



An Updated Policy Roadmap

CARING FOR THOSE WITH COMPLEX NEEDS

EXECUTIVE SUMMARY

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 almost 100 recommendations addressing complex care, some of which have been enacted into law or incorporated into regulations or other agency guidance.

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. Current barriers include the need to use multiple home and community-based services (HCBS) waivers and state plan amendments (SPAs), which creates a complex system for states to administer and beneficiaries to navigate; fragmented care for dual eligible Medicare-Medicaid beneficiaries; a lack of clear federal guidance on Medicaid Buy-In programs for workers with disabilities; and limited access to long-term care for middle- and higher-income individuals.

BPC’s new report, [An Updated Policy Roadmap: Caring for Those with Complex Needs](#) (2022), is a compilation of recommendations from 12 previous reports that Congress and federal agencies should still consider. These recommendations focus on improving long-term services and supports for low-income individuals through the Medicaid program and providing support for middle- and higher-income individuals who are ineligible for Medicaid. We hope BPC’s report and this accompanying brief will be useful to policymakers as they seek solutions to improve care for those with complex needs. For background information and explanation of these recommendations, see the full report.

Improving Medicaid Coverage for Those with Complex Needs

A. Simplifying and Streamlining Medicaid HCBS Authorities

BPC's report includes recommendations to reduce administrative complexity and advance equitable access to HCBS by streamlining and simplifying Medicaid HCBS authorities. Specifically, policymakers should replace the complex patchwork of SPAs and waivers with a single, consolidated SPA that draws from existing authorities. Policymakers could advance the consolidated SPA independently, or as part of other efforts to reform Medicaid HCBS. The SPA should provide necessary services to those in need, while still giving states budget predictability.

- 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.**
- 2. The Centers for Medicare & Medicaid Services 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

All dual eligible individuals should be guaranteed access to integrated care. Although states are in the best position to integrate Medicare benefits with their state Medicaid programs, not all states have the resources required to integrate care. BPC also recognizes that some states will choose not to integrate care. To advance equitable access to integrated care nationwide, BPC's recommendations incentivize states to integrate care themselves while establishing a federal fallback program for states that choose not to do so.

- 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.
- 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

While states currently have the option to establish Medicaid Buy-In programs for workers with disabilities, improvements are necessary to make them more understandable, accessible, and relevant as states seek to ensure pathways to successful employment outcomes for these workers.

Congress, along with the Clinton and George W. Bush administrations, created 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. BBA and TWWIIA provide additional flexibility for states to offer Medicaid coverage to higher-income working 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. The Medicaid Buy-In eligibility option gives workers with disabilities access to Medicaid HCBS not available through other insurers, and those services allow individuals with disabilities to live independently in the community and to work.

The recommendations that follow include ways to improve 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 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 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.

Options to Improve LTSS for Individuals Not Qualifying for Medicaid

Improving access to and financing of LTSS for those whose incomes and resources are too high to qualify for Medicaid will reduce spend-down into the program, as well as inequities experienced by middle- and higher-income groups.

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

While Medicaid is the primary payer for HCBS, significant need for these services exists outside of the program. As the baby boom generation continues to age, many Medicare beneficiaries who are not dually eligible for Medicaid will wish to access care that allows them to remain in their home or community. The following recommendation would permit eligible Medicare beneficiaries to buy-in to certain integrated models to 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 packages and the number of beneficiaries likely served. ATI Advisory estimated approximately 587,000 individuals would enroll, and the most comprehensive benefit package option—which includes 1915(c) waiver HCBS, at a value reflecting 90th percentile state spending—would cost the federal government \$127.5 billion over 10 years (not adjusted for inflation).

- 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

Under the Bipartisan Budget Act of 2018, Congress provided authority for Medicare Advantage plans to offer, beginning in January 2020, special supplemental benefits for the chronically ill (SSBCI) that are not primarily health related. These benefits must have a reasonable expectation of improving or maintaining an individual's health or function. For example, plans may offer benefits such as non-medical transportation, fresh produce, and home modifications.ⁱ

Half of Medicare beneficiaries with complex needs are enrolled in MA, while half are served in fee-for-service (FFS).ⁱⁱ 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. As a part of this work, BPC contracted with Ananya Health Innovations (Ananya Health) to complete an analysis in support of providing special supplemental benefits to Medicare FFS enrollees (see Appendix III of the report.) Ananya Health found that medically-tailored meals provided for two weeks post-hospitalization to certain patients with chronic illness could potentially save \$1.57 for each dollar invested.

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. 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

For individuals with significant functional or cognitive impairment, family members often provide unpaid care while also helping to pay for services and supports delivered by care professionals. Assistance from family caregivers is particularly critical for individuals who are ineligible for Medicaid (which may cover items and services not covered under Medicare), including those who may have limited benefits through private long-term care insurance. The unpaid care and financial assistance that family caregivers provide can help to keep frail individuals in their homes and delay the need for expensive LTSS, such as nursing facility costs.

Almost 80% of unpaid caregivers report having out-of-pocket expenses and spend, on average, about a quarter of their income on caregiving activities.ⁱⁱⁱ

Providing a refundable tax credit to caregivers for LTSS-related out-of-pocket costs would help relieve their financial burden.

- 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

As Medicare does not cover comprehensive LTSS, middle- and higher-income individuals who need additional LTSS must pay for those expenses out-of-pocket—often until they spend-down their savings to qualify for Medicaid—if they do not have private long-term care insurance (LTCI). According to a 2020 [report](#) by the Federal Interagency Task Force on Long-Term Care Insurance, however, the private LTCI market is in steep decline. Contributing factors include the high cost of insurance premiums, out-of-date federal regulatory requirements, lack of information provided by consumers regarding their risk of LTSS need, and difficulties with how care is financed. These challenges have resulted in rising, unpredictable, and unaffordable premiums, carriers dropping out of the market, and private LTCI plans offering limited or insufficient coverage.^{iv} BPC’s new report includes recommendations to improve private LTCI.

- 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” 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 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

Approximately 70% of adults who reach age 65 will eventually develop severe LTSS needs, and almost half of those individuals will receive some paid LTSS care over their lifetime.^v Generally, Americans lack information and may have misconceptions about the need, costs, and coverage 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.

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.**

CONCLUSION

People with complex needs often experience administrative and programmatic barriers to accessing and financing care, particularly LTSS. COVID-19 created a unique opportunity to transform the United States' LTC delivery system. Improving the quality of care and addressing long-term needs will require public- and private-insurance reforms. 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.

ENDNOTES

- ⁱ For additional examples, see: Medicare Drug & Health Plan Contract Administration Group, Centers for Medicare & Medicaid Services, "Implementing Supplemental Benefits for Chronically Ill Enrollees," Memorandum, April 24, 2019. Available at: https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf
- ⁱⁱ Anne Tumlinson, "New Opportunities for Serving Complex Care Populations in Medicare Advantage," The SCAN Foundation, December 2018. Available at: https://www.thescanfoundation.org/sites/default/files/2018-12-12_new_opportunities_for_serving_complex_care_populations_in_medicare_advantage_final_0.pdf
- ⁱⁱⁱ AARP, "Caregiving Out-Of-Pocket Costs Study," June 2021. Available at: https://www.aarp.org/content/dam/aarp/research/surveys_statistics/ltc/2021/familycaregivers-cost-survey-2021.doi.10.26419-2Fres.00473.001.pdf.
- ^{iv} Richard G. Frank, Marc Cohen, and Neale Mahoney, "Making Progress: Expanding Risk Protection for Long-Term Services and Supports through Private Long-Term Care Insurance," The SCAN Foundation, March 2013. Available at: <https://www.thescanfoundation.org/publications/making-progress-expanding-risk-protection-for-long-term-services-and-supports-through-private-long-term-care-insurance/>
- ^v HHS Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy, "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>.

