



Bipartisan Policy Center

BPC's Key Considerations for Developing a Medicaid Home and Community-Based Services Benefit

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In developing legislation to expand the availability of Medicaid home- and community-based services (HCBS), policymakers will need to consider a number of issues. In May of 2021, The Bipartisan Policy Center hosted a private roundtable discussion with experts, supplemented by individual interviews. Experts included state-level policymakers, consumer advocates, plans, and providers. This paper discusses the key challenges and opportunities identified by experts in expanding Medicaid HCBS, and outlines options for congressional consideration. It is important to note however, that some experts indicated that an expansion of HCBS should be done through the Medicare program, rather than Medicaid, and several proposals have been introduced to create a Medicare long-term care benefit.

BACKGROUND

The Medicaid program is the primary source of paid long-term services and supports (LTSS). They are provided in institutional settings, including nursing homes, intermediate care facilities for individuals with intellectual disabilities, and at home and in the community. While not defined in the Medicaid statute as HCBS, they include mandatory and optional Medicaid services including home health, rehabilitation, physical and occupational therapy, personal care, targeted case management, and one or more of a group of services defined as part of the HCBS waiver authority.¹ Finally, Early

¹ In addition to services outlined above, Section 1915(c) of the Social Security Act includes “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.”

and Periodic Screening Diagnosis and Treatment, required services for children under the age of 21, includes coverage of medically necessary HCBS, such as: personal care; private duty nursing; and physical, occupational, and speech-language therapy.ⁱ

Spending on Medicaid LTSS has shifted dramatically from institutional care to HCBS over the last 30 years. In 1988, 90% of the \$23 billion in Medicaid LTSS spending was for institutional services, with only 10% of LTSS spent at home or in the community.ⁱⁱ Today, more than half of Medicaid spending for LTSS spending is for HCBS.ⁱⁱⁱ Despite the significant increase in the availability for HCBS, in some areas of the country, there is still a strong preference for institutional care. Estimates of the percentage of LTSS spending on HCBS range from more than 70% in some states to as low as 3% in others, demonstrating that HCBS are not available to everyone who needs care.^{iv}

Most HCBS are offered through Medicaid waivers under 1915(c) of the Social Security Act (SSA). Under 1915(c) states may provide HCBS to those who require a nursing home level of care. States have also used broader waiver authority permitted under 1115 of the SSA. Both waiver authorities require states to demonstrate that these expansions would not increase federal Medicaid expenditures. While generally states must offer Medicaid benefits throughout the state (a requirement referred to as statewideness) and to every eligible individual (referred to as comparability) under waivers, states may offer services in certain areas and may limit the number of people served. States often limit services to make expenditures more predictable. In 2005 and 2010, Congress passed, and Presidents Bush and Obama signed into law, respectively, two state plan options, allowing states to expand HCBS without obtaining waivers, including 1915(i) and 1915(k).^{v, vi} However, because state plan options for HCBS do not require budget neutrality, states still lean heavily on waivers.

RECENT ACTION

President Biden and Democratic congressional leaders have committed to expanding Medicaid HCBS. The American Rescue Plan included a provision to increase Medicaid matching dollars to states by 10% for one year beginning March 1, 2021.^{vii} In addition, the president's infrastructure proposal included \$400 billion to expand the availability of HCBS and jobs for caregivers.^{viii} The proposal did not include policy details, so developing specific proposals would fall to Congress should they choose to advance the initiative. Democratic members of the House and Senate have introduced legislation to require states to provide HCBS.^{ix} The requirement would be phased in over a 5-year period and include 100% federal matching payments to states.

HCBS EXPANSION CONSIDERATIONS

Without question, the biggest opportunity associated with HCBS expansion is the potential for \$400 billion in new federal spending. For the first time, Congress has considered allocating resources at a level that has the potential to make the Supreme Court holding in *Olmstead v. L.C.* a reality for those with mental illness and other disabilities. In the 1999 *Olmstead* opinion written by the late Justice Ginsburg, the court held that states must provide community-based services to those with mental illness: 1) when state professionals have determined that community placement is appropriate; 2) the individual prefers a community-based setting; and 3) community-based care can be reasonably accommodated, considering the state resources and the needs of others with mental disabilities.^x

RECENT ACTION

Workforce – The challenge most often cited as a barrier to significant expansion of HCBS is the need for qualified caregivers. Between 2019 and 2029, the Bureau of Labor Statistics estimates a 1.9 million increase in jobs for family caregivers, a 37% increase over 10 years.^{xi} They also stressed the need for investment in resources at the state level to implement the expansion, including an increase in personnel and resources for caregiver training.

Quality Measures – States are looking for ways to ensure quality and accountability in the delivery of HCBS through Medicaid and other state waiver programs. State-specific measures exist, but they are imprecise or have not been thoroughly tested, and do not allow cross-state comparison. Existing national measures are clinically oriented and leave gaps in addressing what is often more important to people who need HCBS. Many of the Healthcare Effectiveness Data and Information Set (HEDIS) Medicare Advantage measures were never designed for people with complex health status who are generally the users of HCBS, and these patients are excluded from many measures. While some HEDIS measures are relevant, they are often directed towards measuring undesirable outcomes, such as readmissions, rather than the delivery of high-quality care to complex patients, and they are not designed to measure the quality of HCBS.

State Resources – Another key concern is the lack of state-level fiscal resources required to finance the states' Medicaid matching requirements. States stressed the need for spending predictability on Medicaid, given the demand for services. Today, Medicaid accounts for nearly 30% of states' budgets. The use of HCBS waivers permits states to limit the number of individuals served, allowing an accurate estimate of HCBS costs. Many states, particularly those with significant unmet need, would be reluctant to expand services without significant federal resources. At the same time, there is skepticism that there will be enough federal resources to make services available to

everyone who needs assistance, and most do not believe that \$400 billion in federal spending will address all unmet needs.

State Requirement or State Option – Another key question is whether a state mandate to provide HCBS is needed to address what many consider to be a bias for institutional services over HCBS, since institutional services are required services under the Medicaid program, while HCBS are optional. Others suggest that states with a heavy reliance on nursing home provider taxes to supply the states' share of Medicaid funding creates a disincentive for HCBS expansion.

Eligibility – Today, states set eligibility for HCBS, leading to significant variation from state to state, but also significant variance in eligibility for services from region to region and between populations (e.g., people with intellectual disabilities versus frail older Americans) within a state, given the flexibility to waive statewideness and comparability under waivers. Some experts have suggested the use of a federal floor to create greater equity within a state and between states. A number of other issues also arise in establishing eligibility, including income and resource tests, how individuals would spend existing resources to become eligible for services, and the resources a person will need to pay for ongoing living expenses, such as rent, utilities, food and other expenditures that Medicaid covers for those residing in an institutional setting. Finally, some have suggested the need for review of the amount individuals retain as a personal needs allowance.

Benefits – Most experts believe that it is important to maintain the flexibility to design benefits based on the need of the individual. Given the heterogeneity of people with disabilities, some may need short-term inpatient care to address serious mental illness, while others need long-term personal care assistance services for a physical disability, and others may benefit from targeted case management services along with social services and supports such as minor home modifications to help them remain safely at home. Most agree on the need for a uniform screening tool that will determine the need for services, but the screening tool must be designed to benefit all populations, not one over another. Also, there is an agreement on the need for an individual assessment and the development of a personal care plan developed with an individual and their informal caregivers.

Maintenance of Effort – While most experts agree in making new federal resources available, any new funding should supplement, not supplant, current state spending. This would require states to maintain their current level of spending. At the same time, a maintenance of effort would disadvantage those states that have made significant investments in HCBS, relative to their counterparts that have not expanded coverage of HCBS.

Implementation – As noted above, the shortage of caregivers and state infrastructure will require a significant transition period allowing states to gradually expand services. However, some experts suggest that it will be important to make short-term changes to allow expansion of services as states are able to expand. Some states will be reluctant to expand absent a permanent spending authority. Finally, some expressed concern that

unless benefits are accelerated, future Congresses and administrations will scale-back or repeal expansion.

POLICY OPTIONS

Until Congress secures adequate funding to make HCBS accessible to all who need services, it could take several approaches to expand the availability of HCBS. In addition to introducing legislation to require states to provide Medicaid HCBS, Congress could consider the following options:

Section I – Short-term Transitional Options to Build Capacity

- A. Temporary Expansion of Enhanced Administrative FMAP for HCBS Implementation-Related Costs.** States receive enhanced Federal Medical Assistance Percentages (FMAP) for certain activities that the federal government considers a priority. Enhanced FMAP is provided for both services and for administrative costs. For example, states receive a 90% match for Medicaid fraud control units, 90% match for implementation of MMIS, 90% match for administration of family planning services, and 75% for improved eligibility determination systems. In preparation for an expansion of Medicaid HCBS, Congress could provide a similar enhanced match for activities related to building capacity for HCBS expansion, including hiring of state administrative staff, provider training, costs associated with identifying with agencies and direct service providers, and other non-service-related activities.
- B. Streamline and simplify existing HCBS waiver and state plan amendment authorities into a single, consolidated state plan amendment that retains much of the flexibility of the existing HCBS waiver authorities and state plan options.** Congress could phase out existing HCBS waivers and State Plan Amendments (SPAs) and require states to deliver HCBS through the new SPA within five years of enactment. Transitioning waivers to an improved state plan option would incentivize infrastructure development for HCBS, promote administrative efficiency and access, and support person-centered care for beneficiaries while providing states with the desired budget predictability. A consolidated state plan option should include requirements or incentives for uniform assessments and person-centered care plans, incentives for states to help individuals transition from institutional to community settings, and incentives for streamlined enrollment and a single entry-point to access HCBS. Existing populations should be grandfathered to avoid disruption of services.
- C. Direct the secretaries of the Department of Health and Human Services (HHS) and Labor to develop a system of classification of HCBS Workers for the purposes of payment under the Fair Labor Standards Act.**

D. Direct the secretary of HHS to Review Network Adequacy Requirements for HCBS services in Medicaid Long-term Services and Supports plans, as well as fee-for-service providers, and direct states to develop a statewide plan to reduce caregiver turnover in both managed care and fee-for service. States should also compare access to HCBS by race.

E. Direct the secretary of HHS to issue regulations on a voluntary core set of HCBS quality measures and incent states to report on those measures. To promote person-centered, high quality care delivery, the HCBS quality measurement set should include person-driven outcome measures that reflect whether care is aligned with patient and caregiver goals. In developing the recommended core set, the secretary of HHS should also prioritize outcomes measures that measure beneficiary and caregiver experience. CMS is considering establishing a nationally available set of recommended Medicaid HCBS quality measures; in September 2020, CMS released a request for information seeking public feedback on a draft voluntary set of HCBS quality measures.^{xii} Congressional action would ensure continued progress toward a nationally available set of quality measures for HCBS care delivery. Congress has previously taken similar action to establish certain core quality measurement sets,^{xiii} and established requirements for mandatory state reporting on the child core set^{xiv} and the core set of behavioral health measures for adults.^{xv} Incentives for state reporting on the HCBS measures could be an initial step toward a longer-term goal of mandatory reporting on those measures. Congress should provide a 100% FMAP to states for administrative activities related to the adoption of HCBS quality measures, including stakeholder engagement, data and quality infrastructure, and public reporting of those measures, to incent state adoption of the measures. Congress should also make additional funding available to the Secretary of HHS to provide technical assistance to states, health plans, and providers. As states adopt the proposed HCBS quality measurement set, this would allow for comparisons across states and for tracking changes in HCBS care delivery quality over time. Establishing an HCBS quality measurement set may also encourage more health plans and HCBS providers to seek accreditation distinctions for LTSS.

F. Provide incentive payments to states for achieving milestones that reflect progress toward HCBS capacity building. In September 2020, CMS announced that it will make up to \$5 million in supplemental funding available to the 33 states currently operating Money Follows the Person (MFP) demonstration programs.^{xvi} This funding will be for planning and capacity building activities for LTSS system transformation design and implementation and to expand HCBS capacity. While the funds will support HCBS capacity building in MFP demonstration states, states will not receive additional incentive payments for demonstrating meaningful improvements in HCBS capacity. Also, those funds will not be available to states that are not currently participating in the MFP demonstration. An initiative that provides incentive payments to states that demonstrate improvements in HCBS capacity would promote capacity building more widely across all states. Examples of milestones that states must demonstrate may include a certain percent decrease in caregiver turnover rates or an increase in the number of available providers.

Section II - Expansion

- A. HCBS Mandatory Block Grant similar to CHIP** - Expand the availability of HCBS for individuals under 300% of the Supplemental Security Income (SSI) through a capped entitlement to states similar to the Children's Health Insurance Program (CHIP).

- B. Expand HCBS through fully-integrated plans** - Expand the HCBS to all qualified individuals with incomes below 300% (about 221% of FPL) of SSI, and permit individuals with incomes over 300% of SSI to purchase one of two benefit packages by paying a monthly premium through fully-integrated plans or providers (i.e., FIDE-SNPs, PACE or Washington State's managed fee-for-service health home). When fully implemented, individuals not eligible for Medicaid HCBS could enroll and pay a premium.

ⁱ Section 1905(r) of the Social Security Act.

See also Centers for Medicare and Medicaid Services, “EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents,” Early and Period Screening, Diagnostic, and Treatment (EPSDT), 22, June 2014. Available at:

https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf.

ⁱⁱ Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, “Understanding Medicaid Home and Community-based Services: A Primer 2010 Edition.” October 29, 2010. Available at: <https://aspe.hhs.gov/report/understanding-medicaid-home-and-community-services-primer-2010-edition#note1-4>.

ⁱⁱⁱ Centers for Medicare and Medicaid Services, “Medicaid Long Term Services and Supports Annual Expenditures Report, Federal Fiscal Years 2017 and 2018,” January 7, 2021. Available at: <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures-2017-2018.pdf>

^{iv} Centers for Medicare and Medicaid Services, “Long-Term Services and Supports Expenditures on Home & Community-Based Services.” Available at: <https://www.medicaid.gov/state-overviews/scorecard/lts-expenditures-on-hcbs/index.html>.

^v Section 6086 of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171).

^{vi} Section 2401 of the Patient Protection and Affordable Care Act.

^{vii} Pub. Law 117-2. Available at: <https://www.congress.gov/bill/117th-congress/house-bill/1319/text>.

^{viii} The White House, “FACT SHEET: The American Jobs Plan,” March 31, 2021. Available at: <https://www.whitehouse.gov/briefing-room/statements-releases/2021/03/31/fact-sheet-the-american-jobs-plan/>.

^{ix} HCBS Access Act of 2021. Available at:

https://debbiedingell.house.gov/uploadedfiles/hcbs_access_act.pdf.

^x 527 U.S. 581 (1999). Available at: <https://www.loc.gov/item/usrep527581/>

^{xi} Bureau of Labor Statistics, U.S. Department of Labor, “EMPLOYMENT PROJECTIONS — 2019-2029,” News Release, USDL-20-1646, September 1, 2020. Available at: <https://www.bls.gov/news.release/pdf/ecopro.pdf>.

^{xii} Centers for Medicare and Medicaid Services, “Request for Information: Recommended Measure Set for Medicaid-Funded Home and Community-Based Service.” Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/rfi-hcbs-recommended-measure-set.pdf>.

^{xiii} Sections 1139A and 1139B of the Social Security Act.

^{xiv} Congress.gov, “H.R. 1892 – Bipartisan Budget Act of 2018,” Section 50102(b), 2018. Available at: <https://www.congress.gov/bill/115th-congress/house-bill/1892/text>.

^{xv} Congress.gov, “H.R. 6, “SUPPORT for Patients and Communities Act,” Section 5001, 2018. Available at: <https://www.congress.gov/bill/115th-congress/house-bill/6>.

^{xvi} Centers for Medicare and Medicaid Services, “CMS Announces New Federal Funding for 33 States to Support Transitioning Individuals from Nursing Homes to the Community,” Press Release, September 23, 2020, Available at: <https://www.cms.gov/newsroom/press-releases/cms-announces-new-federal-funding-33-states-support-transitioning-individuals-nursing-homes>.