comprehensive and expensive package of services, which includes 1915(c) waiver HCBS, at a value reflecting 90th percentile state spending. The estimated cost of this approach would be $127.5 billion over 10 years (not adjusted for inflation). For a summary of costs, see Figure 1 in Appendix II. This policy also assumes conservative estimated savings associated with reduced hospitalization, readmissions, emergency department visits, and other post-acute care based on the experiences of states participating in CMS' Financial Alignment Initiative.

Payments to MA plans and Other Eligible Integrated Models: CMS would provide an add-on to the Medicare benchmark payment to plans to cover the cost of providing HCBS. Medicare Advantage plans and other eligible integrated models would act as care managers and marketplaces. They would also negotiate rates with agencies for personal care assistance hours and would manage and integrate health care and LTSS.

Enrollment: Qualifying beneficiaries who are eligible for full subsidies, meaning they have an income of up to 221% of the FPL, could enroll at any time, but other qualifying beneficiaries would enroll during Medicare's open enrollment period.

Adverse Selection Associated with Voluntary Enrollment: BPC was concerned about the impact of adverse selection on federal costs for those who receive full or partial subsidies, and the buy-in cost for unsubsidized enrollees. Because program services would be available at enrollment, a more comprehensive package of services would attract individuals with the highest levels of complexity, thereby increasing the average monthly cost over time. While it is impossible to completely mitigate the effect of adverse selection, BPC sought to account for and address this problem in two ways:

- *Assuming the Highest Potential Cost for Subsidized Individuals* – Costs are based on the 90th percentile of state per capita spending for 1915(c) waiver services. These services are available only to individuals at risk for institutionalization and thus have very high needs. BPC therefore assumes that all enrollees will be the highest-cost individuals. Although there is a normal distribution even within the "institutionally eligible" population, some degree of adverse selection is likely. However, BPC believes any associated costs have been accounted for by assuming high costs.

- *Basing Buy-In on the Actual Cost of Services for Unsubsidized Individuals* – BPC asked ATI Advisory not to think of this proposal as an insurance product under which a plan or provider goes at risk for the cost of services, but instead to think of the plan or provider as a facilitator of services. Plans and providers would charge individuals an amount that represents the average per capita cost of providing services to enrollees each year, less any potential savings associated with care management or integration of services. In summary, the buy-in services should not be considered an insurance product; rather than purchase care directly, individuals could choose to purchase a bundle of services and care management from a plan or provider at what BPC believes would be a lower cost, given the purchasing power of the plan or provider.

To further address costs associated with adverse selection, other options for consideration could include late enrollment penalties, similar to approaches used in Medicare Parts B and D.

Treatment of Dual Eligible Individuals: Financing of HCBS for dual eligible individuals who receive long-term care through Medicaid would continue as mandated under current law. States would be required to maintain their level of spending on HCBS as of date of enactment, and that amount should be adjusted for inflation over time.

Discussion on Program Administration: One open question is how to administer HCBS offered through Medicare Advantage plans and other integrated models. Each of three options for an HCBS expansion—through the federal government under the Medicare program; through states under the Medicaid program; or through an alternative financing model—presents both opportunities and challenges. If done through Medicaid as a buy-in for higher-income individuals, the program would benefit from state experience in contracting for HCBS. However, those residing in states that choose not to operate the program would not receive services. Because BPC assumes that states will continue to finance HCBS for dual eligible individuals, adding this benefit under the Medicare program would set a precedent for excluding certain beneficiaries from a Medicare benefit. Alternative financing models and their feasibility could also be

explored. BPC plans to continue developing this proposal and will provide recommendations on program administration through future work.

See Appendix II for an executive summary of the ATI Advisory report. The full ATI Advisory report with cost estimates for three other benefit package designs can be found here.

B. IMPROVING CHRONIC CARE

Under the Bipartisan Budget Act of 2018, Congress provided authority for MA plans to offer, beginning in January 2020, special supplemental benefits for the chronically ill (SSBCI) that are not primarily health-related.[liii] These benefits must have a reasonable expectation of improving or maintaining an individual's health or function (for example, the ability to perform normal activities of daily living, such as bathing and dressing). Under HHS guidance, plans can determine what benefits to offer, subject to approval by the secretary.[liv] SSBCI are financed within existing Medicare payments to plans; as a result, neither enrollees nor the federal government faces added costs. Under agency guidance, plans may offer benefits, such as medically tailored, home-delivered meals beyond those already permitted in Medicare Advantage; non-medical transportation; fresh produce; and services supporting self-direction, home modifications, or other benefits.[lv]

Advocacy groups, as well as some plans and providers, have raised questions about the implementation of SSBCI.[lvi] Concerns include the adequacy of consumer information about the benefits, whether beneficiaries qualify, and whether providers will have the information they need to provide referrals for services. These groups have also raised concerns about marketing practices that could cause Medicare-Medicaid beneficiaries—who already have reduced cost-sharing and Medicaid-covered services through Medicare Advantage D-SNPs and Medicaid fee-for-service—to enroll in an MA plan, resulting in a loss of benefits.[26]

BPC's Health Project has long advocated for an enhanced number of well-structured and defined options for beneficiaries, including Medicare Advantage as well as alternative payment models (APMs) such as accountable care organizations (ACOs), to improve value in the U.S. health care system. In MA and in APMs with two-sided risk—meaning providers may retain a portion of savings and are responsible for excess costs—there are disincentives to covering services that add costs unless they result in an overall reduction in health spending.

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26 Notably, in California and Ohio (two of the Financial Alignment Initiative Demonstration states), The SCAN Foundation and the National Council on Aging developed the My Care, My Choice online tool that assists Medicare-Medicaid beneficiaries in choosing a plan. Although this tool may prevent choices that would result in loss of benefits, these educational tools are not available in every state.

Half of individuals with complex needs are enrolled in MA, while half receive health care services through Medicare FFS.[lvii] For those receiving care under Medicare FFS, either by choice or because MA plans offering SSBCI are not available, there are opportunities to improve care and offer similar non-medical benefits to individuals with chronic conditions. The availability of these services is particularly critical in rural areas where MA plans have limited market penetration.

In traditional Medicare Part B fee-for-service and non-risk-based APMs, in which providers are not responsible for the total cost of care, added costs could potentially be passed along to beneficiaries in the form of higher cost-sharing, higher premiums, or added costs to taxpayers for the federal government's share of Part B spending.

While Congress should provide authority to the HHS secretary to approve coverage of non-medical benefits for individuals with chronic conditions in Medicare FFS, it should be done through APMs, such as accountable care organizations and primary care models, as well as for individuals receiving chronic care management (CCM) services. To address concerns about increased costs and utilization of services, coverage of non-medical benefits should be subject to conditions, including strong evidence of efficacy and cost-effectiveness. The following recommendations were included in BPC's reports *Next Steps in Chronic Care*, released in July 2019, *Improving Care for Patients with Serious Illness: Part 1*, released in October 2018, and *Improving Care for Patients with Serious Illness: Part 2*, released in November 2018. As a part of this work, BPC contracted with Ananya Health to complete an analysis of providing special supplemental benefits to those enrolled in traditional Medicare FFS (see Appendix III).

Recommendations:

1. **Congress should expand non-medical benefits in Medicare fee-for-service.**

    a. **Congress should give the HHS secretary authority to identify and authorize coverage of and payment for evidence-based, non-medical benefits for patients with chronic conditions under the following conditions:**

    - Peer-reviewed evidence demonstrates that the benefit improves or maintains health or function for a specific subset of patients with certain chronic conditions and/or functional limitations.

    - The CMS Office of the Actuary certifies that coverage of the defined benefit for the defined population would result in no net increase in Medicare spending.

- The chronic condition is being managed by an ACO, a comprehensive primary care model, through chronic care management, or through other payment or delivery models that include a care management component.

b. **In establishing eligibility for non-medical services, the HHS secretary will need to make coverage decisions based on both chronic conditions and functional status. To facilitate this, Congress should direct the secretary to develop a uniform functional assessment tool and define the conditions under which providers would perform the assessment.**

c. **Congress should direct the secretary to establish criteria for organizations that would be eligible to provide non-medical services identified by the secretary in traditional Medicare FFS. The secretary should also establish monitoring programs to minimize fraud, waste, and abuse.**

d. **For any new evidence-based benefits for the chronically ill, the HHS secretary should make available to Medicare providers a list of suppliers in the geographic area in which they provide services.**

e. **Congress should direct the secretary to examine potential modifications to the risk-adjustment model to ensure more accurate predictions of medical expenses for Medicare beneficiaries with functional limitations. The secretary should consider the appropriateness of developing a tool that can determine eligibility and assess risk.**

2. **Congress should improve the chronic care management benefit.**

a. **Congress should eliminate the beneficiary co-pay for CCM services covered under Medicare for calendar years 2024, 2025, and 2026, because the benefit covers provider-to-provider communications outside an office visit and are not obvious to the beneficiary.**

Once this is enacted, CMS should conduct an evaluation to determine whether elimination of the co-payment increases the use of an inappropriate number of services—the primary concern with permanently extending the policy. The HHS secretary should also collect data on whether payment is sufficient to promote the coordination of care for patients with serious illness and adjust the payment based on that data no later than calendar year 2026.

b. **Congress should expand the list of qualified health providers who can bill for CCM services to include licensed clinical social workers working within the scope of practice in such a way as to maximize cost-effective care and minimize program costs.**

Once this change has been made, CMS should clarify the language in both CCM and transitional care management code guidance to permit qualified health providers, such as licensed clinical social workers, to bill under both codes for clinical staff time on the interprofessional team.

c. **Congress should direct the HHS secretary to eliminate beneficiary co-payments for advance-care planning for calendar years 2024, 2025, and 2026.**

The secretary should conduct a review to determine the impact on use and make a recommendation to Congress to permanently waive co-pays if the waiver increases utilization and promotes improved patient decision making.

3. **The HHS secretary should improve the availability of non-medical health-related services and supports in the home and community.**

a. **The HHS secretary should direct CMS and the Administration for Community Living to develop a model contract that could be used to facilitate referrals, coordination, and reimbursement for non-medical, health-related services.**

In developing the model contract, the secretary should consult with Medicare Advantage plans, community-based organizations, and public and private agencies. MA plans and community-based organizations could use the model contract to facilitate partnerships between plans and established social service providers in a community.

C. CREATING A CAREGIVER TAX CREDIT

BPC's September 2021 report, *Bipartisan Solutions to Improve the Availability of Long-term Care*, discussed provisions of current tax benefits available for family caregivers, and recommended the following expansion.

Recommendation:

1. **Congress should establish a refundable tax credit to help caregivers with out-of-pocket costs for paid LTSS-related care.**

The proposal would provide a refundable tax credit equal to 30% of a caregiver's qualified out-of-pocket LTSS-related expenses, up to a maximum $3,000 credit for each older family member (i.e., requiring $10,000 worth of expenses to claim the full $3,000 refundable credit). BPC chose to make the tax credit refundable to help subsidize the expenses of those who have no tax liability. The credit would begin phasing out for couples with an annual household income above $120,000 (or $80,000 for single filers),

and fully phase out at $200,000 for couples (or $133,000 for single filers). For the family caregiver to qualify for the credit, the older family member would need to meet certain family or co-dweller relationship criteria with the family caregiver, and the older family member would have to meet the HIPAA standard for functional or cognitive impairment. For out-of-pocket costs to count toward the tax credit, expenditures for goods, services, and supports must assist the care recipient in accomplishing activities of daily living or instrumental activities of daily living and must be provided solely for the use of the qualified recipient.

BPC's 2017 report, *Financing Long-Term Services and Supports*, explored this refundable caregiver tax credit and contracted with the Urban Institute to evaluate the cost to the federal government.[lviii] At that time, the Urban Institute estimated that the 10-year federal budgetary cost of the tax credit, in the form of reduced federal revenues and increased tax expenditures, would be $130 billion over the 2018-2027 window.[lix] The analysis assumed that approximately 10.9 million taxpayers would claim the proposed caregiver tax credit each year during that period.[lx]

D. IMPROVING THE AVAILABILITY AND AFFORDABILITY OF PRIVATE LONG-TERM CARE INSURANCE

BPC's September 2021 report, *Bipartisan Solutions to Improve the Availability of Long-term Care*, outlined the current challenges with private long-term care insurance and made the following recommendations.

Recommendations:

1. **Congress should standardize and simplify private long-term care insurance to achieve an appropriate balance between coverage and affordability, by making "retirement long-term care insurance" (LTCI) available.**

To address the needs of higher-income Americans who may have long-term care needs, Congress should address statutory and regulatory barriers to permit the sale of lower-cost, limited benefit plans, which BPC calls "retirement LTCI" plans. Congress should ask the National Association of Insurance Commissioners (NAIC) to develop model laws and regulations for these simplified, standardized policies. Retirement LTCI policies should be standardized with three basic plan designs. Each design would have limited options for customization. All retirement LTCI policies would have the following features:

- Plans would have a nonlevel premium design with premiums growing annually at a rate linked to the urban consumer price index until the

policyholder reaches age 75, at which point premiums will stay level and carriers will be required to update premiums every three years based on changes to assumptions on interest rates, investment rates, and lapse rates; and every six years based on changes to assumptions on mortality, morbidity, claim severity, and claim duration, with changes continuing until the policyholder reaches age 85.

- Plans would be tax-qualified and deemed partnership-qualified in states that have adopted long-term care partnership programs. In these states, individuals who purchase a partnership-qualified LTCI policy may exempt additional assets from Medicaid resource tests should they eventually exhaust their savings and rely on Medicaid-covered LTSS.

Consumers would have a choice among basic retirement LTCI features, such as daily coverage amounts, length of benefit period, and the size of the cash deductible, which would in turn simplify consumer decision-making. This lower-cost product would cover two to four years of LTSS needs. The policies would reduce but not eliminate the following: 1) the use of personal and retirement savings for out-of-pocket spending for paid services; and 2) the reliance on friends and family members to provide unpaid care.

2. **Congress should incentivize employers to offer retirement LTCI and to auto-enroll certain employees (ages 45 and older with minimum retirement savings), with an opt-out similar to many employer-sponsored retirement savings accounts.**

To improve the availability of LTCI, employers and health insurance exchanges should be required to offer the LTCI option when individuals are seeking health insurance coverage. Employers would not be required to contribute to premiums. To further improve the uptake of retirement LTCI, automatic enrollment with the option to opt out should be used. Plan sponsors should be offered a safe harbor and expanded "catch-up" contributions if the sponsor automatically enrolls certain plan participants into a retirement LTCI policy with the option to opt out.

If premiums are affordable and automatic enrollment is targeted appropriately, individuals would be less likely to opt out, which could improve the risk pool and make the approach more viable for carriers. Participants should receive notice of default enrollment, and opting out should be simple to do.

If available in the state, conversion LTCI, outlined below, could be offered by employers as an alternative to retirement long-term care insurance.

3. **Congress should permit early penalty-free withdrawal from retirement savings accounts to cover retirement LTCI premiums.**

Employees ages 45 and older who either have defined-contribution retirement plans, such as 401(k) and 403(b) plans, or who have individual

retirement accounts should be allowed to take early distributions from the plan solely for the purchase of retirement LTCI for themselves or a spouse. Distributions from tax-deferred plans to purchase retirement LTCI should be subject to income tax but exempt from the 10% early-withdrawal penalty. This proposal would help middle-income individuals pay for LTCI premiums, which they might not be able to afford with employment income alone. Given that LTSS needs are a major threat to retirement security, individuals should be able to use retirement savings to meet potential LTSS needs. Early withdrawal to purchase LTCI is important, because LTCI premiums are higher if issued at older ages, and older applicants are more likely to be denied coverage due to underwriting. The Interagency Task Force and the National Association of Insurance Commissioners have supported the recommendation to exempt the early-withdrawal penalty for distributions to pay for LTCI premiums.[lxi, lxii]

4. **Congress should ask NAIC to modify model laws and regulations to accommodate products that convert from life insurance to long-term care insurance.**

   To advance the interstate sale of products that convert from life insurance to LTCI, commonly referred to as conversion LTCI, reforms are necessary to make the new conversion LTCI product more viable. Because this is a new product without an existing regulatory framework, Congress should ask NAIC to modify applicable, existing model acts and regulations to allow for the sale of conversion LTCI. States that choose to move forward with conversion LTCI products would be able to adopt the new model language, removing barriers that exist for carriers who wish to sell these products.

   Some states, such as Minnesota, are considering legislation that would expand the state insurance commissioner's authority to incorporate a new product into their regulations. This change would give the commissioner the flexibility to offer a conversion product under the state's current regulatory framework. States that wish to pursue conversion LTCI products before NAIC finalizes model acts and regulations could consider passing similar legislation.

   This product has the potential to help consumers make better, more-informed decisions. They can compare benefits and coverage with traditional LTCI policies and can minimize the number of decisions they need to make. The product also would be tied to an insurance product that most consumers already understand and are comfortable with. The product is bound to term-life insurance, allowing premiums to remain lower and more stable. This makes the product more affordable for middle-income Americans—those with annual incomes between $50,000 and $125,000 who would not qualify for Medicaid unless they had extraordinary LTSS expenses. This product is based on the LifeStage product developed in Minnesota.

E. STRENGTHEN PUBLIC EDUCATION ON LONG-TERM CARE

Approximately 70% of adults who reach age 65 will develop severe LTSS needs at some point in their lives—meaning they will need help with two or more activities of daily living for at least 90 days or will have severe cognitive impairment—and almost half of those individuals will receive some paid LTSS care over their lifetime.[lxiii] Although not all of these individuals will have LTC expenses that exceed their resources, few Americans plan for how they will cover LTSS. Generally, Americans lack information and may have misconceptions about the need for, and costs, of LTSS. Many mistakenly believe that health insurance, such as Medicare, covers these services. This results in individuals having inadequate resources to pay for LTSS, with many spending their assets down to qualify for Medicaid-covered LTSS. Public education on long-term care planning would help to clarify these misconceptions.

Congress sought to promote public education through a national long-term care awareness campaign, but it had limited success. HHS ran the "Own Your Future" campaign from 2005 to 2010. It was an optional federal/state campaign to explain the need for LTCI. Governors of participating states mailed letters to households with residents between the ages of 45 to 65 and encouraged people to order a free long-term care planning kit. The campaigns included press events, public service announcements, and follow-up letters.

Throughout the campaign, 24 states and the District of Columbia participated; 20 million households received letters, and 1.5 million people took the next step of ordering the planning kit.[lxiv] Those who received the kit were more likely to do some type of planning, such as talking to an agent about long-term care, looking into reverse mortgages, reviewing existing coverage, and in some cases buying LTCI.[lxv] However, as the private long-term care industry continues to struggle and individuals continue to spend down into Medicaid to cover LTSS, a new educational approach should be explored.

Recommendation:

1. **The Financial Literacy and Education Commission and partnering federal agencies should coordinate to strengthen educational resources on LTC and incorporate LTC planning into retirement education topics.**

The Financial Literacy and Education Commission (FLEC) was established under the Fair and Accurate Credit Transactions Act of 2003 to develop a national financial education website and national strategy on financial education.[lxvi] The U.S. Department of Treasury's *Federal Interagency Task Force on Long-Term Care Insurance* report recognizes the importance of public

education on LTC and recommends that Treasury, HHS, the Department of Labor, and other agencies working through the FLEC assess federal education resources on LTC needs and planning, and modify, update, and supplement these resources as needed. The report also recommends that the FLEC integrate long-term care planning into retirement education topics.

The educational resources should address common public misperceptions about long-term care. For example, educational efforts should provide clear warnings that Medicare does not cover LTC services and emphasize that the Medicaid program has strict income and asset limits that an individual must meet to qualify for Medicaid-covered LTSS. The federal government should encourage coordination between the agencies that compose the FLEC and provide funding to strengthen educational resources on LTC planning and incorporate them into retirement education.

Conclusion

People with long-term care needs must navigate a variety of complex systems and often find they are ineligible for the programs that provide the care they need. Medicaid beneficiaries and individuals dually eligible for Medicare and Medicaid can usually receive these services through state Medicaid programs. However, the patchwork of waivers and state plan amendments has led to inequal access to HCBS both across and within states. Additionally, dual eligible individuals must navigate two, often fragmented programs, creating additional barriers to access. People who do not qualify for Medicaid may have to pay out of pocket for the care they need and may spend down their assets until they qualify for Medicaid-covered services. They may also rely on unpaid caregivers for LTSS.

The issues faced by the United States' long-term care system throughout the COVID-19 pandemic have created a unique opportunity to transform the LTC delivery system. However, improving the quality of care and addressing the long-term needs of those with complex health conditions will require a range of initiatives. No single approach or program will garner the bipartisan support necessary to ensure long-term sustainability. While expanding HCBS, included in many current proposals in Congress, has received national attention, policymakers should also continue to streamline and simplify programs, and make services available in a way that will achieve long-term sustainability.

Appendix I

BPC'S CONSOLIDATED STATE PLAN AMENDMENT RECOMMENDATION

Note: The policy recommendation for a consolidated SPA, introduced above on pages 17-21, is summarized in the left column of the following table. References to existing statutory authority are in the center column as a point of reference, and how BPC's proposal would affect current law is in the right column.

Consolidated SPA Defined	Elements from Existing Authorities	Proposed Change from Current Law

Key Provisions:
• Establish new consolidated SPA, combining existing authority from Medicaid state plan options, including 1915(i), (j), and (k), and Medicaid waivers, including 1915(c) and Section 1115 (except in limited circumstances).
• Existing enrollees in each of these options should be grandfathered to prevent a disruption in services.
• Under this approach, the HHS secretary would develop a template that includes the following information to be provided by the states:
  • Eligibility, including income and resource standards, and functional status criteria.
  • Benefits covered.
  • An estimate of the number of individuals the state projects will be eligible.
	• The following sections of the SSA:
	  • 1915(i) – HCBS SPA.
	  • 1915(j) – Self-directed personal assistance services for individuals who would otherwise require personal care services or are covered under 1915(c) waiver.
	  • 1915(k) – Community First Choice – Personal attendant services and supports for those who need an institutional level of care.
	  • 1915(c) – Medicaid HCBS waiver.
	  • 1115 – Demonstration Authority.
		• Requires legislation to combine existing waiver and SPA authorities into a single SPA, and to ensure existing enrollees are grandfathered into the new SPA.
		• Requires legislation to replace existing state plan options and waivers; to require states to transition to the new consolidated SPA within five years of enactment; and to direct the HHS secretary to develop the template for states.

Eligibility: • **Income and resources:** States may cover individuals with incomes up to 300% of	• The 300% option (parity). • The following sections of the SSA: • 1915(k).	• No change to current law income and resource limits and flexibilities.

Consolidated SPA Defined	Elements from Existing Authorities	Proposed Change from Current Law
• SSI, or 221% of FPL. States could continue to adopt flexi bilities related to income eli gibility and resource stan dards, such as options under • the Katie Beckett provision of TEFRA, TWWIIA, etc. • **Functional status:** States must establish functional status criteria that requires an assessment of an individual's support needs and capabilities. States must take into account the inability of the individual to perform two or more activities of daily living or the need for significant assistance to perform such activities, or the need for substantial supervision to protect an individual from threats to health and safety due to severe cognitive impairment, and such other risk factors as the state determines to be appropriate. • States may modify the functional criteria without obtaining prior approval by the HHS secretary if enrollment exceeds projections. However, when adopting the consolidated state plan, states are required to describe the process they will use to modify eligibility criteria once the enrollment projection is met, to ensure transparency. Such criteria must be nondiscriminatory to populations. States may engage their consumer and stakeholder advisory boards when setting enrollment targets and determining eligibility criteria modifications.	• 1915(i) – including the option for states to limit participation by modifying the needs-based criteria once actual enrollment exceeds the state's projected enrollment. This effectively limits enrollment growth to those in greater need of services, while allowing the state to continue to serve those who enrolled at the less stringent level of care. • 1915(j). • States have an obligation under *Olmstead* to make services available in the most integrated setting appropriate to the Medicaid beneficiary's need. • Section 1924 of the SSA provides impoverishment protections for spouses of individuals in institutional settings, to include indi-viduals receiving services through 1915 (c), (i), or (k) and 1115 waivers providing HCBS. ◦ Originally set to expire in 2018, Congress has extended these protections through 2023 from subsequent legislation.	*Note: BPC addressed HCBS expansion in our September 2021 report, Bipartisan Solutions to Improve the Availability of Long-term Care.* • Clarify that states set an enrollment target under 1915(i). When that enroll-ment target is reached, the state may modify the needs-based criteria for LTSS by using more stringent crite-ria. Extend this to the new consolidated SPA. • Legislation establishing the consolidated SPA should require states to conduct independent assessments and develop individualized care plans; require states to allow individuals to choose self-directed HCBS; allow states to waive comparability, amount, duration, and scope standards; and should include a maintenance-of-effort requirement. • Requires legislation to make permanent the existing state option, which will sunset in 2023, to extend protection against impoverishment for spouses of individuals receiving Medicaid HCBS.

Consolidated SPA Defined	Elements from Existing Authorities	Proposed Change from Current Law
• Individuals do not need to meet criteria for an institutional level of care, and the state must establish a more stringent needs-based criteria for individuals requiring an institutional level of care. • **Individualized Care Plan:** States must conduct independent assessments; develop individualized care plans in consultation with providers, caregivers, family, or representatives; and identify services to be furnished. • **Self-Directed Services:** States must allow individuals to choose self-directed services. • **Comparability, amount, duration, and scope:** States are not required to meet Medicaid comparability, or amount, scope, and duration of services standards. States, however, must continue to comply with federal nondiscrimination rules. • **Maintenance of Effort:** To receive an enhanced administrative match under the consolidated SPA, states must comply with a maintenance-of-effort requirement for HCBS eligibility and benefit standards to ensure federal funding supplements, not supplants, existing state funds expended for Medicaid HCBS, as of the date Congress passes legislation establishing the consolidated SPA.		

Consolidated SPA Defined	Elements from Existing Authorities	Proposed Change from Current Law
• **Spousal Impoverishment Protections:** Congress should permanently authorize the state option to extend protection against impoverishment for spouses of individuals receiving Medicaid HCBS.		
Optional Coverd Services: • Home health care (remains mandatory as under current law). • State plan personal care services. • Rehabilitation services, including those related to behavioral health. • Case management. • Homemaker/home health aide and personal care. • Adult day health care. • Habilitation. • Respite. • Day treatment or other partial hospitalization services, psychosocial rehabilitation, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness. • HCBS covered through EPSDT. • Other services approved by the HHS secretary.	• Sections 1915(i) cross-referencing 1915(c)(4)(B); 1915(j); 1905(a) of the SSA.	• No change to current law.
• SPA does not require cost neutrality as do waivers.	• Sections 1915(i) and 1915(k) of the SSA.	• No change to current law.

Consolidated SPA Defined	Elements from Existing Authorities	Proposed Change from Current Law

Enhanced Match and Payment for Services:
• **Enhanced Administrative Match:** States are eligible for an enhanced administrative match for activities related to streamlined eligibility and enrollment functions, such as those typically performed by states' No Wrong Door system, as well as for ombudsman activities and infrastructure development. To receive the enhanced match, states must comply with a maintenance-of-effort requirement for HCBS eligibility and benefit standards to ensure federal funding supplements, not supplants, existing state funds expended for Medicaid HCBS, as of the date Congress enacts legislation establishing the consolidated SPA.
• **Additional Enhanced Administrative Match for HCBS Quality Reporting:** States that choose to measure and report on an approved set of HCBS quality measures would be eligible to receive an additional 1% FMAP increase beyond the enhanced administrative match.
	• Section 1943 of the SSA.
	• **No Wrong Door:** Individuals may apply for Medicaid through any means, whether through state or federal marketplaces, state Medicaid agencies, by phone, or by fax. The No Wrong Door single entry point system builds on collaborative efforts of CMS, the Administration for Community Living, and the Veterans Health Administration to support states' efforts to streamline access to LTSS options for all eligible populations. The program promotes:
	  • Public outreach and coordination with key referral sources.
	  • Person-centered counseling.
	  • Streamlining access to public LTSS programs.
	  • State governance and administration.
	States may receive administrative match for administrative activities performed through No Wrong Door systems, including Medicaid outreach; referral, coordination, and monitoring of Medicaid services; facilitating Medicaid eligibility; and other Medicaid administrative functions such as training, program planning, quality improvement, and information technology.[lxvii]
		Requires new legislation to:
		• Establish the enhanced administrative match for activities related to streamlined eligibility and enrollment functions.
		• Direct the HHS secretary to develop a recommended core set and supplemental set of HCBS quality measures.
		• Establish an additional 1% FMAP increase for states that choose to measure and report on an approved set of HCBS quality measures.

Consolidated SPA Defined	Elements from Existing Authorities	Proposed Change from Current Law
	• **Balancing Incentive Program (BIP):** Establishing legislation for the BIP is codified in the notes at 42 U.S.C. § 1396d, "Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes." The program authorized grants to states to increase access to noninstitutional LTSS. Total funding over the four-year program (October 2011 – September 2015) was $2.4 billion in federal enhanced matching payments. States with HCBS spending that accounted for less than half of total LTSS expenditures were eligible to participate in the program.[lxviii] Participating states received an enhanced FMAP for HCBS, and were required to meet certain HCBS spending and infrastructure goals, including creating a No Wrong Door single-entry point for those seeking LTSS.[lxix] Eighteen of 21 participating states continued the program from 2011 to 2015, and most states received extensions through 2017 to complete the work.[lxx] The enhanced FMAP was tied to the percentage of a state's LTSS spending, with lower FMAP increases going to states that needed to make fewer reforms. States spending less than 25% of LTSS dollars on HCBS at baseline received a 5% enhanced FMAP, and were	

Consolidated SPA Defined	Elements from Existing Authorities	Proposed Change from Current Law
	required to increase HCBS spending to at least 25% of total LTSS spending. States spending between 25% to 50% of LTSS on HCBS at baseline received a 2% enhanced FMAP, and were required to spend at least 50% of LTSS dollars on HCBS. States were required to use the enhanced FMAP to provide new or expanded HCBS, and were also subject to a maintenance-of-effort provision prohibiting them from decreasing eligibility below December 31, 2010, levels. • Sections 1139A and 1139B of the SSA– related to core measurement sets for adults and children in Medicaid and CHIP.	
Maintaining Existing Initiatives: • The 6% enhanced FMAP for 1915(k) and the enhanced FMAP available for the Money Follows the Person (MFP) demonstration extend to the consolidated SPA. • Permanently reauthorizes the MFP demonstration. • Through the Medicaid Health Homes model, states may receive a 90% enhanced FMAP for integration and coordination of services, as permitted under current law for eight quarters. • States may develop payment rates for services in accordance with applicable state plan requirements.	• Section 1915(k) of the SSA. • **The Money Follows the Person (MFP) Demonstration:** Section 6071 of the Deficit Reduction Act of 2005, as amended by subsequent legislation. Extended through September 30, 2023, by Section 204 of the Consolidated Appropriations Act, 2021 (P.L. 116-260), which also appropriated $450 million for FY2021 to FY2023. The program provides incentives to states to move individuals from institutional settings to HCBS. Grant awards are available to states for the fiscal year they got the award and four additional fiscal years after.	• Requires legislation to make permanent the existing MFP demonstration. • Legislation establishing the new SPA should incorporate the current law 6% FMAP for 1915(k) and the enhanced FMAP for MFP. States may continue to receive the enhanced FMAP for health home services for eight quarters.

Consolidated SPA Defined	Elements from Existing Authorities	Proposed Change from Current Law
	Eligible individuals include people who live in an institution for more than 90 consecutive days. States receive an enhanced FMAP for covered demonstration and HCBS for the first year the individual receives services in the community after leaving an institution. (Exception: days that a person was living in the institution for the sole purpose of receiving short-term rehabilitation services reimbursed by Medicare do not count toward this 90-day period.) • **Medicaid Health Homes:** Section 1945 of the SSA. Under this state plan option, states receive a 90% enhanced FMAP for Health Home services. The enhanced FMAP is available for the first eight quarters that the program is effective. Required Health Home services include: • Comprehensive care management; • Care coordination; • Health promotion; • Comprehensive transitional care/follow-up; • Patient and family support; • Referral to community and social support services. Use of health information technology to link services where appropriate is strongly encouraged.	

Appendix II

IMPLEMENTING AN INTEGRATED LONG-TERM SERVICES AND SUPPORTS BUY-IN PROGRAM: A COST ESTIMATE BY ATI ADVISORY

This study was prepared for the Bipartisan Policy Center as part of its effort to expand and promote improved, integrated care for individuals with long-term services and support needs. It was prepared by ATI Advisory and made possible by funding from The SCAN Foundation and the Robert Wood Johnson Foundation. This study is a companion to BPC's report, Bipartisan Solutions to Improve the Availability of Long-term Care (September 2021). In this study, ATI Advisory estimated the (1) federal costs associated with subsidizing three potential HCBS service packages for Medicare-only beneficiaries with LTSS needs and (2) total number of beneficiaries likely served (see "HCBS Buy-In Through Integrated Models of Care" above).

Executive Summary

The need for long-term services and supports (LTSS) in the United States will continue to grow as the population ages. Formal LTSS is largely provided through the Medicaid program, limiting these services to individuals who are low-income and already in need of an institutional level of care. This results in a considerable portion of individuals with LTSS needs lacking access to necessary services, and it forces many to "spend down" their income and assets to qualify for Medicaid. In addition, Medicaid recipients who also qualify for Medicare receive acute care benefits and LTSS benefits administered by two disjointed programs. As the magnitude of individuals with unmet need rises, so does the long-term cost to both Medicaid and Medicare through increased and fragmented utilization of acute care and institutional settings.

This study was undertaken to estimate the federal costs associated with subsidizing an LTSS "buy-in" to the Medicare program or alternatively, as a buy-in to Medicaid benefits. The program would integrate LTSS and acute care services for Medicare beneficiaries living in the community with LTSS needs, and who are not receiving full Medicaid benefits.

Initial cost estimates included in this study are limited to Medicare beneficiaries ages 65 and older. LTSS need was determined based on the level of assistance needed with activities of daily living, level of assistance needed with instrumental activities of daily living, and presence of cognitive impairment. Different combinations of LTSS coverage, program eligibility, subsidy levels, and longer-term savings expectations were modeled, resulting in annual federal costs for providing subsidized coverage between $1.1 billion and $12.8 billion.

Model Inputs

The key model inputs used to estimate federal costs included per person "value," acute care savings, subsidy eligibility and amount(s), and program enrollment. Each of these model inputs is described in greater detail below.

Per Person "Value"

Four approaches were developed to approximate the possible per person per month (PPPM) value based on the monetary value of LTSS and the assumed services that would be provided to enrolled individuals.

1. **Base Benefit Package - *$450 PPPM***
   The monetary value of this approach is based on industry trends within private market and other programs similar to this buy-in option, such as the CAPABLE program[27] and previously proposed legislation for a Community-Based Independence Special Needs Plan (CBI-SNP).[28] It allows a limited benefit and assumes that the total combination of services used would be equivalent to $450 PPPM. This package does not specify services.

2. **Personal Care Services Only - *$914 PPPM***

   This approach is based on reimbursement amounts within Medicaid and the private market for personal care services. It assumes that 10 hours of services per week would be provided to an enrolled individual, based on the national median of unpaid caregiver hours. The average reimbursement amounts of personal care services from Medicaid fee schedules across a variety of states were blended with the national averages for private-sector home care to calculate the hourly rate, $21.10, of the services provided.

3. **Median State Home and Community-Based Services (HCBS) Spending on Older Adults - *$1,391 PPPM***

   This approach assumes the buy-in benefit levels would approximate state Medicaid HCBS expenditures for older adults. It uses the median/50th percentile 1915(c) per person spending for aged and physically disabled individuals to account for the substantial variation that exists across states in terms of Medicaid HCBS benefit design and expenditures. The PPPM amount also incorporates a 14 percent adjustment based on the likely increase above Medicaid fee schedules that would occur if similar benefit levels were provided through Medicare. This approach does not account for any unmet need that might exceed state benefit limits or other HCBS and HCBS-like services

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27 Johns Hopkins School of Nursing, "Community Aging in Place – Advancing Better Living for Elders (CAPABLE)." Available at: https://nursing.jhu.edu/faculty_research/research/projects/capable/index.html.

28 Community-Based Independence for Seniors Act of 2019, H.R. 3461, 116th Cong. (2019). Available at: *https://www.congress.gov/bill/116th-congress/house-bill/3461/text?r=6&s=1.*

that individuals might receive through other sources, such as state plan services.

4. **90th Percentile State HCBS Spending on Older Adults - *$2,803 PPPM***

   This approach replicates all aspects of the median HCBS approach described above but uses the 90th percentile of 1915(c) spending for aged and physically disabled individuals. The associated monetary value represents the likely upper-bound cost of providing HCBS in the Medicare program.

Acute Care Savings

This model input represents the assumed medical care savings created as a result of integration of LTSS and acute care needs and services. Three savings values (minimum, average, and maximum) were identified based on findings from the Financial Alignment Initiative and CAPABLE. A higher PPPM value is expected to be associated with greater acute care savings and was modeled as such in this study.

Subsidy Eligibility and Amount(s)

Three subsidy components are included as inputs in this model: whether full *and* partial subsidies are provided (versus full only); the income-level threshold(s), as a percentage of the federal poverty level, for the full and partial subsidy participants; and the amount of the partial subsidy as a percentage of the cost. The subsidy eligibility and amounts act as independent variables in this study, and further research and policy specifications will need to define them.

Enrollment

The enrollment input represents the anticipated demand among fully subsidized, partially subsidized, and unsubsidized individuals. Medicare Advantage enrollment rates, 40 percent nationwide across all Medicare beneficiaries as of December 2020, informed likely enrollment demand since the program would be tied to a Medicare Advantage plan. In addition, as enrollment demand will likely vary based on out-of-pocket costs, enrollment rates vary in each model scenario. For example, for scenarios with higher PPPM values, lower enrollment demand is expected among unsubsidized and partially subsidized individuals.

Outcomes

Twelve cost scenarios were run based on unique combinations of the model inputs described above. These scenarios resulted in annual net federal costs for providing subsidized coverage of between $1.1 billion to $12.8 billion (bolded in Figure 1). In addition, based on the “Base Package” scenario outputs, the federal government could subsidize a limited LTSS benefit for up to 675,052 Medicare beneficiaries (excluding unsubsidized beneficiaries) at an annual cost

of $1.1 billion to $3.1 billion (bolded in Figure 1). It is important to note that this study's savings estimates are likely conservative, and costs to the federal government could be lower. For example, a single prevented hospital stay would save the Medicare program an average of $12,800, which is more than the annual per person cost of two of the four scenarios provided in Figure 1.[29]

Figure 1: Abbreviated Version of Coverage Scenarios and Resulting Outcomes

Cost Approach	Full Subsidy	Partial Subsidy	Standard Eligibility Population	Expanded Eligibility Population
Base Package *$450 PPPM*	≤100% FPL	No partial subsidy	Total Served: 632,633 Total Subsidized: 226,453 **Net Annual Cost: $1,144,420,997**	Total Served: 671,706 Total Subsidized: 239,346 Net Annual Cost: $1,209,578,093
	<221% FPL	221-400% FPL	Total Served: 803,687 Total Subsidized: 633,929 Net Annual Cost: $2,911,402,009	Total Served: 851,987 **Total Subsidized: 675,052** **Net Annual Cost: $3,094,244,091**
Personal Care Services Only *$914 PPPM*	≤100% FPL	No partial subsidy	Total Served: 470,161 Total Subsidized: 226,453 Net Annual Cost: $2,406,217,113	Total Served: 498,762 Total Subsidized: 239,346 Net Annual Cost: $2,543,214,005
	<221% FPL	221-400% FPL	Total Served: 728,123 Total Subsidized: 606,867 Net Annual Cost: $6,002,982,663	Total Served: 772,059 Total Subsidized: 645,677 Net Annual Cost: $6,377,297,949
Median State HCBS Spend *$1,391 PPPM*	≤100% FPL	No partial subsidy	Total Served: 388,925 Total Subsidized: 226,453 Net Annual Cost: $2,489,497,468	Total Served: 412,290 Total Subsidized: 239,346 Net Annual Cost: $2,631,235,890
	<221% FPL	221-400% FPL	Total Served: 652,558 Total Subsidized: 579,805 Net Annual Cost: $5,922,200,824	Total Served: 692,131 Total Subsidized: 616,302 Net Annual Cost: $6,284,809,261
90th Percentile State HCBS Spend *$2,803 PPPM*	≤100% FPL	No partial subsidy	Total Served: 307,689 Total Subsidized: 226,453 Net Annual Cost: $5,111,777,012	Total Served: 325,818 Total Subsidized: 239,346 Net Annual Cost: $5,402,813,744

29 $12,800 was the average Medicare fee-for-service payment of a hospital stay in 2019. Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. (March 2021).

Cost Approach	Full Subsidy	Partial Subsidy	Standard Eligibility Population	Expanded Eligibility Population
90th Percentile State HCBS Spend *$2,803 PPPM*	<221% FPL	221-400% FPL	Total Served: 601,245 Total Subsidized: 552,743 Net Annual Cost: $12,022,089,512	Total Served: 637,480 Total Subsidized: 586,927 **Net Annual Cost: $12,754,836,128**

Considerations and Conclusion

This study provides an initial cost estimate of subsidizing some level of LTSS for Medicare beneficiaries with LTSS needs and without current Medicaid coverage. The study also highlights the value of additional analysis and policy conversation on addressing increasing and unmet LTSS need among an aging population. Further, the program concept modeled in this study could reduce longer-term Medicare and Medicaid spending that results from a current lack of integration and spend-down into long-term residence in an institutional setting.

The following considerations related to program design were considered beyond the scope of this study:

- Emerging policy efforts and policy design, including proposals to expand Medicaid HCBS
- Cost inflation and wage increases year-over-year
- Growing Medicare population and projecting costs in relation to growth in LTSS need
- Medicare solvency and related political considerations
- Integration experiences of individuals ebbing in and out of program eligibility, or of those already qualified for Medicaid LTSS
- State versus federal administration
- Adverse selection and approaches to mitigate its effects
- Policy considerations
    - Program eligibility, including age and frailty requirements
    - Program design and administration, such as whether the program becomes a new type of Medicare Advantage special needs plan (SNP)
    - Intersection with other programs; for example, whether state Medicaid programs should contribute funding
    - Program payment and savings, including who shares in the resulting savings

Addressing these considerations and defining the policy specifications remain an important next step of this research and are essential to long-term success of efforts to provide LTSS to Medicare beneficiaries.

For the complete report, please visit the BPC website.

Appendix III

ANALYSIS IN SUPPORT OF SPECIAL SUPPLEMENTAL BENEFITS FOR MEDICARE FFS BENEFICIARIES WITH CHRONIC ILLNESS PROVIDED BY ANANYA HEALTH INNOVATIONS

This analysis, prepared by Ananya Health Innovations (Ananya Health) for BPC, appears in BPC's report, Next Steps in Chronic Care (July 2019).

BPC has made a series of recommendations to improve the health and functional status for chronically ill beneficiaries, to prevent avoidable adverse outcomes for these individuals, and to generate savings for the Medicare program. BPC's recommendations address SSBCIs for beneficiaries covered by original Medicare and call for additional efforts by the HHS secretary to better define eligibility, assess the specific needs of this population, and identify evidence-based benefits that could prove beneficial. It would be helpful if policymakers would define and empirically illustrate the types of beneficiaries who could potentially qualify for SSBCIs, their relevant needs and circumstances, and potential scenarios leading to cost savings.

This issue brief describes the results of the analysis conducted in support of BPC's efforts to improve the welfare of chronically ill Medicare beneficiaries through the availability of SSBCIs. The objectives of the analyses were to:

- Define and describe six Medicare patient cohorts who could potentially be eligible for specific supplemental benefits based on general criteria related to chronic conditions and functional limitations, as well as other specific considerations.
- Identify and quantify possible opportunities to reduce or offset costs and usage for the patient cohorts.
- Incorporate estimates of the likely cost of one specific supplemental benefit as part of empirical illustrations of the cost versus savings of a benefit.
- Estimate scenarios of scaled programs—such as the total number of plausible users of the selected benefit multiplied by the suggested average cost per person—to produce aggregate total additional spending and net savings.

- Derive estimates of the likely cost and plausible impact of a specific supplemental benefit to illustrate cost versus savings of a benefit.

Data Sources and Methods. Ananya Health used the 2016 Medicare Current Beneficiary Survey (MCBS) Public Use File (PUF) to identify the Medicare patient cohorts for analyses, and to identify the subsets covered under the original (that is, "fee-for-service," or FFS) Medicare program. Ananya Health included all beneficiaries who indicated that they enrolled in original Medicare for the whole year or any part of the year. By including beneficiaries who only enrolled for part of the year in the analysis, Ananya Health could ensure more complete estimates of the possible incremental costs of any new SSBCIs as well as any offsetting savings the Medicare program might capture.

In addition to the MCBS, Ananya Health incorporated information from other published sources in order to determine baseline cost, utilization patterns, and estimates of the affected sizes related to the selected benefit: that is, home delivery of meals to qualified beneficiaries immediately following discharge from inpatient hospital stays.

Ananya Health defined the patient cohorts based on BPC's recommendation that beneficiaries who had at least two chronic conditions and one functional limitation potentially be offered SSBCIs. The MCBS includes questions about a number of chronic conditions. Ananya Health selected a subset of 11 chronic conditions for the cohort analyses in consultation with the BPC project team and based on the plausible relevance of SSBCIs to avoid adverse utilization events and costs in the presence of co-occurring functional limitations:

1. Congestive heart failure (ever);
2. Depression (ever);
3. Diabetes (told on two or more visits);
4. Emphysema/asthma/COPD (ever);
5. Alzheimer's or dementia diagnosis (ever);
6. Osteoporosis/soft bones (ever);
7. Other heart condition—for example, valve/rhythm (ever);
8. Paralysis complete/partial (ever);
9. Parkinson's disease (ever);
10. Rheumatoid arthritis (ever); and
11. Stroke/brain hemorrhage (ever).

Ananya Health calculated the frequency counts of beneficiaries who reported having each of the chronic conditions, and then proceeded to form heterogeneous cohorts comprising all beneficiaries who had two or more of the selected chronic conditions.

In addition, the MCBS asks respondents about their functional limitations, including instrumental activities of daily living and activities of daily living (ADL). Ananya Health presents descriptive details of the eventual patient cohorts for many different functional limitations; however, Ananya Health defined the cohorts based on a variable provided in the MCBS PUF, which indicates whether the beneficiary has zero, one, two, three, or four ADLs.

Ananya Health defined the general patient cohort as those beneficiaries who had any two or more of the 11 chronic conditions listed above, plus one or more ADL. Ananya Health then layered additional criteria on top of this baseline cohort in order to identify five additional subsets of potential interest:

- **Patient Cohort 1:** Beneficiaries enrolled in original Medicare (age or disability) for any part of the year who reported having any two or more of the 11 identified chronic conditions, and at least one ADL.
- **Patient Cohort 2:** Beneficiaries in Cohort 1 who also had an IP stay any time during the year.
- **Patient Cohort 3:** Beneficiaries in Cohort 2 who indicated that they had difficulty eating solid foods because of dental issues.[lxxi]
- **Patient Cohort 4:** Beneficiaries in Cohort 1 who indicated that they had difficulty eating solid foods because of dental issues.
- **Patient Cohort 5:** Beneficiaries in Cohort 1 who indicated they relied on forms of transportation for medical appointments other than being driven.
- **Patient Cohort 6:** Beneficiaries in Cohort 1 who indicated living in a single-person household—that is, living alone.

For these six cohorts, Ananya Health also calculated demographic characteristics, such as age band, gender, rural/urban, race, income, education, and marital status. In addition, Ananya Health calculated usage profiles for these cohorts using data from the MCBS PUF. The MCBS PUF provides the following utilization data for each beneficiary: IP stays, outpatient visits, office visits, skilled nursing facilities (SNF) stays, home health, and hospice visits. The MCBS PUF does not include data on emergency-room visits.

Results

This section shows results that describe the potential beneficiary groups who could be eligible for supplemental benefits based on criteria related to the

presence of chronic conditions and functional limitations. Exhibit 1 shows the 11 selected chronic conditions, which serve as input into the criterion that patients have (two or more) chronic conditions. Each of the 11 conditions is a prevalent problem for different numbers of beneficiaries. Basing eligibility for supplemental benefits on rarer conditions would limit their availability, as well as the specter of increased costs to the Medicare program. For example, Parkinson's disease (N=131) and Alzheimer's or dementia (N=412) had the lowest prevalence rates in the MCBS FFS sample. Expanding criteria to include additional chronic conditions, as done in this exploratory study, would increase potential access to supplemental benefits to larger and more diverse patient cohorts.

Exhibit 1: Selected Chronic Conditions for Medicare FFS Beneficiaries

Chronic Condition	Sample Size
Congestive heart failure (ever)	703
Depression (ever)	2,395
Diabetes (told on two or more visits)	2,167
Emphysema/asthma/COPD (ever)	1,803
Alzheimer's or dementia (ever)	412
Osteoporosis/soft bones (ever)	1,455
Other heart condition (e.g., valve/rhythm) (ever)	2,616
Paralysis complete/partial (ever)	298
Parkinson's disease (ever)	131
Rheumatoid arthritis (ever)	1,309
Stroke/brain hemorrhage (ever)	917

Exhibit 2 shows further steps in the formation of patient cohorts intended for this analysis. In addition to the sample sizes for patient groups reporting each of the 11 selected conditions, Exhibit 2 shows the respective sample sizes for subgroups with each of the individual "anchor" conditions plus any one or more of the 11 chronic conditions. For example, 655 of the 703 beneficiaries with congestive heart failure also have at least one of the other chronic conditions and thus meet the criterion of two or more chronic conditions. The right side of Exhibit 2 describes the functional limitations anchored in each of the 11 chronic conditions for each of the respective sub-cohorts. For example, 40 percent of the sub-cohort who have congestive heart failure (and at least one other chronic condition) reported having no functional limitation defined as an ADL. That means 60 percent of that sub-cohort had one or more ADLs, which corresponds to the proposed criterion for eligibility to supplemental benefits.

Exhibit 2 shows that those 60 percent of the sub-cohort with congestive heart failure comprised 33 percent with one or two ADLs, and 27 percent with three or four ADLs.

Exhibit 2: Selected Chronic Conditions and Functional Limitations

Anchor Chronic Condition (CC) Name	Overall Anchor CC Cohort Size	Anchor CC + Any Cohort CC Sub-cohort Size	No ADL	1 or 2 ADLs	3+ ADLs
Congestive heart failure (ever)	703	655	40%	33%	27%
Depression (ever)	2,395	1,892	46%	30%	24%
Diabetes	2,167	1,671	53%	27%	20%
Emphysema/asthma/COPD (ever)	1,803	1,525	51%	29%	20%
Alzheimer's or dementia (ever)	412	370	29%	30%	41%
Osteoporosis/soft bones (ever)	1,455	1,191	50%	29%	21%
Other heart condition (e.g., valve/rhythm) (ever)	2,616	2,035	54%	29%	17%
Parkinson's disease (ever)	131	119	29%	28%	44%
Paralysis complete/partial (ever)	298	270	27%	30%	43%
Rheumatoid arthritis (ever)	1,309	1,121	44%	31%	25%
Stroke/brain hemorrhage (ever)	917	799	43%	30%	27%

Below are a series of exhibits that describe the six patient cohorts meeting potential criteria related to eligibility for supplemental benefits (and introduced earlier).

Demographic Characteristics of Selected Cohorts

In this section, Ananya Health describes the demographic characteristics of the selected cohorts, including age, gender, income, education, and geographic location (metropolitan versus non-metropolitan). Exhibit 3 shows the counts of beneficiaries in the sample that correspond to the six cohorts described in the "Data Sources and Methods" section and the gender breakdown of each patient cohort.

As a reference, of the 6,576 sampled beneficiaries with any one or more of the 11 chronic conditions, 44 percent were male and 56 percent were female. There were 1,939 beneficiaries in Cohort 1 who met the basic criteria for supplemental benefits: that is, two or more of the chronic conditions and one or more of the ADLs; of those beneficiaries, 36 percent were male and 64 percent were female.

Of the six analytic cohorts, the largest percentage of male beneficiaries (41 percent) was in Cohort 5, which included reports of transportation difficulties (normally driven to doctor visits). The smallest percentage of male beneficiaries (28 percent) was in Cohort 6, which included reports of living alone.

Exhibit 3: Patient Cohorts Based on Selection Criteria: Gender

		Gender	
Cohort definition (FFS for any part of the year)	Count	Male	Female
Any of the 11 CCs	**6,576**	44%	56%
Cohort 1: 2+CCs Plus 1+ADLs	**1,939**	36%	64%
Cohort 2: Cohort 1 Plus IP Stays	**508**	34%	66%
Cohort 3: Cohort 2 Plus Food Difficulties	**183**	37%	63%
Cohort 4: Cohort 1 Plus Food Difficulties	**732**	36%	64%
Cohort 5: Cohort 1 Plus Transportation Difficulties	**965**	41%	59%
Cohort 6: Cohort 1 Plus Living Alone	**627**	28%	72%

Exhibit 4 shows the reported incomes of beneficiaries in each of the patient cohorts, using a dichotomy of less or more than $25,000. The highest percentages of beneficiaries with lower incomes (about two-thirds) were in cohorts that reported experiencing food difficulties (Cohorts 3 and 4) or living alone (Cohort 6).

In addition to income Ananya Health also examined the distribution by educational attainment. Exhibit 5 shows the education levels achieved by beneficiaries in the cohorts. Cohorts with reported food difficulties (Cohorts 3 and 4) tended to have lower educational achievement, which coincides with findings shown in Exhibit 4, as one would expect given that in general income and education are known to be correlated.

Exhibit 4: Patient Cohorts Based on Selection Criteria: Income

		Income	
Cohort definition (FFS for any part of the year)	Count	<$25,000	>=$25,000
Any of the 11 CCs	**6,576**	45%	55%
Cohort 1: 2+CCs Plus 1+ADLs	**1,939**	56%	44%
Cohort 2: Cohort 1 Plus IP Stays	**508**	55%	45%
Cohort 3: Cohort 2 Plus Food Difficulties	**183**	66%	34%
Cohort 4: Cohort 1 Plus Food Difficulties	**732**	67%	33%
Cohort 5: Cohort 1 Plus Transportation Difficulties	**965**	53%	47%
Cohort 6: Cohort 1 Plus Living Alone	**627**	67%	33%

Exhibit 5: Patient Cohorts Based on Selection Criteria: Education

		Education		
Cohort definition (FFS for any part of the year)	Count	Less than high school	High school or vocational, technical, business	More than high school
Any of the 11 CCs	**6,576**	19%	36%	45%
Cohort 1: 2+CCs Plus 1+ADLs	**1,939**	25%	37%	38%
Cohort 2: Cohort 1 Plus IP Stays	**508**	27%	37%	35%
Cohort 3: Cohort 2 Plus Food Difficulties	**183**	35%	34%	30%
Cohort 4: Cohort 1 Plus Food Difficulties	**732**	31%	37%	31%
Cohort 5: Cohort 1 Plus Transportation Difficulties	**965**	21%	36%	43%
Cohort 6: Cohort 1 Plus Living Alone	**627**	23%	36%	40%

Exhibit 6 shows the residence locations of beneficiaries based on metropolitan versus non-metropolitan areas. Cohorts with reported food difficulties, (Cohorts 3 and 4) at around one-third, tended to have slightly higher percentages of living in non-metropolitan areas, although the patterns are fairly similar across all six cohorts.

Exhibit 6: Patient Cohorts Based on Selection Criteria: Living in Metropolitan or Non-Metropolitan Areas

		Location	
Cohort definition (FFS for any part of the year)	Count	Metro area	Non-metro area
Any of the 11 CCs	**6,576**	71%	29%
Cohort 1: 2+CCs Plus 1+ADLs	**1,939**	70%	30%
Cohort 2: Cohort 1 Plus IP Stays	**508**	71%	29%
Cohort 3: Cohort 2 Plus Food Difficulties	**183**	67%	33%
Cohort 4: Cohort 1 Plus Food Difficulties	**732**	67%	33%
Cohort 5: Cohort 1 Plus Transportation Difficulties	**965**	70%	30%
Cohort 6: Cohort 1 Plus Living Alone	**627**	71%	29%

Exhibit 7 shows the marital status of beneficiaries in the respective cohorts. Cohort 6 (living alone) differs the most from other cohorts with more than half (54 percent) widowed and only 5 percent married.

Exhibit 7: Patient Cohorts Based on Selection Criteria: Marital Status

		Marital Status			
Cohort definition (FFS for any part of the year)	Count	Married	Widowed	Divorced/ separated	Never Married
Any of the 11 CCs	**6,576**	47%	26%	16%	12%
Cohort 1: 2+CCs Plus 1+ADLs	**1,939**	38%	32%	18%	11%
Cohort 2: Cohort 1 Plus IP Stays	**508**	37%	37%	17%	9%
Cohort 3: Cohort 2 Plus Food Difficulties	**183**	34%	33%	22%	10%
Cohort 4: Cohort 1 Plus Food Difficulties	**732**	34%	32%	23%	11%
Cohort 5: Cohort 1 Plus Transportation Difficulties	**965**	39%	28%	22%	10%
Cohort 6: Cohort 1 Plus Living Alone	**627**	5%	54%	29%	13%

Exhibit 8 shows beneficiaries' age group, with the highest percentages over 75 (more than 60 percent) among Cohorts 2 and 3, which included an IP stay, and Cohort 6 (living alone). Cohort 4, with food difficulties, had the highest percentage under age 65 (32 percent). Exhibit 9 shows the distribution of cohorts by race. The highest percentages of Hispanics were among cohorts with reported food difficulties (Cohorts 3 and 4).

Exhibit 8: Patient Cohorts Based on Selection Criteria: Age Group

		Age Group		
Cohort definition (FFS for any part of the year)	Count	<65	(65 -75)	>=75
Any of the 11 CCs	**6,576**	20%	29%	50%
Cohort 1: 2+CCs Plus 1+ADLs	**1,939**	25%	20%	55%
Cohort 2: Cohort 1 Plus IP Stays	**508**	18%	19%	63%
Cohort 3: Cohort 2 Plus Food Difficulties	**183**	25%	14%	61%
Cohort 4: Cohort 1 Plus Food Difficulties	**732**	32%	19%	49%
Cohort 5: Cohort 1 Plus Transportation Difficulties	**965**	28%	26%	46%
Cohort 6: Cohort 1 Plus Living Alone	**627**	17%	21%	62%

Exhibit 9: Patient Cohorts Based on Selection Criteria: Race

		Race			
Cohort definition (FFS for any part of the year)	Count	Non-Hispanic white	Non-Hispanic black	Hispanic	Other
Any of the 11 CCs	**6,576**	77%	10%	7%	6%
Cohort 1: 2+CCs Plus 1+ADLs	**1,939**	73%	11%	9%	7%
Cohort 2: Cohort 1 Plus IP Stays	**508**	74%	11%	9%	6%
Cohort 3: Cohort 2 Plus Food Difficulties	**183**	72%	8%	12%	9%
Cohort 4: Cohort 1 Plus Food Difficulties	**732**	69%	12%	10%	9%
Cohort 5: Cohort 1 Plus Transportation Difficulties	**965**	75%	11%	8%	6%
Cohort 6: Cohort 1 Plus Living Alone	**627**	75%	12%	7%	6%

Utilization Patterns for Selected Cohorts

The following tables show the utilization rates by service type for each patient cohort: (a) office visits; (b) outpatient visits; (c) SNF stays; and (d) IP hospital stays. Generally, these patient cohorts had frequent office and outpatient visits during the year. Except for Cohort 2, which required an IP stay, about one-fifth to one-quarter of beneficiaries in the other cohorts had at least one IP hospital stay. Most of the patients in this cohort did not have any SNF stays.

Exhibit 10: Utilization Rates by Service Type: Cohort 1 (2+ CCs plus 1+ADL)

A) Office visits	Counts	Utilization Category Rates	Cumulative
21 or more office visits	224	11.6%	11.6%
16 to 20 office visits	210	10.8%	22.4%
11 to 15 office visits	335	17.3%	39.7%
6 to 10 office visits	468	24.1%	63.8%
1 to 5 office visits	491	25.3%	89.1%
No office visit	211	10.9%	100.0%
Total	**1,939**	**100%**	
B) Outpatient visit	**Counts**	**Utilization Category Rates**	**Cumulative**
Yes	1,551	80.0%	80.0%
No	388	20.0%	100.0%
Total	**1,939**	**100%**	

C) SNF stays	Counts	Utilization Category Rates	Cumulative
Two stays	43	2.2%	2.2%
One stay	113	5.8%	8.0%
No stay	1,783	92.0%	100.0%
Total	**1,939**	**100%**	
D) IP stays	**Counts**	**Admission Category Rates**	**Cumulative**
Four or more stays	46	2.4%	2.4%
Three stays	32	1.7%	4.0%
Two stays	95	4.9%	8.9%
One stay	326	16.8%	25.7%
No stay	1,440	74.3%	100.0%
Total	**1,939**	**100%**	

Exhibit 11: Utilization Rates by Service Type: Cohort 2 (Cohort 1 plus IP stay)

A) Office visits	Counts	Utilization Category Rates	Cumulative
21 or more office visits	98	19.3%	19.3%
16 to 20 office visits	80	15.7%	35.0%
11 to 15 office visits	106	20.9%	55.9%
6 to 10 office visits	108	21.3%	77.2%
1 to 5 office visits	92	18.1%	95.3%
No office visit	24	4.7%	100.0%
Total	**508**	**100.0%**	
B) Outpatient visit	**Counts**	**Utilization Category Rates**	**Cumulative**
Yes	474	93.3%	93.3%
No	34	6.7%	100.0%
Total	**508**	**100.0%**	

C) SNF stays	Counts	Utilization Category Rates	Cumulative
Two stays	43	8.5%	8.5%
One stay	109	21.5%	29.9%
No stay	356	70.1%	100.0%
Total	**508**	**100.0%**	
D) IP stays	**Counts**	**Admission Category Rates**	**Cumulative**
Four or more stays	46	9.1%	9.1%
Three stays	32	6.3%	15.4%
Two stays	95	18.7%	34.1%
One stay	326	64.2%	98.2%
No stay[lxxii]	9	1.8%	100.0%
Total	**508**	**100.0%**	

Exhibit 12: Utilization Rates by Service Type: Cohort 3 (Cohort 2 plus food difficulty)

A) Office visits	Counts	Utilization Category Rates	Cumulative
21 or more office visits	31	16.9%	16.9%
16 to 20 office visits	26	14.2%	31.1%
11 to 15 office visits	42	23.0%	54.1%
6 to 10 office visits	36	19.7%	73.8%
1 to 5 office visits	38	20.8%	94.5%
No office visit	10	5.5%	100.0%
Total	**183**	**100.0%**	
B) Outpatient visit	**Counts**	**Utilization Category Rates**	**Cumulative**
Yes	168	91.8%	91.8%
No	15	8.2%	100.0%
Total	**183**	**100.0%**	

C) SNF stays	Counts	Utilization Category Rates	Cumulative
Two stays	16	8.7%	8.7%
One stay	34	18.6%	27.3%
No stay	133	72.7%	100.0%
Total	**183**	**100.0%**	

D) IP stays	Counts	Admission Category Rates	Cumulative
Four or more stays	20	10.9%	10.9%
Three stays	10	5.5%	16.4%
Two stays	36	19.7%	36.1%
One stay	113	61.7%	97.8%
No stay	4	2.2%	100.0%
Total	**183**	**100.0%**	

Exhibit 13: Utilization Rates by Service Type: Cohort 4 (Cohort 1 plus food difficulty)

A) Office visits	Counts	Utilization Category Rates	Cumulative
21 or more office visits	76	10.4%	10.4%
16 to 20 office visits	73	10.0%	20.4%
11 to 15 office visits	125	17.1%	37.4%
6 to 10 office visits	169	23.1%	60.5%
1 to 5 office visits	197	26.9%	87.4%
No office visit	92	12.6%	100.0%
Total	**732**	**100.0%**	

B) Outpatient visit	Counts	Utilization Category Rates	Cumulative
Yes	575	78.6%	78.6%
No	157	21.4%	100.0%
Total	**732**	**100.0%**	

C) SNF stays	Counts	Utilization Category Rates	Cumulative
Two stays	16	2.2%	2.2%
One stay	35	4.8%	7.0%
No stay	681	93.0%	100.0%
Total	**732**	**100.0%**	

D) IP stays	Counts	Admission Category Rates	Cumulative
Four or more stays	20	2.7%	2.7%
Three stays	10	1.4%	4.1%
Two stays	36	4.9%	9.0%
One stay	113	15.4%	24.5%
No stay	553	75.5%	100.0%
Total	**732**	**100.0%**	

Exhibit 14: Utilization Rates by Service Type: Cohort 5 (Cohort 1 plus transportation difficulty)

A) Office visits	Counts	Utilization Category Rates	Cumulative
21 or more office visits	118	12.2%	12.2%
16 to 20 office visits	103	10.7%	22.9%
11 to 15 office visits	172	17.8%	40.7%
6 to 10 office visits	251	26.0%	66.7%
1 to 5 office visits	226	23.4%	90.2%
0: No office visit	95	9.8%	100.0%
Total	**965**	**100.0%**	

B) Outpatient visit	Counts	Utilization Category Rates	Cumulative
Yes	774	80.2%	80.2%
No	191	19.8%	100.0%
Total	**965**	100.0%	

C) SNF stays	Counts	Utilization Category Rates	Cumulative
Two stays	11	1.1%	1.1%
One stay	37	3.8%	5.0%
No stay	917	95.0%	100.0%
Total	**965**	**100.0%**	

D) IP stays	Counts	Admission Category Rates	Cumulative
Four or more stays	16	1.7%	1.7%
Three stays	8	0.8%	2.5%
Two stays	38	3.9%	6.4%
One stay	145	15.0%	21.5%
No stay	758	78.5%	100.0%
Total	**965**	**100.0%**	

Exhibit 15: Utilization Rates by Service Type: Cohort 6 (Cohort 1 plus living alone)

A) Office visits	Counts	Utilization Category Rates	Cumulative
21 or more office visits	85	13.6%	13.6%
16 to 20 office visits	64	10.2%	23.8%
11 to 15 office visits	115	18.3%	42.1%
6 to 10 office visits	153	24.4%	66.5%
1 to 5 office visits	149	23.8%	90.3%
0: No office visit	61	9.7%	100.0%
Total	**627**	**100.0%**	

B) Outpatient visit	Counts	Utilization Category Rates	Cumulative
Yes	515	82.1%	82.1%
No	112	17.9%	100.0%
Total	**627**	100.0%	

C) SNF stays	Counts	Utilization Category Rates	Cumulative
Two stays	13	2.1%	2.1%
One stay	42	6.7%	8.8%
No stay	572	91.2%	100.0%
Total	**627**	**100.0%**	
D) IP stays	**Counts**	**Admission Category Rates**	**Cumulative**
Four or more stays	12	1.9%	1.9%
Three stays	8	1.3%	3.2%
Two stays	27	4.3%	7.5%
One stay	110	17.5%	25.0%
No stay	470	75.0%	100.0%
Total	**627**	**100.0%**	

Analysis of Medically Tailored Meals Following an IP Stay

Next, Ananya Health considers the illustration of a supplemental benefit matched to one of the patient cohorts. Specifically, Ananya Health considers a hypothetical benefit comprising meals delivered to beneficiaries who were discharged following an IP stay for a period of approximately seven days. In this illustration, Ananya Health applies that supplemental benefit to Cohort 3, which meets the general criteria of two or more chronic conditions plus one or more ADLs and adds an additional criterion that the patient must have difficulties related to meals.

Exhibit 16 shows the step-by-step logic that results in a count of the IP readmissions that might be attributable to the intervention comprising the meals delivered to eligible beneficiaries. The left side of the table repeats the information provided earlier in Exhibit 12 regarding the number of IP stays reported by patients in this cohort.

The remainder of the table illustrates the application of the delivered-meals benefit. Because this cohort has characteristics that match the eligibility criteria for this hypothetical benefit, all of the patients would qualify at least once for the meals program.[30] Each of those patients will be eligible for the meals benefit according to the number of IP stays they reported for that year.

30 The count of four patients with "no stay" reflects discrepancies within the source and MCBS data. Ananya Health kept the four patients in order to keep running counts of patients in this cohort consistent; however, Ananya Health does not use them in these calculations of averted readmissions.

For example, the 113 patients who reported one IP stay would be eligible for 113 instances of delivered meals. Other patients in the cohort who had more IP stays that year would be eligible for delivered meals more than once. For example, the 20 patients with four or more stays would be eligible for approximately 100 instances in the aggregate, based on the assumption of an average of five IP stays for that subgroup. Similarly, the other subgroups would be eligible for meals more than once based on the total number of IP stays they reported for that year.

While a patient would be eligible for the meals program with each IP stay, a main hypothesized effect of the meals program is to reduce the probability of readmission. Exhibit 16 shows the count of readmissions targeted by the intervention. For example, the 36 patients who had reported IP stays had 72 IP stays in the aggregate, 36 of which are considered index admissions and not avoidable by the IP-triggered meal program, while the other "second" admission of the year might be a readmission that also might be averted. Ananya Health drew from the literature an estimate that 17.1 percent of Medicare IP discharges result in readmissions.[lxxiii] In other words, every 100 admissions would spawn about 17 additional IP stays. Ananya Health applied that estimate of 17.1 percent to the number of IP stays observed after the initial or index stay of the year in order to estimate the number of readmissions occurring absent the meals program. Ananya Health also drew from the literature an estimate that 13 percent of readmissions can be averted by delivering meals to patients following hospital discharges.[lxxiv] The result shown at the right of Exhibit 16 is the hypothetical number of readmissions adverted by the supplemental meals benefit.

Exhibit 17 shows an aggregate incremental cost of the meals program of $31,000 for the sample or $175.98 per participant, which is based loosely on estimates of program costs drawn from the literature.[lxxv] This example uses $100 per patient/discharge, which could be modified based on actual specifications and applicable prices. The corresponding averted readmission yield is $49,340 in savings and $17,840 in net savings, which is about $99.66 per participant in the supplemental benefits.

Exhibits 18 and 19 are identical conceptually to Exhibits 16 and 17, respectively, except that the numbers are extrapolated from the MCBS sample to the national Medicare population. The basic inputs in the extrapolations are the same, including the underlying utilization rates and assumptions about effect sizes from the hypothetical supplemental benefit. Also, the same are the estimates of cost, savings, and net savings per person. The extrapolations merely scale the case volumes to provide national estimates of results that might pertain if the supplemental benefit was used by all eligible beneficiaries covered by original Medicare at any time during the year.

Exhibit 18 shows simulated results for a hypothetical supplemental benefit involving medically tailored meals following an IP stay. Full participation

might lead to 575,408 eligible beneficiaries, 1,012,590 eligible IP stays, and 9,719 fewer readmissions attributable to the supplemental benefit. The literature suggests other utilization offsets, including reduced emergency-department visits and SNF stays, which would be additional savings attributable to the same supplemental benefit. The data source did not include emergency-department utilization rates for the analytic cohorts. Achieving significant reductions in SNF benefits should be considered especially in conjunction with supplemental benefits that include medically tailored meals and home visits that include clinical monitoring, social support, and early intervention as needed.

Exhibit 19 presents national estimates based on the sample data shown previously in Exhibit 16. The aggregate cost of full participation among eligible beneficiaries would be $101,258,974 (which is $175.98 per person). The gross savings due to reduced readmission rates would be $158,606,687, resulting in a net savings of $57,347,713. Most of the net savings come from the subgroup with several hospitalizations, while beneficiaries with a single IP stay would incur incremental costs from the meals program but have no readmissions to avert. All of the subgroups could potentially have additional savings due to averted emergency-department visits or even SNF stays under a national program with tailored supplemental benefits. In this illustration, the ratio of savings to cost for the hypothetical supplemental benefit was 1 to 57; on average, every dollar spent on the meals program resulted in $1.57 in savings.

Exhibit 16: Readmissions Averted by Hypothetical Meals Supplemental Benefit for Beneficiaries: Cohort 3: 2+ Chronic Conditions plus 1+ADL plus IP stay plus food difficulty

Impatient Stays Current Year	Counts	Admission Category Rates	Cumulative	# Meals Eligible Pts.	# Meals Eligible Pt-Admission	# Subsequent Admits Targeted by Intervention	Expected Re-Admit Rate (Literature)	# Expected Re-admit w/o Intervention	Rate Re-Admit Averted by Food (Angel 2018=13%)	# Re-Admit Averted by Meals
Four or more stays	20	10.9%	10.9%	20	100	80	17.1%	14	13.0%	1.78
Three Stays	10	5.5%	16.4%	10	30	20	17.1%	3	13.0%	0.44
Two Stays	36	19.7%	36.1%	36	72	36	17.1%	6	13.0%	0.80
One stay	113	61.7%	97.8%	113	113	-	0.0%	-	0.0%	-
No Stay	4	2.2	100.0%	-	-	-	0.0%	-	0.0%	-
	183	100.0%		179	315	136		23		3

Exhibit 17: Aggregate Cost, Savings, and Net Savings from Hypothetical Meals Supplemental Benefit for Beneficiaries: Cohort 3: 2+ Chronic Conditions plus 1+ADL plus IP stay plus food difficulty

Impatient Stays Current Year	Counts	Admission Category Rates	Cumulative	Meals Cost per Post-IP Discharge	Cost Saving: (Martin 2018: average cost per readmission of $16,320 per high-risk patient)	Net Saving	Comments
Four or more stays	20	10.9%	10.9%	10,000	$29,023	$19,023	Best Saving
Three Stays	10	5.5%	16.4%	3,000	$7,200	$4,256	Good
Two Stays	36	19.7%	36.1%	7,200	$13,061	$15,861	Good
One stay	113	61.7%	97.8%	11,300	$-	($11,300)	No Saving, All Cost
No Stay	4	2.2%	100%	-	$-	$0	
	183	100.0%		31,500	$49,340	$17,840	
				175.98	$275.64	$99.66	
				Save/Cost Ratio	1.57		

Exhibit 18: National Estimates of Readmissions Averted by Hypothetical Meals Supplemental Benefit for Beneficiaries: Cohort3: 2+ Chronic Conditions plus 1+ADL plus IP stay plus food difficulty

Impatient Stays Current Year	Counts	Admission Category Rates	Cumulative	# Meals Eligible Pts.	# Meals Eligible Pt-Admission	# Subsequent Admits Targeted by Intervention	Expected Re-Admit Rate (Literature)	# Expected Re-admit w/o Intervention	Rate Re-Admit Averted by Food (Angel 2018=13%)	# Re-Admit Averted by Meals
Four or more stays	64,291	10.9%	10.9%	64,291	321,457	257,166	17.1%	43,975	13.0%	5,716.79
Three Stays	32,146	5.5%	16.4%	32,146	96,437	64,291	17.1%	10,994	13.0%	1,429.20
Two Stays	115,725	19.7%	36.1%	115,725	231,449	115,725	17.1%	19,789	13.0%	2,572.56
One stay	363,246	61.7%	97.8%	363,246	363,246	-	0.0%	-	0.0%	-
No Stay	12,858	2.2	100.0%	-	-	-	0.0%	-	0.0%	-
	588,266	100.0%		575,408	1, 012,590	437,182		74,758		9,719

Note: The patients with "no stay" reflect discrepancies within the source and MCBS data. Ananya Health kept those patients in order to keep running counts of patients in this cohort consistent; however, Ananya Health does not use them in these calculations of averted readmissions.

Exhibit 19: National Estimates of Aggregate Cost, Savings, and Net Savings from Hypothetical Meals Supplemental Benefit for Beneficiaries: Cohort 3: 2+ Chronic Conditions plus 1+ADL plus IP stay plus food difficulty

Impatient Stays Current Year	Counts	Admission Category Rates	Cumulative	Meals Cost per Post-IP Discharge	Cost Saving: (Martin 2018: average cost per readmission of $16,320 per high-risk patient)	Net Saving	Comments
Four or more stays	64,291	10.9%	10.9%	32,145,706	$93,298,051	$61,152,345	Best Saving
Three Stays	32,146	5.5%	16.4%	9,643,712	$23,324,513	$13,680,801	Good
Two Stays	115,725	19.7%	36.1%	23,144,908	$41,984,123	$18,839,215	Good
One stay	363,246	61.7%	97.8%	36,324,648	$-	($36,324,648)	No Saving, All Cost
No Stay	12,858	2.2%	100%	-	$-	$0	
	588,266	100.0%		101,258,974	$158,606,687	$57,347,713	
				175.98	$275.64	$99.66	
				Save/Cost Ratio	1.57		

Discussion

In this issue brief, BPC and Ananya Health used publicly available data, combined with assumptions drawn from the literature, in order to illustrate the possible size and characteristics of Medicare beneficiary populations who could become eligible for supplemental benefits. Exhibit 20 shows national estimates of the number of beneficiaries covered under original Medicare for any part of the year and belonging to any of the six analytic cohorts defined in this study.

Exhibit 20: Patient Cohorts Based on Selection Criteria: Estimated National Eligible Population Sizes

Cohort definition (FFS for any part of the year)	Count
Any of the 11 CCs	26,083,966
Cohort 1: 2+CCs Plus 1+ADLs	7,049,507
Cohort 2: Cohort 1 Plus IP Stays	1,750,611
Cohort 3: Cohort 2 Plus Food Difficulties	588,266
Cohort 4: Cohort 1 Plus Food Difficulties	2,688,098
Cohort 5: Cohort 1 Plus Transportation Difficulties	3,931,686
Cohort 6: Cohort 1 Plus Living Alone	2,209,976

Ananya Health described each of these cohorts in terms of demographic and socioeconomic characteristics, as well as utilization rates reported in the MCBS survey. Ananya Health chose Cohort 3 to illustrate a type of supplemental benefit involving medically tailored meals delivered after discharge from an inpatient stay. Based on simple assumptions drawn from the literature, Ananya Health was able to illustrate potential positive net savings due to reduced readmission rates. Actual projections would require specification of a benefit, and refined assumptions about targeting, realistic participation, gaming, and operational details, including market prices. Meanwhile, policymakers and analysts can consider potential supplemental benefits in light of the eligibility criteria and resulting beneficiary populations described in this issue brief.

Appendix IV

HCBS Waivers and State Plan Amendments

HCBS Authorities	Eligibility	Limits and Flexibilities	Population Targeting (Comparability)	Geographic Targeting (Statewideness)	Self-Direction
Section 1915(c)	Individuals who meet the state's institutional level of care (meaning individuals could be admitted to a nursing facility, hospital, ICF/IID); the need for services must be based on an assessed need and identified in a state-approved service plan.	States may cap enrollment. In the aggregate, program services must not cost more than what would have been incurred to care for participants in an institution, referred to as "cost neutrality."	States may target based on age or diagnosis, including children, adults with physical disabilities, individuals with intellectual or developmental disabilities, individuals with traumatic brain injuries, individuals with MH/SUD, and older adults, among others.	States may limit a program geographically.	States can choose to offer self-directed HCBS under this benefit.
Section 1915(i)	Individuals who are eligible for medical assistance under the state plan, meet state-defined needs-based criteria, and reside in the community.	No cost neutrality requirement. States may not cap enrollment or maintain waiting lists. States may limit participation through needs-based eligibility criteria.	Option to target the benefit to a specific population based on age, disability, diagnosis, and/or Medicaid eligibility group. The lower threshold of needs-based criteria must be "less stringent" than institutional and HCBS waiver program level of care.	Benefit must be offered statewide.	States can choose to offer self-directed HCBS under this benefit.
Section 1915(k) Community First Choice Optional State Plan Benefit	Individuals who meet the state's institutional level of care (meeting the individual could be admitted to a nursing facility, hospital, ICF/IID, an institution providing psychiatric services for individuals under	States cannot limit the number of eligible individuals served.	States cannot target the benefit to a particular population.	Benefit must be offered statewide.	States can choose to offer self-directed HCBS under this benefit.

HCBS Authorities	Eligibility	Limits and Flexibilities	Population Targeting (Comparability)	Geographic Targeting (Statewideness)	Self-Direction
	age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the state plan) can qualify for services under section 1915(k).				
Section 1915(j) Optional Self-Directed Personal Assistance Services (PAS)	Individuals must be eligible for state plan personal care services or a section 1915(c) waiver program to qualify for services under section 1915(j).	States may limit the number of people who will self-direct their PAS.	States can target people already getting section 1915(c) waiver services.	PAS may be offered in certain areas of the state or statewide.	PAS is self-directed.

Research and Demonstration Programs

HCBS Authorities	Eligibility	Limits and Flexibilities	Population Targeting (Comparability)	Geographic Targeting (Statewideness)	Self-Direction
Section 1115 Demonstration Authority	States may waive certain statutory provisions such as "comparability" to define target populations for demonstration services/activities, which should be available based on individual assessments of need as defined by state.	Demonstrations must be budget neutral, meaning that the federal costs associated with the proposed demonstrations cannot exceed the federal Medicaid costs absent the demonstration.	States can target section 1115 demonstration services to particular populations meeting defined characteristics.	Statescan waive "statewideness" to target demonstration services at particular geographic areas.	States can choose to offer self-directed HCBS under this authority.
Money Follows the Person Demonstration	Participants must be Medicaid beneficiaries residing in an institution for 90 days or more, not counting short-term rehabilitation days. In addition, participants must move to a qualified residence in the community.	States project annual transition benchmarks to determine enrollment based on an annual grant-funded budget.	States can target demonstration services to particular populations meeting a state's institutional level of care and MFP eligibility criteria.	States can target MFP demonstration services at particular geographic areas.	States can choose to offer self-directed HCBS under this project.

Source: CMS, LTSS Rebalancing Toolkit (2020)

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[liv] Centers for Medicare & Medicaid Services, NOTE TO: *Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties Announcement of Calendar Year (CY) 2020 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, April 1, 2019. Available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2020.pdf.

[lv] For a full list of examples provided by CMS, see Kathryn Coleman, CMS Memorandum: "Implementing Supplemental Benefits for Chronically Ill Enrollees," Centers for Medicare and Medicaid Services, April 24, 2019. Available at: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf.

[lvi] Over the years, BPC has held various public events and private roundtable discussions about SSBCI. Participants have raised these concerns at one or more of these events or discussions.

[lvii] Anne Tumlinson, "New Opportunities for Serving Complex Care Populations in Medicare Advantage," The SCAN Foundation, December 2018. Available at: https://www.thescanfoundation.org/media/2019/08/2018-12-12_New-Opportunities-for-Serving-Complex-Care-Populations-in-MA.pdf.

[lviii] Bipartisan Policy Center, *Financing Long-Term Services and Supports: Seeking Bipartisan Solutions in Politically Challenging Times*, July 2017. Available at: https://bipartisanpolicy.org/report/financing-long-term-services-and-supports/.

[lix] Ibid., 19-22.

[lx] Ibid.

[lxi] U.S. Department of the Treasury, "Long-Term Care Insurance: Recommendations for Improvement of Regulation (Report of the Federal Interagency Task Force on Long-Term Care Insurance)," August 2020, 61. Available at: https://home.treasury.gov/system/files/136/Report-Federal-Interagency-Task-Force-Long-Term-Care-Insurance.pdf.

[lxii] NAIC, "Long-Term Care Innovation (B) Subgroup: Federal Policy Options to Present to Congress," 2017, 2. Available at: https://www.naic.org/documents/cmte_e_res_mech_wg_related_federal_policy_issues.pdf.

[lxiii] Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy, U.S. Department of Health and Human Services, "What Is the Lifetime Risk of Needing and Receiving Long-Term Services and Supports?," April 2019. Available at: https://aspe.hhs.gov/system/files/pdf/261036/LifetimeRisk.pdf.

[lxiv] Eileen J. Tell, "The Own Your Future Long-Term Care Awareness Campaign: Implications for CLASS," The SCAN Foundation, April 2011, 3. Available at: https://www.thescanfoundation.org/publications/the-own-your-future-long-term-care-awareness-campaign-implications-for-class/

[lxv] Ibid., 4-5.

[lxvi] U.S. Department of the Treasury, "Financial Literacy and Education Commission." Available at: https://home.treasury.gov/policy-issues/consumer-policy/financial-literacy-and-education-commission.

[lxvii] Centers for Medicare & Medicaid Services, "No Wrong Door System Reference Document for Medicaid Administrative Claiming Guidance," 8. Available at: https://www.Medicaid.gov/Medicaid/downloads/no-wrong-door-guidance.pdf

[lxviii] Office of the Assistant Secretary for Planning And Evaluation, U.S. Department of Health and Human Services, "Final Outcome Evaluation of the Balancing Incentive Program," February 11, 2019. Available at: https://aspe.hhs.gov/basic-report/final-outcome-evaluation-balancing-incentive-program.

[lxix] Ibid. See also Centers for Medicare & Medicaid Services, "Balancing Incentive Program." Available at: https://www.medicaid.gov/medicaid/long-term-services-supports/balancing-incentive-program/balancing-incentive-program/index.html.

[lxx] Office of the Assistant Secretary for Planning And Evaluation, U.S. Department of Health and Human Services, "Final Outcome Evaluation of the Balancing Incentive Program," February 11, 2019. Available at: https://aspe.hhs.gov/basic-report/final-outcome-evaluation-balancing-incentive-program.

[lxxi] The specific variable of interest used in the MCBS involved reported difficulty eating solid foods due to dental problems. This was a practical question to use because the survey asked it of all respondents and because it related to difficulties people might have with meals and nutrition. But actual eligibility criteria for a supplemental benefit involving meals might target additional needs that point to the potential value of delivered meals.

[lxxii] Ananya defined this cohort as those individuals in cohort 1 who had an inpatient stay, but it found an anomaly in the source data that had nine patients who fell into category of "no stay."

[lxxiii] Molly K. Bailey, Audrey J. Weiss, et al., *Characteristics of 30-Day All-Cause Hospital Readmissions, 2010-2016*, Statistical Brief #248, Healthcare Cost and Utilization Project, February 2019. Available at: https://hcup-us.ahrq.gov/reports/statbriefs/sb248-Hospital-Readmissions-2010-2016.jsp.

[lxxiv] The Commonwealth Fund, *Guide to Evidence on the Health Care Impacts of Interventions to Address the Social Determinants of Health*, June 2018. Available at: www.commonwealthfund.org/sites/default/files/2019-06/ROI-Calculator-Evidence-Guide%20-%20FINAL.pdf.

[lxxv] Ibid.

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