



Bipartisan Policy Center

Streamlining and Simplifying Medicaid HCBS Part I

June 15, 2021

The Bipartisan Policy Center (BPC) is continuing its efforts to improve access to long-term services and supports (LTSS). In previous reports, BPC highlighted the growing challenges associated with improving access to and financing of LTSS.¹ Building on our previous work around LTSS and Medicaid home and community-based services (HCBS), BPC’s work will focus on three key policy areas:

1. Expanding Medicaid HCBS	Report released in June 2021
2. Improving the Availability of Long-Term Services & Supports (includes Medicaid HCBS Expansion)	September 2021
3. Streamlining and Simplifying Medicaid HCBS	October 2021

In this report, part I of a two-part series, BPC: 1) outlines policy options to streamline and simplify the current system of HCBS waivers and state plan options; and 2) solicits feedback from stakeholders to help inform part II, which will be released in September. Part II will include final recommendations to policymakers on streamlining and simplifying Medicaid HCBS.

¹ Bipartisan Policy Center, “Financing Long-Term Services and Supports: Seeking Bipartisan Solutions in Politically Challenging Times,” July 2017. Available at: <https://bipartisanpolicy.org/wp-content/uploads/2019/03/BPC-Health-Financing-Long-Term-Services-and-Supports.pdf>.

Bipartisan Policy Center, “Initial Recommendations to Improve the Financing of Long-Term Care,” February 2016. Available at: <https://bipartisanpolicy.org/wp-content/uploads/2019/03/BPC-Health-Long-Term-Care-Financing-Recommendations.pdf>.

Bipartisan Policy Center, “America’s Long-Term Care Crisis: Challenges in Financing and Delivery,” April 2014. Available at: <https://bipartisanpolicy.org/wp-content/uploads/2019/03/BPC-Long-Term-Care-Initiative.pdf>.

This report includes a brief overview of existing HCBS waivers and state plan options, followed by draft policy options. The report also includes a set of questions to help guide BPC in the development of final recommendations.

To provide feedback, please send comments to:
HCBScomments@bipartisanpolicy.org

POLICY OPTIONS:

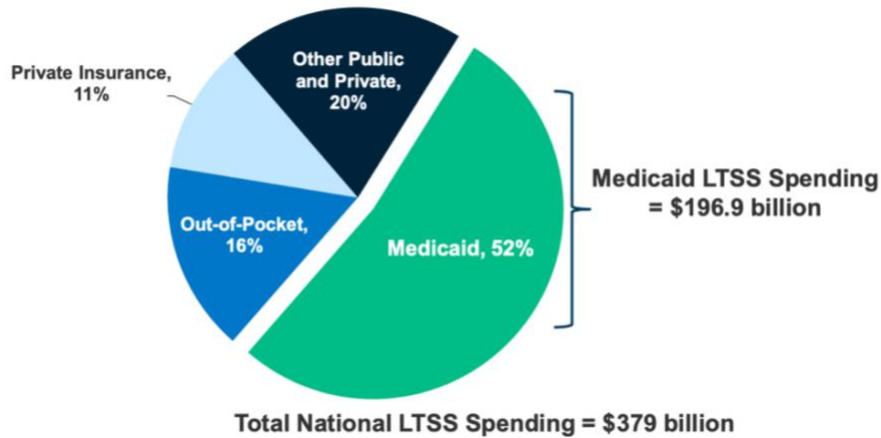
- 1. Congress should streamline and simplify existing HCBS waiver and state plan amendment (SPA) authorities into a single, consolidated state plan amendment that retains much of the flexibility of the existing HCBS waiver authorities and state plan options. Congress should phase out existing HCBS waivers and SPAs, and require states to deliver HCBS through the new SPA within five years of enactment.**
- 2. Congress should provide additional resources to the Centers for Medicare & Medicaid Services (CMS) to provide comprehensive technical assistance to states on transitioning to the new consolidated HCBS state plan authority.**

BACKGROUND

In 2018, an estimated 14 million adults in the United States reported a need for long-term services and supports (LTSS).ⁱ LTSS refers to a broad range of paid and unpaid medical and personal care assistance that individuals may need when they have difficulty completing self-care tasks due to age, chronic illness, or disability.ⁱⁱ LTSS includes assistance with activities of daily living (ADLs), such as eating, bathing, and dressing, and instrumental activities of daily living (IADLs), such as medication management and meal preparation.ⁱⁱⁱ People who need LTSS typically have physical, cognitive, developmental, mental, or other chronic health conditions.^{iv}

The majority of paid LTSS is jointly financed by the federal government and states through the Medicaid program.^v Medicaid spent \$196.9 billion on LTSS in calendar year (CY) 2018, accounting for more than half of the \$379 billion spent by all payers (Figure 1).^{vi} LTSS includes both institutional care, those provided in skilled nursing facilities or other congregate care settings, as well as services provided at home or in other community-based settings, typically referred to as HCBS.^{vii}

Figure 1: LTSS Spending, by Payer, CY 2018



Note: Total LTSS expenditures include spending on residential care facilities, nursing homes, home health services, and home and community-based waiver services. Expenditures also include spending on LTSS-related ambulance services and some post-acute care. This chart does not include Medicare spending on post-acute care (\$83.3 billion in 2018). All home and community-based waiver services are attributed to Medicaid.

Source: [KFF](#) estimates based on 2018 National Health Expenditure Accounts data from CMS, Office of the Actuary, February 2020.

A. Brief History of Medicaid LTSS Coverage

Since enactment of the Medicaid program in 1965, states have been required to provide LTSS to individuals age 21 and older in skilled nursing facilities, an institutional setting. Home health care services, which refer to a limited category of HCBS,^{viii} were initially optional under the program until 1970, at which point Congress required states to cover the benefit for those entitled to skilled nursing facility care.^{ix} New institutional service options became available to states in the early 1970s; these included intermediate care nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and psychiatric hospitals for children under age 21.^x Beginning in 1981, Congress started to expand HCBS with the enactment of section 1915(c) waivers; the federal government began providing federal matching dollars allowing states to cover a broad range of HCBS, provided federal spending does not exceed what the federal government would have spent on institutional care for those receiving HCBS.^{xi}

The expansion of HCBS was also directly impacted by the 1999 Supreme Court Decision in *Olmstead v. L.C.*,² when the court held that medically unjustifiable institutionalization of individuals violates the Americans with Disabilities Act. This

² *Olmstead v. L.C.*, [527 U.S. 581 \(1999\)](#). In this 1999 opinion written by Justice Ginsburg, the Court held that states must provide community-based services to those with mental illness, when: 1) 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.

effectively established the most integrated setting as the policy framework for long-term services and supports. The decision also allows for HCBS waiting lists if they are cleared at a “reasonable pace.”^{xii}

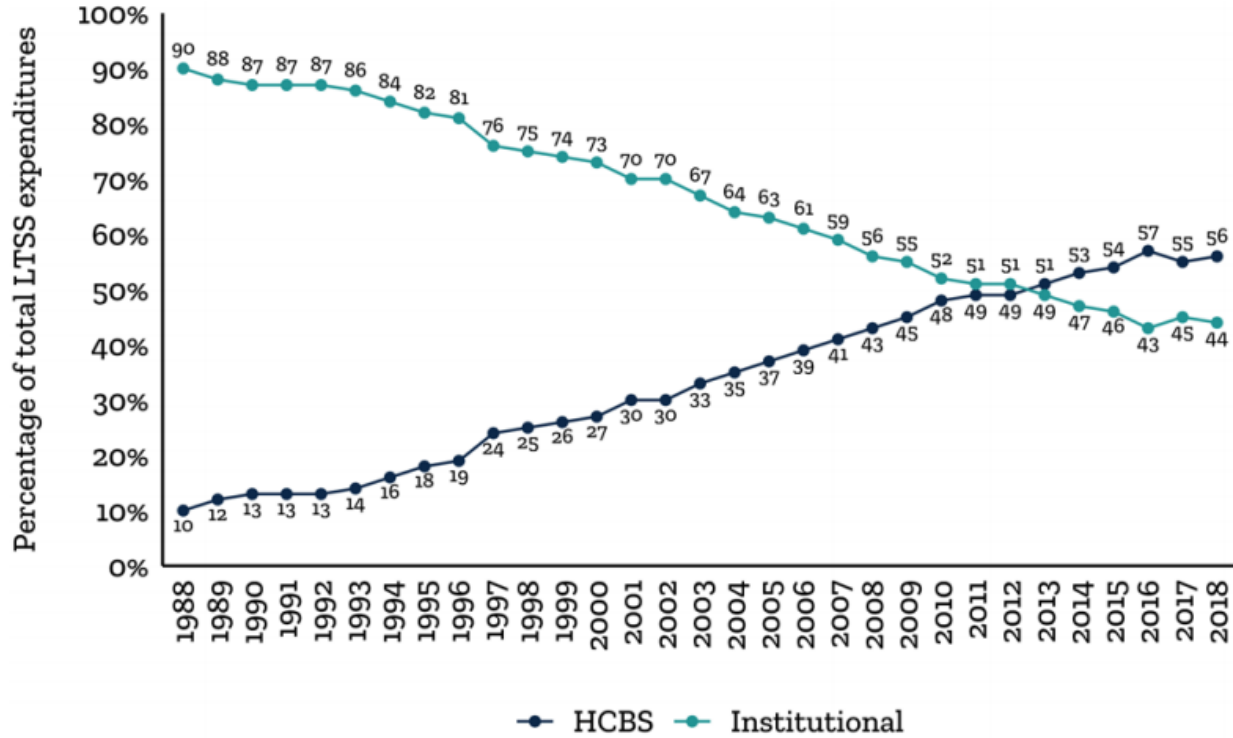
In 2005, Congress sought to further expand HCBS through state plan options, rather than requiring federal waivers. The Deficit Reduction Act authorized: the first HCBS state plan option under section 1915(i), creating a state plan option to provide services to those who do not require an institutional level of care; section 1915(j), which added self-directed care to Medicaid HCBS; and the Money Follows the Person Demonstration Program (MFP).^{xiii} The Affordable Care Act (ACA) included an additional state plan option under section 1915(k), known as the Community First Choice Option. The ACA also established the Balancing Incentive Program.^{xiv, 3} The state plan options are explained in detail below.

Although not specific to HCBS, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) has become a critical source of HCBS for children with disabilities. EPSDT requires states to offer comprehensive services to children, and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions.^{xv} HCBS covered by the EPSDT benefit may include, for example, private duty nursing, personal care services, home health and medical equipment and supplies, and rehabilitative services, among others.^{xvi}

Collectively, the *Olmstead* decision and federal statutory and policy changes resulted in a significant increase in the provision of HCBS. From fiscal year (FY) 1999 to FY2018, Medicaid LTSS spending on institutional care decreased from 74% to 44% of total Medicaid LTSS expenditures, while spending on HCBS grew from 26% to 56% of total Medicaid LTSS expenditures.^{xvii} Although, as outlined below, these numbers are averages, and do not provide a full picture of access to services (Figure 2).

³ The Balancing Incentive Program was enacted under the ACA and made enhanced matching dollars available to participating states to increase the share of LTSS dollars spent on HCBS, and to improve the LTSS infrastructure to create a more consumer-friendly, consistent, and equitable system.

Figure 2: Changes in Federal Spending on LTSS, FY 1988 to 2018



Source: CMS, [Long-Term Services and Supports Rebalancing Toolkit](#), November 2020.

B. HCBS Covered Services and Pathways

Home and community-based services include a broad range of medical and non-medical services designed to support individuals living in the community. States often combine optional and mandatory medical services, such as home health or rehabilitation services with non-medical services, primarily specified under section 1915(c) of the Social Security Act. These services include case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and other services requested by the state and approved by the Secretary of HHS.^{xviii} These services may also include 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.^{xix} All states offer HCBS, either through benefits, waivers, HCBS-specific state plan amendments (SPAs), or a combination of benefits, waivers, and amendments.^{xx}

1. Waivers

Waivers allow states to avoid certain requirements of the Social Security Act (SSA) that would otherwise be required for benefits provided through a SPA. When providing HCBS, states generally seek to waive requirements in Section 1902 of the SSA that: benefits must be available in all geographic areas of the state (statewide); benefits must be provided in the same amount, duration, and scope to all enrollees (comparability); beneficiaries may select any Medicaid-participating provider (freedom of choice); and certain income and resource rules applicable in the community. For example, under a single 1915(c) waiver, states may waive statewide, comparability, and income and resource standards.^{xxi}

This allows states to use waivers to target HCBS by specific population, geographic location, age, diagnosis, or other criteria. As a result, states may target HCBS to certain populations based on age or diagnosis, such as autism, cerebral palsy, or HIV/AIDS.^{xxii} Under waivers, states may also generally cap enrollment and cap average costs per person to limit costs to the state. While these flexibilities are important, they have also led to long waiting lists to receive HCBS, and unequal access to services for individuals with similar needs who live in the same state.

Waivers also have certain limitations related to the federal approval process and oversight requirements that differ from the SPAs. CMS approves 1915(c) and 1115 waivers for a time-limited period of, generally, three to five years.^{xxiii} States must request renewals upon waiver expiration.^{xxiv} These waivers must also be cost-neutral, meaning that federal spending during the waiver period cannot exceed projected spending absent the waiver.^{xxv} In FY2018, the most recent year for which this data is available, 1.8 million individuals received services through 256 separate 1915(c) waivers.^{xxvi}

2. State Plan Amendments

Federal Medicaid rules give states the authority to design their Medicaid state plans through the state plan amendment process.^{xxvii} A Medicaid state plan is an agreement between states and the federal government that outlines how a state administers its Medicaid program.^{xxviii} States have a federal legal entitlement to open-ended federal financing for benefits and services covered under a state plan, and the state plan amendment process sets the parameters of that state entitlement.^{xxix}

When a state wishes to make a change to its program, such as add coverage for benefits considered optional, it submits an SPA to CMS for review and approval.^{xxx} CMS has 90 days to decide on a proposed SPA, at which point it automatically goes into effect if CMS has not acted.^{xxxi} There are three state plan amendments that states may use to provide HCBS:

- **1915(i) – State Plan HCBS:** States may use 1915(i) authority to provide certain acute-care medical services (e.g., dental services, skilled nursing services) and long-term services (e.g., respite, case management,

supported employment, and environmental modifications) to eligible individuals in HCBS settings. To be eligible, individuals must have incomes below 150% of the federal poverty level, must meet state-defined criteria based on need, and be at risk for institutional care. States must establish an individualized care plan for the individual. States may allow self-directed HCBS. States may include individuals with incomes up to 300% SSI.

- **1915(j) – Self-Directed Personal Assistance Services:** States may offer self-directed personal assistance services, which provide the option for states to offer self-directed personal care. The Self-Directed Personal Assistance Services state option is provided under the Medicaid state plan and/or section 1915(c) waivers that the state already has in place.
- **1915(k) – Community First Choice Option:** States may provide HCBS attendant services and supports on a statewide basis to individuals who would otherwise require institutional care. The SPA must cover individuals with incomes up to 150% of the federal poverty level or those eligible for nursing home services, but the state may expand financial eligibility. States that pursue this option receive a 6% increase in federal matching assistance percentage (FMAP).

SPAs have different requirements and federal oversight rules than waivers. Unlike waivers, SPAs do not require periodic renewal; do not need to meet budget neutrality requirements because they are entitlements established by the state plan and amendment process; and do not require approval from the secretary of HHS through a lengthy application process.

When provided through an SPA, the state must generally provide HCBS to all eligible individuals, but federal rules have refined the SPA pathway in recent years. The 1915(i) state plan option retains the simplicity of a SPA, but includes certain state controls; it permits states to take certain actions to limit enrollment. Specifically, when a state implements a 1915(i) SPA, the state projects the number of beneficiaries that will receive HCBS and, if actual enrollment exceeds the projected enrollment, the state may modify the needs-based criteria for determining eligibility for HCBS without obtaining prior approval from the HHS secretary.^{xxxii} However, no states have used this option under 1915(i) to limit eligibility for HCBS through more stringent functional eligibility criteria.^{xxxiii}

3. Incentive and Demonstration Programs

Congress has also enacted other incentives to increase the availability of HCBS and to provide greater opportunities for consumer involvement in their care plans. Through the Deficit Reduction Act of 2005 and subsequent legislation, Congress authorized and extended the MFP demonstration.^{xxxiv} MFP helps states transition beneficiaries from institutional settings into the community by providing an enhanced FMAP for certain HCBS.^{xxxv} From 2008 through 2019, states participating in MFP have transitioned 101,540 beneficiaries from long-term institutional care to community-based settings.^{xxxvi}

To further increase the use of Medicaid HCBS and improve the infrastructure to provide those services, Congress enacted the Balancing Incentive Program as a part of the ACA.^{xxxvii} States with HCBS spending that accounted for less than half their total LTSS expenditures were eligible to participate in the program.^{xxxviii} Participating states received an enhanced FMAP for HCBS, and were required to meet certain HCBS spending and infrastructure goals.^{xxxix} All 21 participating states increased the share of total LTSS spending on HCBS, and those states saw a greater increase in HCBS spending as a share of total LTSS spending compared to states that were eligible but did not participate.^{xl}

C. Eligibility for HCBS

States generally define eligibility for mandatory and optional HCBS through financial, categorical, and level-of-care criteria.

1. Eligibility for HCBS

Individuals must have low incomes to be financially eligible for Medicaid services, including HCBS. States set income and resource limits for various categories of mandatory and optional eligibility groups, in accordance with federal requirements. Most HCBS programs target older adults and individuals with disabilities. Those populations may qualify for Medicaid through either mandatory or optional eligibility pathways.

Federal rules require states to provide Medicaid coverage to individuals age 65 and over, and to individuals with blindness or disabilities who receive cash assistance through the Supplemental Security Income (SSI) program.^{xli} In 2021, the income limit for SSI for an individual is \$794 per month and the resource limit is \$2,000.^{xlii} States may rely on the SSI financial eligibility criteria, or they may set more restrictive criteria for individuals who qualify based on SSI.^{xliii} States may also cover other low-income individuals age 65+ or those with disabilities who are not receiving SSI cash assistance.^{xliv} States may use more generous financial limits for that optional eligibility group.

HCBS participants can generally be categorized into several subpopulations:

- I/DD (intellectual/developmental disabilities)
- SMI (serious mental illness)
- individuals ages 65+
- those under age 65 with physical disabilities^{xlv}

A large majority of HCBS users (63.9%) and almost all users who tend to incur the highest cost (86.6%) were eligible for Medicaid HCBS due to disability in 2012.^{xlvi} The most common diagnoses for those with high costs were intellectual disorders and related conditions, mobility impairments, and epilepsy.^{xlvii} Those who tend to incur high costs were less likely than all HCBS users (11.4% versus 29.8%) to be eligible due to age.^{xlviii}

2. Level-of-Care Criteria

In addition to financial and categorical eligibility requirements, individuals generally must meet level-of-care criteria for HCBS. Level-of-care eligibility criteria for most Medicaid LTSS services, including HCBS, generally mandate that individuals require care that would otherwise be provided in an institutional setting, such as a nursing home. As there is no federal definition for level-of-care criteria, most states define the need for HCBS through a mix of “functional” criteria (ability to perform activities of daily living) and “clinical” criteria (diagnosis of an injury, illness, disability, etc.).^{xlix}

D. State Variation in HCBS: Coverage and Expenditures

A key consideration of states—in deciding whether to cover HCBS, what authority to use, and to what degree those services will be covered—is the cost to the state. Care in a nursing home is more costly than HCBS on a per capita basis; however, there is a natural limit on the number of people seeking nursing home care, because most individuals would prefer to remain at home or in a community setting. Entering a nursing home is a last resort for most.

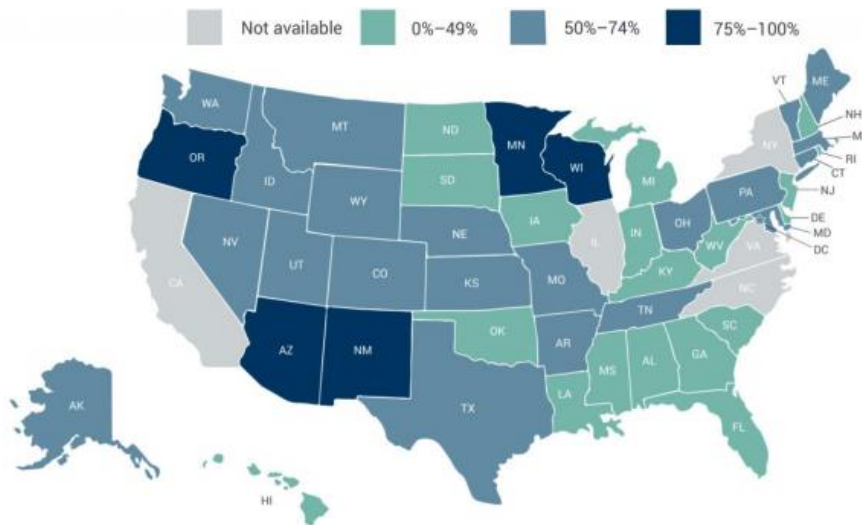
States that choose to cover optional Medicaid HCBS may deliver these services through a variety of waivers or state plan options. Most often, states rely on 1915(c) waiver authority to deliver these services. In FY2018, expenditures for Section 1915(c) waiver programs reached approximately \$35.7 billion,⁴ and accounted for over half of Medicaid HCBS expenditures.¹ Only a small percentage of HCBS expenditures were for services provided through the 1915(k), 1915(i), or 1915(j) state plan options.^{li}

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 age 65 and older (64 waivers).^{lii} States may operate multiple 1915(c) waivers simultaneously to target different populations or provide different services, with some states operating up to 11 waivers at once.^{liii} The use of multiple waivers or a combination of waivers and SPAs creates an incredibly complex system for states to manage and beneficiaries to navigate. Additionally, this can lead to inequitable access to services within a single state. For example, two residents of a state may have similar diagnoses and LTSS need, but may not be eligible to receive the same services due to the targeting allowed under 1915(c) waivers.

⁴ Due to data limitations, CMS excluded FY2017 and FY2018 data for California, Illinois, New York, and Virginia in reporting expenditures by service category. Excluding those states, total HCBS expenditures were approximately \$70.4 billion, and Section 1915(c) waiver program expenditures were approximately \$35.7 billion in FY2018. Including those states, total section 1915(c) waiver program expenditures were approximately \$49.7 billion.

Because of the flexibility given to states to determine how they deliver HCBS, state spending on these services varies significantly. In 2018, HCBS as a portion of state LTSS expenditures ranged from 30% in Rhode Island to 83.4% in Oregon (Figure 3).^{liv, 5} For states where spending data was available, HCBS accounted for 50% or more of total LTSS expenditures in 27 states.^{lv} Generally, spending on HCBS made up a larger portion of total LTSS expenditures in states that provide these services through an MLTSS program.^{lvi}

Figure 3: Percentage of Medicaid LTSS Spending for HCBS by State, FY2018



Source: [MACPAC](#), April 2021

RECENT ACTION

Policymakers have sought to expand the availability of Medicaid HCBS for more than 40 years to address the growing number of Americans who need assistance with daily activities. More recently, in the wake of the high mortality rates during the COVID-19 pandemic, efforts to expand access to HCBS have occurred as a means of providing alternatives to congregate settings, such as nursing homes.

The American Rescue Plan Act of 2021 contained a 10% increase in federal share of Medicaid expenditures or FMAP for certain activities that enhance, expand, or strengthen Medicaid HCBS.^{lvii} In May 2021, CMS released [guidance](#) on implementing

⁵ CMS excluded California, Illinois, New York, North Carolina, and Virginia from this ranking because of lack of data.

the enhanced FMAP, and detailed the activities eligible for the increased federal match. Examples of these activities include: new and/or additional HCBS; HCBS provider payment rate and benefit enhancements; supplies and equipment; caregiver support; support to improve functional capabilities of persons with disabilities; transition support; mental health and substance use disorder services; outreach; and access to COVID-19 vaccines.^{lviii} The additional federal funding is available to states from April 1, 2021 to March 31, 2022.^{lix} States must use the funds to increase HCBS spending above current levels.^{lx} The Congressional Budget Office estimates this will cost the federal government about \$12.7 billion.^{lxi} Additionally, President Biden’s proposed American Jobs Plan calls for a \$400 billion investment in HCBS to expand access to services, extension of the Money Follows the Person program, and increased wages for caregivers.^{lxii}

Disability advocates view President Biden’s proposal as a way to create a policy in which HCBS and institutional care are equally available to an individual. Today, about half (56% in 2018) of Medicaid spending on LTSS goes toward HCBS.^{lxiii} The distinction between mandatory and optional services in the provision of long-term services and supports has long been viewed by advocates as evidence of an institutional bias in the provision of services in a nursing home or International Classification of Functioning, Disability and Health (ICF) and intellectual and developmental disabilities (IDD) services provided in the community. For many advocates, as long as institutional care is mandatory and HCBS are optional, the state, rather than the individual, ultimately controls where beneficiaries live.

CHALLENGES AND OPPORTUNITIES

The features of existing authorities create challenges as well as opportunities for states, consumers, and the federal government. Some of the components that make waivers so attractive to states present significant challenges for beneficiaries.

A. Administrative Complexity for States and Beneficiaries

While the current structure provides flexibility to allow states to design programs to address specific populations, and provides predictability by capping services, it also creates administrative complexities for those seeking to expand coverage. In developing waivers, states must identify and combine multiple waiver authorities, administer different sets of eligibility rules, and oversee distinct quality measures for each HCBS option.^{lxiv}

The complexities of the Medicaid program also create challenges for beneficiaries, as they must navigate different sets of requirements to determine which eligibility pathway leads to the benefit package that best fits their needs.^{lxv} Beneficiaries may have multiple complex conditions and may not have access to all necessary services when those are offered through distinct programs. One benefit package, for example, may include

supports such as personal care targeted to people with physical limitations, while specialty behavioral health services may be available through a different benefit package.^{lxvi} When services are offered through separate programs, beneficiaries may have to make difficult choices between equally important services.^{lxvii}

B. Inequities Across States and Populations

As discussed earlier in Section D., while all states offer HCBS, the services covered, access to those services, and spending varies significantly across states and within states. These gaps contribute to inequitable access to HCBS. The availability of waiver slots in Michigan is one example; there is only one waiver slot for every 58 eligible individuals in certain counties compared to one slot for every 20 eligible individuals in the rest of the state.^{lxviii} When states administer HCBS through a patchwork of waiver programs with separate benefit packages targeted to certain populations based on, for example, diagnosis or geographic location, beneficiaries with similar needs in the same state may not all be able to access the same services in the community.

In addition to certain target groups receiving more or different services within a state, federal cost neutrality formula requirements for waivers can contribute to imbalances in total HCBS spending across populations. In FY2017 and FY2018, almost three-quarters of total 1915(c) waiver program expenditures were spent on individuals with intellectual or developmental disabilities or autism spectrum disorder.^{lxix} During that same period, older adults and individuals with physical or other disabilities accounted for the remaining 22% of total 1915(c) waiver program expenditures.^{lxx} Since ICF-IDD facilities have historically had higher payment rates than nursing homes, the cost neutrality formula generally allows higher HCBS expenditures for waiver programs that target individuals with developmental disabilities.^{lxxi} Inequities in allowable HCBS spending between populations could contribute to unmet needs for certain populations.

C. Lack of Information on Unmet Needs and Potential Cost of Expansion

States and the federal government have been concerned about the cost of expansion because of the perceived unmet need for services, often referred to as the “woodwork effect” because of the belief that when services become widely available, qualified individuals will “come out of the woodwork” to seek care. It is unclear, however, how many people may be waiting for services. According to a report by the Kaiser Family Foundation (KFF), in 2018, nearly 820,000 individuals were on waiting lists across 41 states.^{lxxii} However, KFF and the Medicaid and CHIP Payment and Access Commission note that waiting list accuracy varies significantly from state to state, and should not be considered a precise measure of unmet need for HCBS.^{lxxiii} Similarly, while data shows that wait times vary significantly based on the state, waiver, and target population, ranging from 1 to 14 years, stakeholders have reported that many of those on waiting lists may be receiving state plan services through Medicaid state plan services, or through family caregivers while they wait for HCBS.^{lxxiv}

POLICY OPTIONS

The following policy options seek to increase the availability of HCBS in Medicaid by streamlining and simplifying administrative requirements and incentivizing states to expand the number of people receiving services in the community. This goal could be achieved by replacing the current, complex patchwork of state plan amendments 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 a larger expansion of Medicaid HCBS. Ideally, the SPA would strike a balance between providing necessary services to those in need while still providing states with budget predictability.

A. Proposed Consolidated State Plan Amendment

Congress should streamline and simplify existing HCBS waiver and SPA authorities into a single, consolidated SPA that retains much of the flexibility of the existing HCBS waiver authorities and state plan options. Congress should phase out existing HCBS waivers and 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; incentives for streamlined enrollment; and a single entry point to access HCBS.

1. Key Provisions

Congress establishes a 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). Under this approach, the Secretary of HHS 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

a. Eligibility

Income and resources: Under the new consolidated SPA, states may cover individuals with incomes up to 300% of SSI.

Functional status: Status must establish functional status criteria that requires an assessment of an individual's support needs and capabilities, and 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 criteria without obtaining prior approval by the Secretary of HHS if enrollment exceeds projections. However, 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, to ensure transparency. States must conduct independent assessments; develop individualized care plans in consultation with providers, caregivers, family, or representatives; and identify services to be furnished. States must allow individuals to choose self-directed services. States would not be required to meet Medicaid comparability, or amount, scope, and duration of services standards.

b. Covered Benefits

The new consolidated SPA would allow states to cover the full range of HCBS currently authorized under sections 1915 and 1115 of the SSA. Examples of services that states could cover would include:

- Case management
- Homemaker/home health aide and personal care
- Adult day health
- 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
- Other services approved by the Secretary of HHS

c. Enhanced Match and Payment for Services

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. This would allow states to establish administrative structures that ensure individuals are informed about how to access Medicaid HCBS, furthering the efforts of rebalancing the LTSS system and promoting person-centered care in the community. States may also receive a 90% enhanced FMAP for integration and coordination of services, as permitted under the Medicaid Health Homes model for eight quarters.

States may develop payment rates for services in accordance with applicable state plan requirements.

2. Questions:

- i. How should states be incentivized to streamline eligibility and enrollment functions, such as those typically performed by states' No Wrong Door system, as well as for ombudsman activities?
- ii. Should this structure be used to incentivize increased workforce? If so, how? See: [Improving Home and Community-Based Services Infrastructure: A Policy Proposal](#).
- iii. What, if any, protections should be put in place to assure that the new structure does not result in a loss of services for specific populations?
- iv. Because 1915(k) does not permit states to limit enrollment, should that program be exempt from consolidation?
- v. What value should be placed on establishing more uniform eligibility across populations within states and across states?
- vi. How can assets and income limits be set to help eliminate the institutional bias or equalize the entitlement?
- vii. How can services best address the individual's needs? Should states be required to develop a more standardized, person-centered care plan based on assessment of function and community-integration needs?
- viii. Does the current definition of services included in 1915(i) capture the full range of services necessary? How should we address housing-related services? See: [CMS Informational Bulletin](#), "Coverage of Housing-Related Activities and Services for Individuals with Disabilities," June 26, 2015; [CMS State Health Official Letter](#), "RE: Opportunities for Medicaid and CHIP to Address Social Determinants of Health (SDOH)," January 7, 2021.
- ix. What, if any, is the impact of nursing home provider taxes on the availability of HCBS?
- x. How should quality be measured? In September 2020, CMS issued a [Request for Information](#) seeking feedback on a draft set of recommended

quality measures for Medicaid HCBS. The draft set of measures was organized in two parts: 1) a base set of measures, which would support data comparisons across states; and 2) an extended set of measures that would include additional measures that states, health plans, or other entities could select to supplement the base set to address their priorities and needs.

B. Provide Comprehensive Technical Assistance to States on Transitioning 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. To help CMS meet these needs, Congress should provide additional resources to CMS to provide organized and systematic technical assistance to states on implementing the new streamlined HCBS authority. CMS should work closely with states in implementing the new streamlined SPA and helping states prepare to transition from current authorities to the new SPA. CMS could implement this HCBS technical assistance initiative similar to the Integrated Care Resource Center (ICRC), which helps states develop integrated care programs for dual eligible Medicare-Medicaid beneficiaries.

Questions:

- i. What resources will states need to provide organized and systematic technical assistance to states on implementing the new streamlined HCBS authority?
- ii. Does CMS have the resources and personnel to provide the level of technical assistance needed? If not, what is needed?
- iii. Could the ICRC be used as a model to assist states in the transition? What are the relevant lessons learned from the ICRC?

Appendix

HCBS Consolidated SPA: Key Features and Proposed Changes

Note: The draft policy option for a consolidated SPA is explained in the far left column of the table below. We have included references to existing statutory authority in the center column as a point of reference, and how our proposal would affect current law in the right column.

Consolidated SPA Defined	Drawing from Existing Authorities	Proposed Change from Current Law
<p>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.</p> <p>Under this approach, the Secretary of HHS would develop a template that includes the following information to be provided by the states:</p> <ul style="list-style-type: none"> • 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 	<p>Sec. 1915(c) – Medicaid HCBS waiver. Must be budget-neutral; states may limit number of eligible individuals. Waives the following:</p> <ul style="list-style-type: none"> • 1902(1)(a) – statewideness – allows geographic targeting • 1902(a)(10)(B) – comparability – allows coverage of discrete populations • 1902(a)(10)(c)(i)(III) – income and resource standards – to permit coverage of those who would otherwise be ineligible • Must be renewed every five years <p>Sec. 1915 (i) – HCBS SPA</p> <ul style="list-style-type: none"> • No budget-neutrality requirement • States may offer HCBS to discrete populations, but all who meet the criteria are eligible. States may close enrollment if actual enrollment exceeds state projections. • Requires renewal every five years. No renewal required if states do not target populations, but makes services available to all based on income, resources, functional status • Permits waiver of comparability and income and resources, but not state-wideness. <p>Section 1915 (j) – Self-directed personal assistance services for individuals who would otherwise</p>	<p>Combine existing waiver and SPA authorities.</p> <p>Replace existing waivers and state plan options; require states to transition to the new consolidated state plan option.</p>

Consolidated SPA Defined	Drawing from Existing Authorities	Proposed Change from Current Law
	<p>require personal care services or are covered under 1915(c) waiver.</p> <p>Section 1915 (k) – Community First Choice – Personal attendant services and supports for those who need an institutional level of care. Does not waive statewideness or comparability.</p> <p>Section 1115 – Permits waiver of most Medicaid requirements for demonstration purposes.</p>	
<p>Eligibility:</p> <ul style="list-style-type: none"> • Income and resources: States may cover individuals with incomes up to 300% of SSI. • Functional status: HIPAA standard defined as the inability to perform two or more ADLs or severe cognitive impairment. 	<p>Sec. 1915 (k) SSA</p> <p>Sec.1915 (i) SSA</p>	<p>Current law. <i>Note: BPC will address HCBS expansion in our September 2021 report.</i></p>
<p>Optional Covered Services:</p> <ul style="list-style-type: none"> • Case management • Homemaker/home health aide and personal care • Adult day health • Habilitation • Respite • Other services approved by the Secretary • Day treatment or other partial hospitalization services, psychosocial rehabilitation, and clinic services (whether or not furnished in a 	<p>Sections 1915 (i) cross-referencing 1915 (c)(4)(B); 1915(j) of the SSA</p>	<p>Current law</p>

Consolidated SPA Defined	Drawing from Existing Authorities	Proposed Change from Current Law
<p>facility) for individuals with chronic mental illness</p>		
<p>States must define eligibility and benefits. States may modify the criteria without obtaining prior approval by the Secretary if enrollment exceeds projections. However, 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 to ensure transparency.</p> <p>States must conduct independent assessments; develop individualized care plans in consultation with providers, caregivers, family, or representatives; and must identify services to be furnished.</p> <p>States may allow individuals to choose self-directed services.</p> <p>States are not required to meet Medicaid comparability, or amount, scope, and duration of services standards.</p>	<p>1915 (i), 1915 (j) SSA</p>	<p>Clarify that states set an enrollment target under 1915(i). When that enrollment target is reached, the state may modify the needs-based criteria for LTSS by using more stringent criteria. 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. In addition, states have an <i>Olmstead</i> obligation that 1915(i) allows them to address by making services available in the most integrated setting appropriate to the Medicaid beneficiary's need.</p>
<p>SPA does not require</p>	<p>Sec. 1915 (i), 1915 (k) SSA</p>	<p>Current law</p>

Consolidated SPA Defined	Drawing from Existing Authorities	Proposed Change from Current Law
budget neutrality as do waivers.		
States may receive the increased FMAP for integration and coordination of services under the Medicaid Health Homes model.	<p>Sec. 1945 of the SSA, Sec. 2703 of the ACA – Medicaid Health Homes – 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; and referral to community and social support services. Use of health information technology to link services where appropriate is strongly encouraged.</p>	Current law
Make permanent the MFP demonstration program and incorporate it into the new SPA.	<p>Sec. 6071 of the Deficit Reduction Act of 2005, as amended by subsequent legislation – MFP demonstration:</p> <p>Sec. 204 of the Consolidated Appropriations Act, 2021 (P.L. 116-260) extended the program through September 30, 2023, and appropriated \$450 million for FY2021 – FY2023.</p> <p>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. 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</p>	Make permanent the existing demonstration.

Consolidated SPA Defined	Drawing from Existing Authorities	Proposed Change from Current Law
	<p>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 don't count toward this 90-day period.)</p>	
<p>Allow states to develop payment rates for services in accordance with applicable state plan requirements.</p> <p>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. This would allow states to establish administrative structures that ensure individuals are informed about how to access Medicaid HCBS, furthering the efforts of rebalancing the LTSS system and promoting person-centered care in the community.</p>	<p>Sec. 1943 of the SSA</p> <p>No Wrong Door: The ACA allows individuals to apply for Medicaid through any means, whether through state or federal marketplaces, state Medicaid agencies, by phone, or by fax. This extends the No Wrong Door policy enacted as part of the ACA for individuals applying for Medicaid, CHIP, and premium subsidies to include Medicaid coverage for persons in need of LTSS, Aging and Disability Resource Centers (ADRC) and the Veterans Health Administration (VHA). The purpose is to support state efforts to streamline access to LTSS options for older adults and persons with disabilities. Built on a program developed and administered by the Administration for Community Living (ACL), formerly the Administration on Aging, the program promotes:</p> <ul style="list-style-type: none"> ● Public outreach and coordination with key referral sources ● Person-centered counseling ● Streamlining access to public LTSS programs ● State governance and administration <p>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</p>	<p>Requires new legislation to provide enhanced administrative match for activities related to streamlined eligibility and enrollment functions</p>

Consolidated SPA Defined	Drawing from Existing Authorities	Proposed Change from Current Law
	<p>Medicaid administrative functions such as training, program planning, quality improvement, and information technology.^{lxxv}</p> <p>Balancing Incentive Program (BIP)- Sec. 10202 of the ACA established the BIP. 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.^{lxxvi} 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.^{lxxvii} Eighteen of 21 participating states continued the program from 2011 to 2015, and most states received extensions through 2017 to complete the work.^{lxxviii}</p> <p>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 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.</p> <p>States were required to use the</p>	

Consolidated SPA Defined	Drawing from Existing Authorities	Proposed Change from Current Law
	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.	

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^{vi} Ibid.

^{vii} Centers for Medicare & Medicaid Services, “Medicaid Long Term Services and Supports Annual Expenditures Report, Federal Fiscal Years 2017 and 2018,” January 7, 2021, 9. Available at:

<https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures-2017-2018.pdf>.

viii 42 CFR § 440.70.

ix Section 224(c) of the Social Security Amendments of 1967, P.L. 90-248.

x Act of December 14, 1971 (P.L. 92-223). *See also* Social Security Amendments of 1972 (P.L. 92-603).

xi Omnibus Budget Reconciliation Act of 1981 (OBRA 81, P.L. 97-35).

xii 527 U.S. 581 (1999).

xiii Sections 6071, 6086, and 6087 of the Deficit Reduction Act of 2005 (DRA, P.L. 109-171).

xiv Sections 2401 and 10202 of the Patient Protection and Affordable Care Act.

xv Sections 1902(a)(43) and 1905(a)(4)(B) of the SSA.

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xix *Ibid.*

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xxi Section 1915(c)(3) of the Social Security Act.

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xxvii Section 1902 of the Social Security Act. *See also* 42 CFR § 430.12.

xxviii 42 CFR § 430.10.

xxix Sections 1903(a) and 1902 of the Social Security Act.

xxx 42 CFR § 430.12.

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