



BIPARTISAN POLICY CENTER

A Policy Roadmap for Individuals with Complex Care Needs



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HEALTH PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, BPC's Health Project seeks to develop bipartisan policy recommendations that will improve health care quality, lower costs, and enhance health care coverage and delivery. The Health Project focuses on coverage and access to care, delivery system reform and cost containment, and long-term care.

LONG-TERM CARE INITIATIVE

In December 2013, BPC launched a Long-Term Care Initiative under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, former Congressional Budget Office Director Dr. Alice Rivlin, and former Wisconsin Governor and Secretary of the Department of Health and Human Services Tommy Thompson. BPC's Long-Term Care Initiative seeks to raise awareness about the importance of finding a sustainable means of financing and delivering long-term services and supports, and to improve the quality and efficiency of publicly and privately financed long-term care.

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Executive Summary

Providing quality care for individuals with complex care needs is one of the most pressing challenges facing the United States health care system. The Bipartisan Policy Center, with the support of The SCAN Foundation, The Robert Wood Johnson Foundation, The Peterson Center on Healthcare, and The Commonwealth Fund, has been working since 2013 to develop policy solutions focused on *how to finance* and *deliver quality care* to individuals with complex care needs.

This report draws from six previous reports to identify a *roadmap of policy solutions* that can begin to tackle the barriers to financing and delivering high-quality, person- and family-centered, coordinated health and social services and supports to individuals with complex care needs.

Individuals with complex care needs have been a population of focus as policymakers have worked to develop and implement program-wide health care delivery system reforms in Medicare. In 2010, 37 percent of Medicare beneficiaries had four or more chronic conditions.¹ These beneficiaries accounted for 90 percent of Medicare hospital readmissions in 2010.² Medicare beneficiaries with four or more chronic conditions also comprised 74 percent of Medicare program spending in 2010.

Challenges for high-need people can be even greater for low-income older adults and individuals with disabilities who are eligible for both Medicare and Medicaid coverage. Many of these so-called “dual-eligible” beneficiaries have higher medical acuity, significant cognitive and functional impairments, and a greater need for care coordination and assistance with activities of daily living (ADLs).³

Looking across BPC’s recommendations to improve the delivery of clinical services and long-term services and supports (LTSS)—a range of health and social services provided to individuals who need help with daily tasks or ADLs—a number of consistent findings have emerged. The pathway to improving the quality of care and controlling the cost of serving individuals with complex care needs must address the following issues:

- A focus on person- and family-centered care, that places a priority on understanding the care goals of families and delivering the services that support them;
- An emphasis on coordinating care to ensure that services work across programmatic silos and avoid unnecessary or duplicative care and costs;
- Strategies to eliminate programmatic barriers to delivering coordinated care;
- Creating a path from medical-driven models that provide care based on what is reimbursed to person-centered models that provide what people need and want;
- Support for family caregivers; and
- Efforts to identify financing strategies, both public and private, to support the delivery of LTSS.

While BPC’s previous work acknowledged that there was no single solution to address the financing of LTSS, the recommendations presented below would lead to significant improvements in the financing and delivery of care to individuals with complex care needs.

^a Bipartisan Policy Center, *Improving Care for High-Need, High-Cost Medicare Patients*, April 2017. Available at: <https://bipartisanpolicy.org/library/improving-care-for-high-need-high-cost-medicare-patients>.

Recommendations:

DELIVERY SYSTEM REFORM^a

1. Improve Medicare's risk adjustment model to account for functional impairment;
2. Incentivize the provision of non-Medicare-covered supports through quality measurement;
3. Modify the Medicare Advantage (MA) uniform benefit requirement to allow MA plans to target non-Medicare-covered health-related social supports and services to plan enrollees;
4. Waive the primarily health-related requirement and other supplemental benefit rules;
5. Modify the definition of "incurred claims costs" in medical loss ratio (MLR) regulations to include the costs of health-related supports and services provided on an in-kind basis to enrollees who are not dually eligible for full Medicaid benefits;
6. Clarify that the patient incentive waiver under the Medicare Shared Savings Program (MSSP) and the Next Generation Accountable Care Organization (ACO) Program will allow for the free or no-charge provision of non-Medicare-covered health-related supports and services that optimize health or functional status for ACO-attributed beneficiaries who meet eligibility criteria; and
7. Establish voluntary enrollment processes within the MSSP and make related changes to the underlying attribution and payment reconciliation structures to ensure that ACOs have a more predictable pool of attributed beneficiaries and care expenses, as ACO participants transition to greater risk-sharing.

ALIGN PROGRAMS SERVING DUAL-ELIGIBLE MEDICARE AND MEDICAID BENEFICIARIES TO BETTER COORDINATE CARE^b

Medicare Advantage Special-Needs Plans (SNPs)

1. Permanently authorize Medicare Advantage Dual-Eligible SNPs;
2. Align the Medicare and Medicaid grievance and appeals processes; and
3. Ensure that the combined Medicare and Medicaid benefits offered through all SNPs are seamless to the beneficiary and to providers.

Financial Alignment Demonstrations

For ongoing demonstrations, Centers for Medicare and Medicaid Services (CMS) should:

1. Revise contracts to ensure that, where appropriate, rates reflect unanticipated costs of infrastructure investment or significant differences in cost associated with serving certain special-needs populations;
2. Ensure that adjustments do not result in increased cost to the federal government over the five-year demonstration period;
3. Work with states to develop unique state-specific quality and access measures, and to the extent there are savings, permit states to share in a greater percentage of those savings;
4. Align coverage standards for Medicare and Medicaid benefits that overlap, including durable medical equipment and home health services; and

^b Bipartisan Policy Center, *Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid*, September 2016. Available at: <https://bipartisanpolicy.org/library/dually-eligible-medicare-medicaid>.



5. Establish additional demonstrations to integrate Medicare and Medicaid for dual-eligible beneficiaries based on findings from the evaluations of the first-round demonstrations.

Program of All-Inclusive Care for the Elderly (PACE)

Through newly authorized demonstration authority, CMS should:

1. Test an expansion to individuals, regardless of age, who meet all other PACE criteria and who do not require a nursing home level of care;
2. Test an option that permits individuals to enroll in PACE, but opt out of adult day services;
3. Test an option that includes both Medicare-covered services and a beneficiary “buy-in” of a limited LTSS benefit that is less than the full-range of Medicaid-covered LTSS;
4. Permit PACE organizations to enroll beneficiaries during the month;
5. Align oversight of programs serving dual-eligible beneficiaries within CMS; and
6. Consolidate regulatory authority for reimbursement structures serving dual-eligible beneficiaries into a single office or center within CMS, such as the Medicare-Medicaid Coordination Office.

Develop a Revised Regulatory Structure

1. Policymakers should build on lessons learned from existing programs and demonstrations to develop a contractual model similar to the innovative “three-way” contract between CMS, states, and plans under the financial alignment demonstration.
2. In developing a framework for a model contract, the Secretary of Health and Human Services (HHS) should make decisions based on recommendations of an informal working group consisting of stakeholder organizations, or alternatively, require negotiated rulemaking under the Administrative Procedure Act to develop the framework of a three-way contract.

EXPAND MEDICAID OPTIONS AT HOME AND IN THE COMMUNITY

1. Create incentives for states to expand the availability of Home- and Community-Based Services (HCBS) by streamlining and consolidating state plan amendments and waivers;
2. Permit states to offer an innovative LTSS-only “buy-in” for individuals with disabilities whose employment income would result in the loss of Medicaid coverage; and design the LTSS-only plan to “wrap around” employer-provided insurance, qualified health plans offered through insurance marketplaces, and Medicare to make the buy-in more affordable.

LONG-TERM CARE FINANCING

Increasing the Availability and Affordability of Private Long-Term Care Insurance (LTCI) to Extend Existing Resources^c

1. Establish simplified lower-cost, limited-benefit retirement LTCI policies;
2. Allow working-age retirement plan participants aged 45 and older to use retirement savings, without early withdrawal penalties, to purchase retirement LTCI;

^c Bipartisan Policy Center, *Initial Recommendations to Improve the Financing of Long-Term Care*, February 2016. Available at: <https://bipartisanpolicy.org/library/long-term-care-financing-recommendations>.

3. Provide incentives for employers to offer them through workplace retirement plans on an opt-out basis;
4. Allow retirement LTCI policies to be sold on state and federal health insurance marketplaces;

SUPPORT FAMILY CAREGIVERS AND MAKE LONG-TERM SERVICES AND SUPPORTS AVAILABLE THROUGH MEDICARE ADVANTAGE AND MEDIGAP^d

1. Permit Medicare Advantage (MA) plans, and other Medicare provider organizations operating under a “benchmark,” the flexibility to offer a respite care benefit to high-need, high-cost Medicare beneficiaries; and
2. Permit Medigap and MA plans to market a limited LTSS benefit as an optional supplemental benefit, or as a separate insurance policy, financed exclusively through additional premiums paid by Medicare beneficiaries who choose to enroll.

^d 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/2017/07/BPC-Health-Financing-Long-Term-Services-and-Supports.pdf>.



Introduction

Providing quality care for individuals with complex care needs is one of the most pressing challenges facing the United States health care system. Meeting the care needs of this population is challenging because they frequently have multiple chronic conditions as well as functional or cognitive impairments that limit their ability to perform activities of daily living that are essential to maintaining their quality of life and ability to live in the community. Existing care models and financing make it difficult to provide the clinical care and support services for individuals with complex care needs and the resulting patchwork reduces the quality of care and drives costs upward. The shortcomings of existing arrangements will only become more acute as the aging of the population increases the number of individuals in need of complex care.

The Bipartisan Policy Center, with the support of The SCAN Foundation, The Robert Wood Johnson Foundation, The Peterson Center on Healthcare, and The Commonwealth Fund has been working since 2013 to develop policy solutions focused on *how to finance* and *deliver quality care* to individuals with complex care needs. BPC's Health Project, under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, has worked on proposals to remove barriers to the integration of care for individuals with complex care needs. Over the same period, the two leaders worked with former Governor and Secretary of Health and Human Services (HHS) Tommy Thompson and former Congressional Budget Office (CBO) Director Alice Rivlin to develop solutions to the growing need for long-term services and supports (LTSS).

This report draws from six previous reports to identify a roadmap of policy solutions that can begin to tackle the barriers to financing and delivering high-quality, person- and family-centered, coordinated health and social services and supports to individuals with complex care needs (Table 1). Solutions include short-term approaches to better coordinate care for individuals with complex care needs and interim steps to improve financing of social services and supports. This report also discusses the need for a more thoughtful way of paying for the cost of care for individuals with long-term care needs.

BPC's initial work in this area acknowledged that there was no single solution to address these important issues. "Due to the diversity of the LTSS population and the current political environment, it is extremely unlikely that a single solution will adequately address [the] challenges," BPC said.⁴ Subsequent work on delivery-system reform identified the impediments that Medicare regulations create to providing health-related non-clinical supports and services for complex Medicare-only individuals, or to coordinating care for individuals dually eligible for Medicaid and Medicare.⁵

Table 1: Previous BPC Reports on Serving Individuals with Complex Care Needs

Report	Date Published	Funder	Key Findings
Financing Long-Term Services and Supports: Seeking Bipartisan Solutions in Politically Challenging Times	July 2017	The SCAN Foundation	<ul style="list-style-type: none"> Permit Medicare Advantage (MA) plans, and other Medicare provider organizations operating under a “benchmark,” the flexibility to offer a respite care benefit to high-need, high-cost Medicare beneficiaries. Permit Medigap and MA plans to market a limited LTSS benefit as an optional supplemental benefit, or as a separate insurance policy, financed exclusively through additional premiums paid by Medicare beneficiaries who choose to enroll.
Improving Care for High-Need, High-Cost Medicare Patients	April 2017	The Commonwealth Fund and The SCAN Foundation	<ul style="list-style-type: none"> Improve Medicare’s risk-adjustment model to account for functional impairment. Incentivize the provision of non-Medicare-covered supports through quality measurement. Modify the MA uniform benefit requirement Waive the MA primarily health-related requirement and other supplemental benefit rules. Count health-related non-medical supports and services costs toward the MA medical loss ratio. Clarify ACO patient incentive waivers and extending waivers to the CPC plus model. Establish voluntary enrollment pathways within MSSP ACOs.
Challenges and Opportunities in Caring for High-Need, High-Cost Medicare Patients: BPC Preliminary Findings and Policy Options	February 2017	The Commonwealth Fund and The SCAN Foundation	<ul style="list-style-type: none"> Individuals could often greatly benefit from the integration of non-Medicare-covered social supports into the medical-care model offered to them in the Medicare program. Medicare’s payment rules and regulations create significant care-integration barriers for MA plans, ACOs and patient-centered medical homes which would otherwise furnish and finance these non-Medicare-covered supports and services.
Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid	September 2016	The Peterson Center on Healthcare, part of collaborative effort with the National Academy of Medicine and the Harvard T.H. Chan School of Public Health	<ul style="list-style-type: none"> Align Programs for Dual-Eligible Beneficiaries served through Medicare Advantage Special-Needs Plans (SNPs), Financial Alignment Demonstrations and Program of All-Inclusive Care for the Elderly (PACE). Integrate Care for Dual-Eligible Beneficiaries by aligning oversight of programs serving dual-eligible beneficiaries within the Centers for Medicare and Medicaid Services and developing a revised regulatory structure.
Initial Recommendations to Improve the Financing of Long-Term Care	February 2016	The SCAN Foundation	<ul style="list-style-type: none"> Redesign the long-term care insurance benefit structure to make private insurance more accessible and affordable; allow purchase using retirement savings through their employers or state and federal insurance marketplaces. Provide incentives for employers to enroll in insurance with an employee opt-out. Give states incentives to improve Medicaid programs and provide more care in people’s homes. Create a new option for working individuals with disabilities that allows states to offer an innovative long-term care-only “buy-in” plan designed as a supplement to public and private health insurance. Pursue a public insurance approach for catastrophic long-term costs that does not increase the deficit and protects Americans from ruinous out-of-pocket costs.
America’s Long-Term Care Crisis: Challenges in Financing and Delivery	April 2014	The SCAN Foundation	<ul style="list-style-type: none"> Owing to the disparate populations in need of LTSS and the challenges both in terms of politics and budgets, a solution to financing LTSS will require a series of policy options—including public and private options as well as long-term and short-term options—and will require legislative and regulatory changes.



The desire to improve the financing and delivery of clinical and social support services to individuals with complex care needs coincides with broader system-wide movements to address the quality and cost of care. Increasingly, both public and private sector policymakers have called for solutions to reduce spending on medical services. Because individuals with complex care needs account for a disproportionate share of health spending, slowing the rate of cost growth will require serious efforts to address the costs of care for these individuals. Improving care for these individuals will require a series of solutions that better coordinate care for people with complex care needs, and begin to improve the availability of social services and supports, including long-term care.

Looking across BPC's recommendations to improve the delivery of clinical services and LTSS, consistent findings have emerged. The pathway to improving the quality of care and controlling the cost of serving individuals with complex care needs must address the following issues:

- A focus on person- and family-centered care, that places a priority on understanding the care goals of families and delivering the services that support them;
- An emphasis on coordinating care to ensure services that work across programmatic silos and avoid unnecessary or duplicative care and costs;
- Strategies to eliminate programmatic barriers to delivering coordinated care;
- Creating a path from medical-driven models that provide care based on what is reimbursed to person-centered models that provide what people need and want;
- Support for family caregivers; and
- Efforts to identify financing strategies, both public and private, to support the delivery of LTSS.

Characteristics of Individuals with Complex Care Needs

Sixty percent of adults in this country have at least one chronic condition, and 40 percent have two or more. Individuals with multiple chronic conditions are costly to serve. According to the Centers for Disease Control and Prevention, 86 percent of the \$3.3 trillion dollars in U.S. health expenditures were spent on people with chronic conditions. The federal government and families paid the majority of these costs in 2016, each paying 28 percent. Private businesses paid 20 percent of these costs, and state and local governments paid 17 percent.

Individuals with complex care needs have been a population of focus as policymakers work to develop and implement program-wide health care delivery system reforms in Medicare. In 2010, 37 percent of Medicare beneficiaries had four or more chronic conditions.⁶ These beneficiaries accounted for 90 percent of Medicare hospital readmissions in 2010.⁷ Medicare beneficiaries with four or more chronic conditions also comprised 74 percent of Medicare program spending in 2010.

In addition to much higher levels of hospitalizations, emergency department visits, and hospital readmissions, Medicare beneficiaries with four or more chronic conditions also had disproportionately high utilization of post-acute care (PAC) services.⁸ “Medicare-only” individuals with six or more chronic conditions incurred \$30,109 in Medicare costs on average in 2010, or nearly three times the overall per-capita average.⁹ Recent analyses also suggest that the presence of functional or cognitive impairment can be a strong predictor of a beneficiary’s health care needs and Medicare costs.¹⁰ Beneficiaries with functional impairment and one or more chronic conditions have Medicare expenses that are more than three times as high as Medicare beneficiaries who have chronic conditions but do not have functional impairment.¹¹

Challenges for high-need people can be even greater for low-income older adults and individuals with disabilities who are eligible for both Medicare and Medicaid coverage. Many dual-eligible beneficiaries have higher medical acuity, significant cognitive and functional impairments, and a greater need for care coordination and assistance with activities of daily living (ADLs).¹²

- While only 20 percent of Medicare beneficiaries (and only 14 percent of Medicaid beneficiaries) were dually eligible in 2011, dual-eligible individuals accounted for 35 percent of the Medicare program spending, and 33 percent of combined federal and state spending on Medicaid.¹³
- On average, full-benefit dual-eligible beneficiaries have risk scores that are 50 percent higher than the average risk score for all other Medicare beneficiaries.
- The average full-benefit dual-eligible beneficiary has six chronic conditions, while all other Medicare beneficiaries average only four chronic conditions.¹⁴
- One-tenth of the full-benefit dual-eligible population accounted for 38.5 percent of total combined Medicare and Medicaid spending on all full-benefit dual-eligible beneficiaries in 2011.¹⁵
- Average annual Medicare spending for full-benefit dual-eligible beneficiaries is more than twice as high as average annual Medicare spending for all other Medicare beneficiaries.¹⁶



Opportunities to Enhance Person- and Family-Centered Care in the Move to Value-Based Care

As the health care system continues the long-term shift from a volume-based to a value-based system of care—which emphasizes the goal of eliminating waste—it is important that this does not diminish the quality of care or undermine efforts to put individuals and their families at the center of decision-making.

While it is unlikely that policymakers will make significant investments in long-term services and supports in the near-term, Congress acted this year to improve care for people with chronic conditions, many of whom would benefit from enhanced social supports that are not traditionally covered by the Medicare program. The Senate-passed CHRONIC Care Act, discussed in greater detail below, begins to address care for these people, building on emerging evidence in treating individuals with high needs.

Attempts to address the high cost of serving individuals with complex care needs should be mindful of how it affects the quality of care delivered. The SCAN Foundation worked with an array of national experts working on the care of adults with complex needs within the fields of health, long-term services and supports, quality measurement, and consumer advocacy to develop a goal statement and key attributes of a high-quality system of care for adults with complex care needs. This framework, [What Matters Most: Essential Attributes of a High-Quality System of Care for Adults with Complex Care Needs](#), serves as a useful basis for assessing efforts to improve the delivery of care for individuals with complex needs.¹⁷

The group defined the goal of a high-quality system of care for adults with complex care needs as:

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“Individuals are able to live their lives with services and supports reflecting their values and preferences in the least restrictive, most independent setting possible with access to a delivery system that respects and supports their choices and decisions.”

ATTRIBUTES OF A HIGH-QUALITY SYSTEM FOR ADULTS WITH COMPLEX CARE NEEDS

ATTRIBUTE 1: Each individual’s range of needs and goals, both medical and non-medical, as well as for family/caregivers, are identified and re-evaluated on an ongoing basis to drive care plans.

ATTRIBUTE 2: Each individual’s needs are addressed in a compassionate, meaningful, and person-focused way and incorporated into a care plan that is tailored, safe, and timely.

ATTRIBUTE 3: Individuals have a cohesive, easily navigable delivery system so that they can get the services and information they want by themselves or with support when needed, and avoid the services they do not need or want.

ATTRIBUTE 4: Individuals and their family/caregivers continually inform the way the delivery system is structured to ensure that it is addressing their needs and providing resources tailored to them.

Source: What Matters Most: Essential Attributes of a High-Quality System of Care for Adults with Complex Care Needs, The SCAN Foundation, September 2016

Promoting Person-Centered Care

Putting the individual at the center of their own care, and having their preferences guide care, is essential for promoting high-quality care for individuals with chronic conditions. As caregivers, an individual's family members are also part of the unit of care, and their experiences are important to measure as well. An expert panel organized by the American Geriatrics Society and the University of Southern California further developed the following [definition](#) of person-centered care and its characteristics: *“Person-centered care’ means that individuals’ values and preferences are elicited and, once expressed, guide all aspects of their health care, supporting their realistic health and life goals. Person-centered care is achieved through a dynamic relationship among individuals, others who are important to them, and all relevant providers.”* This collaboration informs decision-making to the extent that the individual desires.¹⁸

Care Coordination

Care coordination is a critical component in bridging the gap between medical care and supportive service systems in a way that meets people's needs, values, and preferences. It is central to person-centered care and a means to improve the quality of care as well as to lower overall costs for high-need populations. Care coordination has been defined as:

“[A] service based on consultations and information with and among the individual, his/her providers, and family members where appropriate, facilitated by a knowledgeable and trained professional that leads to the individual obtaining the right care, in the right place, at the right time to address his/her needs with an appropriate use of resources.”¹⁹

Academic and clinical research suggests that for individuals with complex needs—particularly frail and older individuals with complex conditions—the application of non-clinical interventions and other social supports to address social determinants of health can improve health outcomes and reduce the need for expensive acute care services.²⁰ Such interventions can include in-home meal delivery, supportive housing and home modifications, non-emergent medical transportation to medical appointments, targeted care management, and personal care services or other home- or community-based assistive services to address functional impairment.²¹

Clinical evidence suggests that frail and chronically ill Medicare beneficiaries who are not dually eligible for full Medicaid benefits could often greatly benefit from the integration of non-Medicare-covered social supports into the medical care model offered to them in the Medicare program. For instance, non-Medicare-covered support services such as in-home meal delivery, non-emergent transportation to medical appointments, and targeted case management services have demonstrated the propensity for reducing the need for avoidable hospitalizations.^{22,23,24}

These interventions can be particularly valuable for Medicare beneficiaries who are not dually eligible for full Medicaid benefits, reside in the community setting, have three or more chronic conditions, and have functional or cognitive impairment. A data analysis performed on behalf of the BPC projects that approximately 3.65 million Medicare beneficiaries meet these criteria; and that these beneficiaries incur roughly \$30,000 in annual Medicare costs, or more than twice the national average annual Medicare fee-for-service (FFS) spending amount per beneficiary.²⁵

The Centers for Medicare and Medicaid Services (CMS) has also recognized the importance of many of these services and supports. Through the Accountable Health Communities model, the CMS Center for Medicare and Medicaid Innovation (CMMI) is testing the efficacy of supplying grant funding to providers and community organizations that will screen individuals for social determinants of health-related needs and connect in-need individuals with community-based social support providers and organizations.²⁶

Helping individuals with complex care needs identify non-clinical support and service needs and connect with community support organizations is an important step in addressing the clinical disparities that stem from social determinants of health for the high-need, high-cost, Medicare-only population. However, CMMI explicitly prohibits the Accountable Health Communities model participants from using any grant funding under the program to finance the actual delivery of the needed supports and services.²⁷ In many instances, Medicare regulations and payment approaches can serve as barriers for health plans and providers that might otherwise seek to furnish and finance health-related non-clinical supports and services for high-need, high-cost, Medicare-only individuals.



Over the course of 2016, the Senate Finance Committee's Chronic Care Working Group—led by Committee Chairman Orrin Hatch (R-UT), Ranking Member Ron Wyden (D-OR), Senator Johnny Isakson (R-GA), and Senator Mark Warner (D-VA)—sought input from stakeholders on ways to alleviate barriers to care improvement for high-need Medicare beneficiaries with chronic conditions. This important work resulted in the introduction of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act, which would help to break down the barriers faced by Medicare Advantage plans and other providers.

For low-income individuals with multiple chronic conditions and functional limitations, many services that are not covered under Medicare are instead covered by state Medicaid programs, and include social services such as long-term services and supports. These services include in-home meal delivery, supportive housing and home modifications, non-emergent medical transportation to medical appointments, targeted care management, and personal care services or other home- or community-based assistive services to address functional impairment.²⁸

Whether or not full integration of Medicare and Medicaid services will improve quality and lower the total cost of care for dual-eligible beneficiaries will likely vary based on the care delivery model and state implementation, but there is potential for improved quality and greater value. For example, a 2016 evaluation of the Minnesota Senior Health Options program by RTI International demonstrated that from 2010 to 2012 the program achieved a 48 percent reduction in inpatient hospitalizations and a 26 percent reduction in the total number of hospital stays for patients who were hospitalized during the year.²⁹ In addition, the program was successful in reducing emergency department visits and increasing the use of home- and community-based services.³⁰

While the Minnesota study compares individuals in Medicare FFS with those enrolled in fully integrated plans, other evidence indicates that fully integrated Special-Needs Plans (SNPs) demonstrate higher quality than non-integrated SNPs, particularly for individuals with disabilities. In a 2014 report, the Government Accountability Office noted that Fully Integrated Dual-Eligible Special-Needs Plans (FIDE-SNPs) were far more likely than other Dual Eligible Special Needs Plans (D-SNPs) to meet criteria for high quality.³¹ Further surveys of patients enrolled in the Financial Alignment Initiative indicate high rates of satisfaction with the care they receive.³²

Financing Long-Term Services and Supports

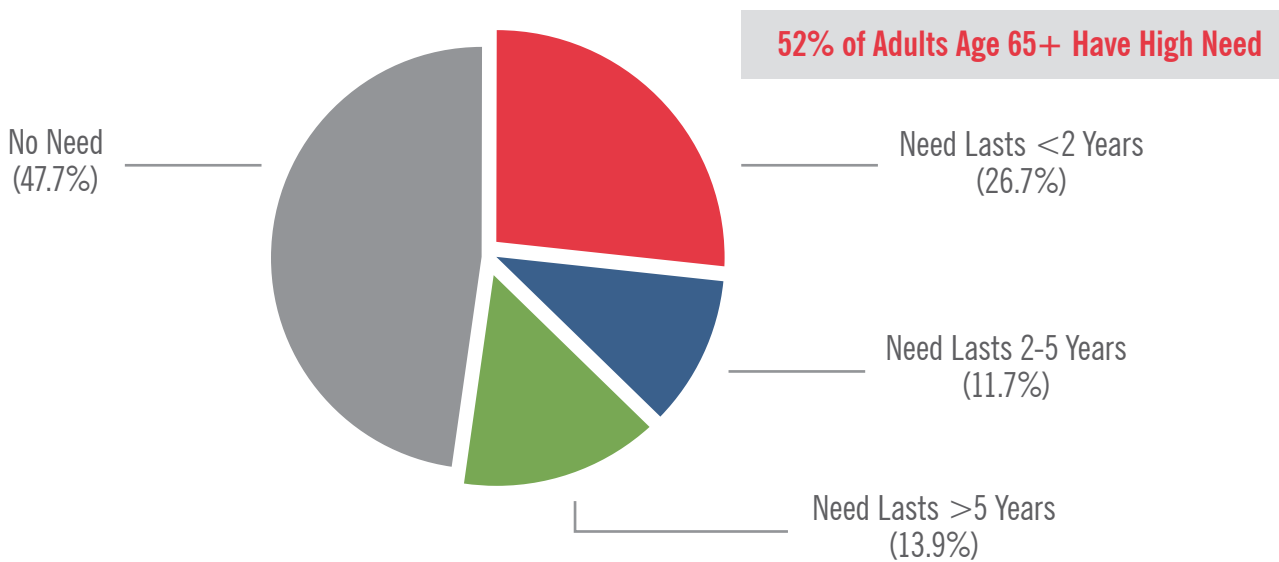
In addition to medical needs and social services and supports, individuals with multiple chronic conditions or functional or cognitive impairments often have needs that limit their ability to remain at home without assistance, including long-term services and supports (LTSS).

LTSS refers to a range of health and social services provided to individuals who need help with daily tasks or activities of daily living (ADLs), such as eating, bathing, or dressing, or with instrumental tasks, such as medication management or meal preparation. People who need these types of services typically have physical, cognitive, developmental, or other chronic health conditions and require assistance with one or more of these tasks.³³ LTSS can be provided in institutional settings, which include nursing homes and assisted living facilities, or through home- and community-based services (HCBS). In recent decades, there has been a shift toward HCBS and away from institutional care, driven in part by a preference among most individuals with LTSS needs to remain in their homes.^{34,35}

The Need for Long-Term Services and Supports

Over 12 million adults in the United States rely on LTSS, and the need is expected to rise dramatically in the coming decades.³⁶ Approximately 70 percent of adults age 65 and older will need LTSS at some point in their lives, and more than half will experience a high level of need, defined as assistance with two or more ADLs for at least 90 days or severe cognitive impairment (Figure 1).^{37,38} Among older adults who develop a high level-of-care need, the average duration of LTSS need is 3.9 years, with about 14 percent of individuals needing care for five or more years.³⁹ Women age 65 and older are more likely to have high levels of care need on average compared to men, and are expected to need LTSS for an average of 4.4 years, compared to 3.2 years for men.⁴⁰

Figure 1: Length of High Need for Adults Aged 65+



Source: Original data: Favreault, M. M., & Dey, J. 2015. Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief. Available at: <https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief>.

Graphical concept: Anne Tumlinson Innovations. 2016. The Case for Financing Older America's Long-Term Care Need. Available at: http://www.thescanfoundation.org/sites/default/files/financing_long-term_care_chartpack_092016_final.pptx.

Of the approximately 10.9 million older adults who reported having LTSS needs in 2011, 1.1 million received care in nursing homes, 1.6 million lived in supportive care settings (e.g., assisted living facilities), and 8.2 million lived in the community.⁴¹ Among those receiving help in non-nursing home settings, nearly two-thirds reported receiving all of their LTSS care from unpaid caregivers; only 5.3 percent reported relying solely on paid help.^{42,43} As the diversity of LTSS settings and the roles of informal caregivers have increased in recent decades, concerns about unmet needs have grown; about 20 percent of community-dwelling older adults with LTSS needs report having unmet care needs.^{44,45}



The Costs of Long-Term Services and Supports

The costs of LTSS can be significant regardless of setting. In 2015, the median annual cost for a home health aide was approximately \$45,800; the median annual cost for community-based adult day-care centers was \$17,900; and the median annual cost to live in a nursing facility was approximately \$91,300.⁴⁶ In 2013, total national spending for formal LTSS services amounted to \$339 billion, with public spending accounting for about 72 percent of this amount.⁴⁷ Formal LTSS spending for older Americans was approximately \$192 billion in 2011.⁴⁸ These costs are expected to rise as the population ages, consuming a larger portion of federal and state Medicaid budgets and placing an even greater burden on older Americans' and their families' personal finances.

Formal LTSS expenditures do not tell the whole story—most LTSS in the United States are provided by unpaid informal caregivers who are family members or friends of the care recipient.⁴⁹ In 2013, informal caregivers provided an estimated \$470 billion worth of unpaid care.⁵⁰ The responsibilities of caregiving often take a heavy toll on informal caregivers; caregiving can cause significant physical and emotional stress for caregivers, leading to poorer health outcomes.⁵¹ Additionally, informal caregivers often experience financial strain because of lost income and out-of-pocket expenses to provide care. The 2011 MetLife Study of Caregiving Costs found that family caregivers aged 50 and older sustain an average of \$303,880 in lost income and benefits over the caregiver's lifetime.⁵²

Who Pays for Long-Term Services and Supports?

There is significant variation in LTSS spending across individuals. While nearly half of Americans turning 65 today are expected to have no LTSS expenditures, approximately 27 percent will have costs of at least \$100,000, and approximately 15 percent will have costs exceeding \$250,000.⁵³ The average expected lifetime LTSS cost for a 65-year-old American today is \$138,000. Average lifetime LTSS costs for women are twice as much as those of men—\$182,000 compared to \$91,000.⁵⁴ People who receive these services rely heavily on out-of-pocket spending to meet their needs. An estimated 52 percent of average lifetime LTSS costs of people turning 65 today will be paid out-of-pocket by individuals and their families. According to an Urban Institute projection of national LTSS spending by payer, in 2030 about 53 percent of total LTSS spending across all ages will be covered out-of-pocket, assuming no changes in financing options.⁵⁵ Private long-term care insurance (LTCI) is virtually inaccessible to most people who need it, and only accounts for an estimated 2.7 percent of average lifetime costs for adults age 65 and older.

Challenges in Financing Long-Term Services and Supports through Private Insurance Alone

Only about 11 percent of older adults have private LTCI coverage, and the private market is in decline.^{56,57} Currently available LTCI policies are too expensive and complex for most consumers, and the traditional policy design has not been sustainable for carriers. Even for those who can afford limited-benefit, private-insurance-based LTCI products, such policies are not widely available. As a result, many middle-income Americans rely on modest personal savings and the support of unpaid caregivers to meet LTSS needs. In recent years, plans have limited policies to a capped “indemnity policy,” meaning plans will reimburse covered services up to a lifetime cap, while others may offer a cash benefit that is capped at a daily, weekly, or monthly amount.⁵⁸ Individuals with catastrophic LTSS costs must spend down their personal resources before qualifying for Medicaid. As the population ages and the need for LTSS grows, the increased burden on Medicaid is expected to place unsustainable strain on both state and federal budgets.⁵⁹

Improving the delivery and financing of care for individuals with complex needs will require a range of changes, including reforms in the payment and delivery of health and social supports in the Medicare and Medicaid programs. These changes can be made in the short-term and should help slow the rate of growth in these programs by reducing hospitalizations and emergency department visits.

Medicaid Home- and Community-Based Services

Steps can be taken in the short-term to address long-term care financing through reform of private LTCI, streamlining and consolidating state plan options and waivers for home- and community-based care in Medicaid, and permitting an “LTSS-only” buy-in for working individuals with disabilities.

Under Medicaid, states must provide nursing home care and other in-patient facility care to eligible individuals who need LTSS, however Medicaid coverage of services received at home or in the community varies significantly from state to state and these services are often unavailable

altogether. In recent decades, there has been a shift away from institutional delivery of care to HCBS. Generally, states have increased the availability of HCBS through the use of waivers of federal Medicaid requirements. For example, Medicaid services must be comparable across different categories of eligible individuals (e.g., children with behavioral health needs, and adults who need home health aide services), and services must be offered statewide.⁶⁰ Through the use of waivers, such as section 1915(c) of the Social Security Act, states have the ability to provide a defined set of HCBS to target populations, without making services available to all eligible individuals in the state. Under this waiver authority, states may provide HCBS to individuals who require an institutional level of care, so long as states demonstrate to CMS that they would spend no more than would have otherwise been spent on institutional care.

In addition to the waiver process, Congress has enacted a series of state plan amendments (SPAs) designed to make it easier for states to expand HCBS. While the existing waiver process may be preferable in the short term because it permits states to predict costs by capping the number of individuals eligible, over time, states may have greater incentive to use SPAs and avoid the complexity of waivers. Under the current structure of HCBS, the combination of several SPAs and the waiver authority creates an unnecessary level of complexity that is often difficult to navigate for administrators and beneficiaries alike.⁶¹ As states begin to see increased demand for LTSS, the combination of administrative simplification and financial incentives could lead states to expand services to meet those demands.

Caregivers

The needs of family caregivers are important because they deliver a disproportionate share of assistance to individuals with complex care needs. Wolff, Spillman, Freedman, and Kasper (2016) report that 14.7 million family and unpaid caregivers gave assistance with daily activities to 7.7 million community-dwelling older adults in 2011.⁶² The rationale for supporting family care is described in the text box below.

Historically, policymakers have raised concerns about the federal fiscal impact of paying for services that have been provided by family members. Allowing capitated payment models such as Medicare Advantage to offer a respite care benefit on a case-by-case basis for individuals with complex needs would help provide limited relief to family caregivers without adding significantly to costs. These and other recommendations are outlined in greater detail in the following section of the report.

SUPPORT FOR FAMILY CAREGIVERS

Caregiver policies can strive to meet several important social and fiscal objectives. They may be aimed at:

1. Keeping workers who also need to provide care in the labor force, so that they can continue to support their families, can leverage their firm-specific and position-specific experience, and can contribute to collective well-being through their income and payroll tax contributions;
2. Keeping care recipients in their homes, where most would prefer to be, in order to avoid or at least slow down institutionalization, which imposes significant financial burdens on families and governments;
3. Increasing the quality of care for people with disabilities and increasing self-direction of care by beneficiaries and their families; and
4. Protecting caregivers financially during their periods of caregiving, or at least limiting their financial losses, especially if they are economically vulnerable.

Source: Melissa Favreault and Brenda Spillman, The Urban Institute



Recommendations:

DELIVERY SYSTEM REFORM^{e,f}

This report recommends providing additional flexibility in Medicare to better integrate health and social services and supports for the Medicare beneficiaries with the greatest needs and highest costs. Medicare's payment rules and regulations have created significant care integration barriers for Medicare Advantage (MA) plans and health care provider groups, such as Accountable Care Organizations (ACOs) and patient-centered medical homes, which would otherwise furnish and finance these non-Medicare-covered supports and services. This report recommends ways to address the barriers in a fiscally responsible manner. The report findings also underscore the centrality of coordinated, person-centered approaches in integrating medical care and services and supports.

1. **Improve Medicare's risk adjustment model to account for functional impairment:** CMS should examine potential modifications to the CMS-Hierarchical Condition Categories (CMS-HCC) risk-adjustment model to ensure more accurate predictions of medical expenses for the highest- and lowest-cost Medicare beneficiaries. If feasible, it would support the use of a frailty adjustment factor or other functional status measure in the risk model, meaning the otherwise applicable risk scores could be adjusted upward for MA plans and ACOs with higher proportions of beneficiaries with functional impairments, and adjusted downward for MA plans and ACOs that treat fewer beneficiaries with functional impairments.
2. **Incentivize the provision of non-Medicare-covered supports through quality measurement:** CMS should develop MA Star Ratings Program measures and ACO Quality Measurement metrics that evaluate the incorporation of non-Medicare-covered health-related social supports and services (financed within existing MA rebates and ACO shared savings amounts) into the MA and ACO care model. MA plans and ACOs with greater levels of social support and service integration should be rewarded with higher scores on these quality measures. To the extent feasible, CMS should improve the Star Ratings Program by examining options for assessing these and other quality measures at the plan benefit-package level, rather than the contract level.
3. **Modify the Medicare Advantage (MA) uniform benefit requirement to allow MA plans to target non-Medicare-covered health-related social supports and services to plan enrollees** who: (1) are not dually eligible for full Medicaid benefits; (2) have three or more chronic conditions; and (3) either have functional or cognitive impairment. Supports and services covered under this policy must be reasonably related to optimizing health or functional status, and must be part of a "person-centered care plan," as defined by CMS. CMS should take steps to establish appropriate conditions of participation for MA plans availing themselves of this flexibility and should ensure that the offer of these targeted services cannot be inappropriately used for marketing purposes by MA plans. These non-Medicare-covered health-related supports and services can be included as mandatory supplemental benefits, financed through existing MA rebates. This recommendation is consistent with the general policy approach of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act, which was the product of a bipartisan dialogue and was passed in the U.S. Senate with unanimous support in September of 2017.
4. **Waive the primarily health-related requirement and other supplemental benefit rules:** CMS should provide an exception to the current requirement that supplemental benefits be primarily health-related and should also waive existing regulatory limitations on the provision of in-home meal delivery services, case management services, and home modifications as supplemental benefits. This exception should only apply to benefits that are targeted to enrollees who are not dually eligible for full Medicaid benefits and who have three or more chronic conditions and functional or cognitive impairment. Such benefits must be a part of a person-centered care plan, as defined by CMS. This recommendation is consistent with the general policy approach of the CHRONIC Care Act.

^e Bipartisan Policy Center, *Improving Care for High-Need, High-Cost Medicare Patients*

^f Additional detail on recommendations presented in this report is provided in Appendix A. Further detail on the Medicaid Streamlined Home and Community-Based Services (HCBS) State Plan Amendment Proposals is provided in Appendix B.

5. **Modify the definition of “incurred claims costs” in medical loss ratio (MLR) regulations to include the costs of health-related supports and services provided on an in-kind basis to enrollees who are not dually eligible for full Medicaid benefits, have three or more chronic conditions, and have functional or cognitive impairment.** Such supports and services must be a part of a person-centered care plan. For audit and verification purposes, MA plans should be required to keep records of payment of claims or other invoices for such services whose costs are included in the “incurred claims costs” calculation.
6. **Clarify that the patient incentive waiver under the Medicare Shared Savings Program (MSSP) and the Next Generation Accountable Care Organization (ACO) Program will allow for the free or no-charge provision of non-Medicare-covered health-related supports and services that optimize health or functional status for ACO-attributed beneficiaries who meet eligibility criteria.** The waiver should be limited to supports that are identified in a person-centered care plan, as defined by CMS. CMS should also provide a Patient Incentive Waiver, similar to the waiver applicable for MSSP ACOs and Next Generation ACOs, for participants in “Track Two” of the Comprehensive Primary Care (CPC) Plus Initiative, provided that the in-kind furnishing of supports and services by CPC Plus practices are part of a person-centered care plan, as defined by CMS.
7. **Establish voluntary enrollment processes within the MSSP and make related changes to the underlying attribution and payment reconciliation structures to ensure that ACOs have a more predictable pool of attributed beneficiaries and care expenses, as ACO participants transition to greater risk-sharing.**

In this report, BPC also provides a data analysis of the costs of providing four illustrative non-Medicare-covered supports. While BPC’s recommendations would provide the flexibility for MA plans, ACOs, and health care providers to prescribe, furnish, and finance the specific non-medical support interventions that work best for a particular chronically ill Medicare recipient, for the purposes of illustration, the analysis projected the costs of four services: in-home meal delivery, minor home modifications, non-emergent medical transportation, and targeted case management.

The analysis suggests that if changes to the uniform benefit requirement were adopted, MA plans would be able to finance many if not all of the four benefits to high-need populations by making only minor reductions in the value of existing supplemental benefits that are offered to all MA enrollees. The analysis also indicates that while some of the four supports could be financed by ACOs through shared savings payments, the ACOs might need to target these services to smaller groups of very high-need people in order to make free provision of these supports financially viable.

Through the policy changes included in the recommendations of this report, the Medicare program could create pathways for MA plans, ACOs, and other providers to better tailor care plans for frail and chronically ill Medicare recipients, in a manner that integrates traditional medical care with non-Medicare-covered social supports. Although more work needs to be done to develop analogous solutions to address the non-Medicare-covered social support needs and chronic care management issues for beneficiaries enrolled in Medicare Fee-for-Service, these recommendations present the opportunity for tangible, bipartisan fixes to policy problems that have impeded the evolution of person-centered care in the Medicare program.



Recommendations:

ALIGN PROGRAMS SERVING DUAL-ELIGIBLE MEDICARE AND MEDICAID BENEFICIARIES TO BETTER COORDINATE CARE^g

Improving care for individuals eligible for both Medicare and Medicaid is often more challenging given higher complexity and costs. However, the availability of social services and supports under Medicaid, including more comprehensive case management services and long-term services and supports, could provide the means to better finance care.

Medicare Advantage Special-Needs Plans (SNPs)

1. **Permanently authorize Medicare Advantage Dual-Eligible SNPs.** However, all plans should meet the requirements of Fully Integrated Dual Special-Needs Plans, which fully integrate clinical health services, behavioral health, and LTSS by January 1, 2020.
2. **Align the Medicare and Medicaid grievance and appeals processes.** Where adopting one standard would adversely affect a beneficiary, the HHS Secretary should resolve the issue to the benefit of the enrollee.
3. **Ensure that the combined Medicare and Medicaid benefits offered through all SNPs are seamless to the beneficiary and to providers.** Materials provided to a beneficiary must show the combined benefit, and the plan must have a single cost-sharing structure, care manager, enrollment process, enrollment card, submission process, and contact number for beneficiaries and providers.

Financial Alignment Demonstrations

For ongoing demonstrations, Centers for Medicare and Medicaid Services (CMS) should:

1. **Revise contracts to ensure that, where appropriate, rates reflect unanticipated costs of infrastructure investment or significant differences in costs associated with serving certain special-needs populations,** such as those with previously untreated mental illnesses or homeless individuals (note: CMS has made these adjustments in some states);
2. **Ensure that adjustments do not result in increased costs to the federal government over the five-year demonstration period;**
3. **Work with states to develop unique state-specific quality and access measures, and to the extent there are savings, permit states to share in a greater percentage of those savings;** or, where appropriate for high-performing states, permit added flexibility in the scope of covered benefits, while assuring that beneficiaries continue to receive optimal access to care;
4. **Align coverage standards for Medicare and Medicaid benefits that overlap, including durable medical equipment and home health services; and**
5. **Establish additional demonstrations to integrate Medicare and Medicaid for dual-eligible beneficiaries based on findings from the evaluations of the first-round demonstrations.** New demonstrations will allow additional states to gain experience providing managed LTSS to dual-eligible populations and coordinating these services with Medicare acute care.

Program of All-Inclusive Care for the Elderly (PACE)

Through newly authorized demonstration authority, CMS should:

1. **Test an expansion to individuals, regardless of age, who meet all other PACE criteria and who do not require a nursing home level of care;**

^g Bipartisan Policy Center, *Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid*

2. **Test an option that permits individuals to enroll in PACE, but opt out of adult day services;**
3. **Test an option that includes both Medicare-covered services and a beneficiary “buy-in” of a limited LTSS benefit that is less than the full-range of Medicaid-covered LTSS** for individuals who are not eligible for Medicaid and whose income exceeds 300 percent of Social Security income;
4. **Permit PACE organizations to enroll beneficiaries during the month**, rather than requiring them to wait until the first of the month to enroll. CMS should pro-rate the monthly per-capita payment;
5. **Align oversight of programs serving dual-eligible beneficiaries within CMS;** and
6. **Consolidate regulatory authority for reimbursement structures serving dual-eligible beneficiaries into a single office or center within CMS, such as the Medicare-Medicaid Coordination Office.** Reimbursement structures would include SNPs, PACE, current and future demonstrations, and a new contract authority described below. Such an approach would allow Medicare and Medicaid experts from CMS to work together under a leadership team whose single focus is addressing the unique needs of low-income populations with complex needs through an entity that has the authority to address those needs.

Develop a Revised Regulatory Structure

1. **Policymakers should build on lessons learned from existing programs and demonstrations to develop a contractual model similar to the innovative “three-way” contract between CMS, states, and plans under the financial alignment demonstration.** A new model three-way contract should be uniform with respect to basic structure, beneficiary protections, quality requirements, care coordination, and continuity of care requirements. At the same time, it should be flexible enough to permit variation in delivery, provider, and reimbursement models, as well as state-level decisions, such as eligibility for optional populations.
2. **In developing a framework for a model contract:**
 - a. The HHS secretary should make decisions based on recommendations of an informal working group consisting of stakeholder organizations, including consumer and family representatives, non-provider experts in the delivery of clinical health services, LTSS, including home and community-based care, community and public health services for special-needs populations, employers (for those participating in a Medicaid buy-in program), disability experts, health plans, health care providers, state Medicaid officials and other relevant stakeholder organizations. The HHS secretary should promulgate regulations based on the framework developed; or
 - b. Alternatively, the secretary should require negotiated rulemaking under the Administrative Procedure Act to develop the framework of a three-way contract. This approach, while more complicated than the regular “notice-and-comment” rulemaking process, would provide for greater transparency and give an equal voice to all members of the appointed rulemaking committee.



Recommendations:

EXPAND MEDICAID OPTIONS AT HOME AND IN THE COMMUNITY

1. **Create incentives for states to expand the availability of Home- and Community-Based Services (HCBS).** The HHS secretary should streamline and simplify existing authorities under current law waivers and State Plan Amendments (SPAs) and extend enhanced federal matching to encourage states to take advantage of the new streamlined authority. States should retain the ability to use the existing waiver process, and existing HCBS SPAs should be grandfathered in. Finally, once operational, the HHS secretary should make recommendations to Congress on whether to repeal existing SPAs. (See Appendix B for detailed policy options.)
2. **Permit states to offer an innovative LTSS-only “buy-in” for individuals with disabilities whose employment income would result in the loss of Medicaid coverage; and design the LTSS-only plan to “wrap around” employer-provided insurance, qualified health plans offered through insurance marketplaces, and Medicare to make the buy-in more affordable.**

Streamlining and consolidating existing waiver authority into a single SPA would assist states seeking to expand the availability of HCBS. Combining features of existing SPAs would permit states to offer HCBS in a way that moves toward eliminating Medicaid’s bias for institutional or facility-based care, give states the flexibility and predictability they need to expand services to best address the needs of varying populations, and maintain essential provisions of federal law that allow individuals to direct their own care.

If adopted by states, the Enhanced Medicaid Buy-In (EMBI) option would be available to individuals with earned income equal to or above 250 percent of the federal poverty level (in 2017, \$30,150) and who have proof of health insurance coverage. States would allow individuals to participate in the EMBI until they reach the Social Security Administration’s full retirement age. States that adopt this new option would be prohibited from imposing an asset test and would charge a sliding-scale premium based on income, ranging from 2 percent to 10 percent of income.

Recommendations:

LONG-TERM CARE FINANCING

Increasing the Availability and Affordability of Private Long-Term Care Insurance to Extend Existing Resources^h

This report's recommendations focus on the role of the private market, improvements to public programs such as Medicaid, and the potential for catastrophic coverage. Recognizing that incremental changes will not solve every problem with LTSS financing, these changes could make a meaningful difference for millions of Americans.

1. **Establish lower-cost, limited-benefit retirement LTCI policies.** Permit the sale of lower-cost, limited-benefit “retirement LTCI.” Policies would be standardized, with three basic plan designs. Consumers would have choice among basic features, such as daily coverage amounts, length of benefit period, and the size of the cash deductible, simplifying decision-making. These plans would be designed to meet the needs of individuals that would need LTSS for two years or less.
2. **Allow working-age retirement plan participants aged 45 and older to use retirement savings, without early withdrawal penalties, to purchase retirement LTCI.** Employees aged 45 and older in defined-contribution retirement plans, such as 401(k) and 403(b) plans, and IRA owners aged 45 and older, would be allowed to take distributions from the plan solely for the purchase of retirement LTCI for themselves and/or a spouse. Distributions for the purchase of retirement LTCI from tax-deferred plans would be subject to income tax but exempt from the 10 percent early withdrawal penalty.
3. **Provide incentives for employers to offer retirement LTCI through workplace retirement plans on an opt-out basis.** Plan sponsors should be offered a safe harbor and expanded “catch-up” contributions if the sponsor automatically enrolls certain plan participants (who would have the ability to opt out) into a retirement LTCI policy. The proposed safe harbor would limit fiduciary liability for plan sponsors that implement automatic enrollment according to certain standards.
4. **Allow retirement LTCI policies to be sold on state and federal health insurance marketplaces.** All health insurance marketplaces would have the option to facilitate sales of retirement LTCI policies. Participating marketplaces could accept distributions from workplace retirement plans and IRAs for the payment of retirement LTCI premiums from savers aged 45 and older.

While many older adults are able to meet their LTSS needs through out-of-pocket spending and unpaid care, these resources are not adequate for most individuals who face extraordinary LTSS expenses, such as the approximately 15 percent of older adults who will have lifetime costs over \$250,000. Most private LTCI policies are not designed to cover such catastrophic LTSS costs; private policies are generally capped to a lifetime maximum and are limited to three to five years of coverage.⁶³ Therefore, the vast majority of older adults who face catastrophic costs must deplete their personal resources to qualify for Medicaid.⁶⁴ In many cases, LTSS costs are shifted to younger generations, as family caregivers often incur income losses in order to provide care and may even use their own retirement savings to pay for their loved one's care.

The current state of LTSS financing is burdensome on individuals and their families and unsustainable for state and federal Medicaid budgets. Additionally, current proposals to significantly reduce federal Medicaid funding would further strain state budgets. If these cuts are realized, many states will need to choose between cutting LTSS services, eligibility, and/or provider payment rates. Advocates have advanced a number of approaches to funding LTSS. In 2016, BPC concluded that scarce federal resources should be targeted to populations that cannot be served either through the private market or through personal savings. The most promising approach is to target federal resources to cover the catastrophic or back-end costs of LTSS for those with the highest needs. Such a program could include a two- to three-year waiting period, and would need to be mandatory in order to spread risk and remain financially feasible. By covering catastrophic costs, this approach would lower state and federal Medicaid spending. Additionally, the insurance industry has argued that a catastrophic backstop would increase sales of private policies.

^h Bipartisan Policy Center, *Initial Recommendations to Improve the Financing of Long-Term Care*.



Additional Consideration: Federal Catastrophic Long-Term Care Insurance

Changing demographics, as well as the increasing burdens on working-age individuals, require a thoughtful discussion on the financing of LTSS for the 15 percent of individuals who will incur catastrophic levels of expenses. While we are not able to reach agreement on a politically viable means of financing a public catastrophic benefit, we agree that a credible overall LTSS framework would include a public catastrophic LTSS program with a waiting period of two to three years. Such a policy, which should not add to the deficit, would help address unmet LTSS needs and incentivize the purchase and greater use of private LTCI. Should a catastrophic program be adopted, states that offer expanded HCBS through the new SPA would have lower maintenance-of-effort requirements.

Recommendations:

SUPPORT FAMILY CAREGIVERS AND MAKE LTSS AVAILABLE THROUGH MEDICARE ADVANTAGE AND MEDIGAPⁱ

This report's recommendations were built upon the initial recommendations from February 2016 and presented analysis on estimated costs and coverage of a Medicare Respite Care Benefit, Tax Credits for Family Caregivers, and a limited LTSS Benefit in Medicare Advantage and Medigap Supplemental Insurance Coverage. The report focused on the needs of family caregivers, and the importance of person- and family-centered care planning and coordinated care. The report presented two new recommendations:

1. **Permit Medicare Advantage (MA) plans, and other Medicare provider organizations operating under a “benchmark,” the flexibility to offer a respite-care benefit to high-need, high-cost Medicare beneficiaries.** Respite care, along with other services, could be offered under this flexibility, so long as the services are part of a person- and family-centered care plan for a subset of individuals that meet the eligibility criteria, which includes people with three or more chronic conditions and functional or cognitive impairment.
2. **Permit Medigap and MA plans to market a limited LTSS benefit as an optional supplemental benefit, or as a separate insurance policy, financed exclusively through additional premiums paid by Medicare beneficiaries who choose to enroll.** For the purposes of estimating the added cost of the benefit to Medigap or MA premiums, BPC assumed a \$75 maximum daily benefit, with a 180-day elimination period that would need to be satisfied prior to the commencement of the benefit. Consistent with existing Medigap policies, beneficiaries would have a one-time option to purchase this coverage when they enroll in Medicare. BPC's analysis suggests that such a policy could result in premiums of \$35 to \$40 per member per month.

ⁱ Bipartisan Policy Center, *Financing Long-Term Services and Supports: Seeking Bipartisan Solutions in Politically Challenging Times*.



Conclusions and Next Steps

Increasingly, research has shown that individuals with complex care needs can benefit from a broad range of services, including traditional medical services as well as social services and supports that can prevent unnecessary hospitalizations and emergency department visits. At the same time, many services do not fit squarely within the traditional program design—which is a medical model—and do not necessarily need to be provided by licensed medical professionals. Program financing can be an impediment to providing coordinated care. Successful care models provide services, both medical and social, as part of an individualized care plan developed collaboratively by a care team, individuals, and their family members or caregivers.

As policymakers seek ways to improve quality and value in our health care system, including demonstrations of alternative payment models under the Medicare and Medicaid programs, as well as implementation of the Medicare Access and CHIP Reauthorization Act (MACRA), there are opportunities to address some of the problems identified in this report. CMS will continue testing approaches to reimbursement and patient care, with a specific interest in providing new flexibility to health plans. BPC will continue work to improve the policy models and the financing and delivery of care for individuals with complex care needs.

BPC will continue efforts to improve access to care for patients with complex care needs. Current and future areas of research and policy development include an increased focus on patient-centered care, further refining reimbursement for patients with complex care needs, the integration of clinical and behavioral health services, and improving access to care in rural areas.

Appendix A:

DETAILED SUMMARY OF BPC'S LONG-TERM SERVICES AND SUPPORTS RECOMMENDATIONS

Expand Access to Private Long-Term Care Insurance for Middle-Income Americans	
<i>Establish lower-cost, limited-benefit retirement</i>	LTCI policies should be standardized, with three basic plan designs, each of which would have limited options for customization. Consumers would have choice among basic retirement LTCI features, such as daily coverage amounts, length of benefit period, and the size of the cash deductible, simplifying decision-making. This lower-cost product would be designed to cover <i>two to four years of benefits</i> after a cash deductible or waiting period is met. The product would also include coinsurance.
<i>Allow working-age retirement plan participants aged 45 and older to use retirement savings, without early withdrawal penalties, and to purchase retirement LTCI for themselves and/or a spouse.</i>	Employees aged 45 and older in defined-contribution retirement plans, such as 401(k) and 403(b) plans, and IRA owners aged 45 and older, would be allowed to take distributions from the plan solely for the purchase of retirement LTCI from tax-deferred plans would be subject to income tax but exempt from the 10 percent early withdrawal penalty.
<i>Make retirement LTCI policies more widely available by providing incentives for employers to offer them through workplace retirement plans on an opt-out basis.</i>	Plan sponsors should be offered a safe harbor and expanded “catch-up” contributions if the sponsor automatically enrolls certain plan participants (who would have the ability to opt out) into a retirement LTCI policy. The proposed safe harbor would limit fiduciary liability for plan sponsors that implement automatic enrollment according to certain standards.
<i>Allow retirement LTCI policies to be sold on state and federal health insurance marketplaces.</i>	All health insurance marketplaces would have the option to facilitate sales of retirement LTCI policies. Participating marketplaces could accept distributions from workplace retirement plans and IRAs for the payment of retirement LTCI premiums from savers aged 45 and older
Create incentives for states to expand the availability of Home and Community Based Services (HCBS)	
<i>Streamline and simplify existing authorities under current law waivers and State Plan Amendments (SPAs).</i>	States should retain the ability to use the existing waiver process, and existing HCBS SPAs should be grandfathered in. Finally, once operational, the HHS secretary should make recommendations to Congress on whether to repeal existing SPAs.
<i>Extend enhanced federal matching to encourage states to take advantage of the new streamlined authority.</i>	Extend the 6 percent enhanced federal matching assistance percentage from 1915(k) and the Money Follows the Person Rebalancing Demonstration and provide an enhanced administrative match for activities related to streamlined eligibility and enrollment functions, as well as for ombudsman activities.
Provide Support for Caregivers	
<i>Permit Medicare Advantage (MA) plans, and other Medicare provider organizations operating under a “benchmark,” to offer a respite care benefit to high-need, high-cost Medicare beneficiaries.</i>	Respite care, along with other services, could be offered under this flexibility, so long as the services are part of a person and family-centered care plan for a subset of individuals that meet the eligibility criteria, which includes people with three or more chronic conditions and functional or cognitive impairment.
Provide Access to Limited LTSS Benefits through Medicare	
<i>Permit Medigap and MA plans to market a limited LTSS benefit as an optional supplemental benefit, or as a separate insurance policy, financed exclusively through additional premiums paid by Medicare beneficiaries who choose to enroll.</i>	Consistent with existing Medigap policies, beneficiaries would have a one-time option to purchase this coverage when they enroll in Medicare. For the purposes of estimating the added cost of the benefit to Medigap or MA premiums, BPC assumed a \$75 maximum daily benefit, with a 180-day elimination period that would need to be satisfied prior to the commencement of the benefit. BPC’s analysis suggests that such a policy could result in premiums of \$35 to \$40 per member per month.
Provide Access to Medicaid LTSS Benefits through Medicaid for Working Americans with Disabilities	
<i>Allow states to offer an LTSS-only “buy-in” for individuals with disabilities whose employment income would result in the loss of Medicaid coverage.</i>	To make the buy-in more affordable, the LTSS-only plan is designed to “wrap around” employer-provided insurance, qualified health plans offered through insurance marketplaces, and Medicare



Align Programs Serving Dual-Eligible Medicare and Medicaid Beneficiaries to Better Coordinate Care

Special Needs Programs

<i>Permanently authorize Medicare Advantage Dual-Eligible Special Needs Plans (SNPs).</i>	All plans should meet the requirements of Fully Integrated Duals Special-Needs Plans, which fully integrate clinical health services, behavioral health, and LTSS by January 1, 2020.
<i>Authorize the secretary of HHS to align the Medicare and Medicaid grievance and appeals processes.</i>	Where adopting one standard would adversely affect a beneficiary, the HHS secretary should resolve the issue to the benefit of the enrollee. For example, under the aligned process, Medicare claims, like Medicaid claims under current law, should be paid during appeal.
<i>The secretary of HHS should ensure that the combined Medicare and Medicaid benefits offered through all SNPs are seamless to the beneficiary and to providers.</i>	Materials provided to a beneficiary must show the combined benefit, the plan must have a single cost-sharing structure, a single care manager, a single enrollment process and enrollment card, a single claims submission process, and a single contact number for beneficiaries and providers.

Building Upon the Financial Alignment Demonstrations

<i>For ongoing demonstrations, CMS should make the following revisions based on results to-date:</i>	<ul style="list-style-type: none"> a. Revise contracts to ensure that, where appropriate, rates reflect unanticipated costs of infrastructure investment or significant differences in cost associated with serving certain special-needs populations, such as those with previously untreated mental illnesses or homeless individuals. Note: CMS has made these adjustments in some states; b. Ensure that adjustments do not result in increased cost to the federal government over the five-year demonstration period; c. Work with states to develop unique state-specific quality and access measures, and to the extent there are savings, permit states to share in a greater percentage of those savings or, where appropriate for high-performing states, permit added flexibility in the scope of covered benefits, while assuring that beneficiaries continue to receive optimal access to care; and d. Align coverage standards for Medicare and Medicaid benefits that overlap, including durable medical equipment and home health services.
<i>CMS should establish additional demonstrations to integrate Medicare and Medicaid for dual-eligible beneficiaries based on findings from the evaluations of the first-round demonstrations.</i>	CMS should develop a contractual model similar to the innovative “three-way” contract between CMS, states, and plans under the financial alignment demonstration—uniform with respect to basic structure, beneficiary protections, quality requirements, care coordination, and continuity of care requirements, but, flexible enough to permit variation in delivery, provider, and reimbursement models, as well as state-level decisions, such as eligibility for optional populations.

Program of All-Inclusive Care for the Elderly (PACE)

<i>Through newly authorized demonstration authority, CMS should test:</i>	<ul style="list-style-type: none"> a. An expansion to individuals, regardless of age, who meet all other PACE criteria and who do not require a nursing home level of care; b. An option that permits individuals to enroll in PACE, but opt out of adult day services; and c. An option that includes both Medicare-covered services and a beneficiary “buy-in” of a limited LTSS benefit that is less than the full-range of Medicaid-covered LTSS for individuals who are not eligible for Medicaid and whose income exceeds 300 percent of Social Security income.
<i>Permit PACE organizations to enroll beneficiaries during the month, rather than requiring them to wait until the first of the month to enroll.</i>	CMS should pro-rate the monthly per-capita payment.

Integrate Care for Dual-Eligible Beneficiaries by Aligning Oversight of Programs Serving Dual-Eligible Beneficiaries within the Centers for Medicare and Medicaid Services

<i>Consolidate regulatory authority for reimbursement structures serving dual-eligible beneficiaries into a single office or center within CMS, such as the Medicare-Medicaid Coordination Office.</i>	Consolidating this authority will help ensure that decisions affecting these programs are made through the lens of an integrated program that takes into account the impact on beneficiaries, as well as state implementation. Reimbursement structures would include SNPs, PACE, current and future demonstrations, and a new contract authority described below.
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Reform Payment Models to Support Provision of LTSS

<p><i>Improve Medicare’s Risk Adjustment Model to Account for Functional Impairment.</i></p>	<p>CMS should examine potential modifications to the CMS-Hierarchical Condition Categories (CMS-HCC) risk adjustment model to ensure more accurate predictions of medical expenses for the highest- and lowest-cost Medicare beneficiaries. Existing survey platforms used to measure frailty and/or develop a functional status assessment tool that would be implemented and used across MA and Medicare FFS to evaluate and document functional impairment of the Medicare beneficiary. If this approach proves feasible—and data gathered by CMS support the use of a frailty adjustment factor or other functional status measure in the risk model—the otherwise applicable risk scores could be adjusted upward for MA plans and ACOs with higher proportions of beneficiaries with functional impairments, and adjusted downward for MA plans and ACOs that treat fewer beneficiaries with functional impairments.</p> <p>To allow MA plans and ACOs to become more familiar with the impact that a frailty or functional impairment adjustment factor would have on risk scores, benchmarks, and bid pricing, CMS should phase in any finalized adjustment factor policy over multiple years.</p>
<p><i>Incentivize the Provision of Non-Medicare-Covered Supports Through Quality Measurement.</i></p>	<p>CMS should develop MA Star Ratings Program measures and ACO Quality Measurement metrics that evaluate the incorporation of non-Medicare-covered health-related social supports and services (that can be reasonably financed within existing MA rebates and ACO shared savings amounts) into the MA and ACO care model. MA plans and ACOs with greater levels of social support and service integration should be rewarded with higher scores on these quality measures, while MA plans and ACOs with less comprehensive integration of these services should receive lower scores. Additional quality measure-focused approaches could include applying one measure of all-cause hospital readmissions for beneficiaries with multiple chronic conditions and functional or cognitive impairments, and a separate measure of all-cause hospital readmissions for all other enrolled or attributed beneficiaries.</p>
<p><i>Modify the Uniform Benefit Requirement.</i></p>	<p>Congress should direct CMS to modify the MA uniform benefit requirement to allow MA plans to target non-Medicare-covered health-related social supports and services to plan enrollees who: (1) are not dually eligible for full Medicaid benefits; (2) have three or more chronic conditions; and (3) either have functional or cognitive impairment. Supports and services covered under this policy must be reasonably related to optimizing health or functional status, and must be part of a “person-centered care plan,” as defined by CMS. These non-Medicare-covered health-related supports and services can be included as mandatory supplemental benefits, financed through existing MA rebates.</p>
<p><i>Waiving the Primarily Health-Related Requirement and Other Supplemental Benefit Rules:</i></p>	<p>CMS should provide an exception to the current requirement that supplemental benefits be primarily health-related and should also waive existing regulatory limitations on the provision of in-home meal delivery services, case management services, and home modifications as supplemental benefits. This exception should only apply to benefits that are targeted to enrollees who are not dually eligible for full Medicaid benefits and who have three or more chronic conditions and functional or cognitive impairment. Such benefits must be a part of a person-centered care plan, as defined by CMS. This recommendation is consistent with the general policy approach of the CHRONIC Care Act.</p>
<p><i>Counting Health-Related Non-Medical Supports and Services Costs Toward the Medical Loss Ratio.</i></p>	<p>CMS should modify the definition of “incurred claims costs” in medical loss ratio (MLR) regulations to include the costs of health-related supports and services provided on an in-kind basis to enrollees who are not dually eligible for full Medicaid benefits, have three or more chronic conditions, and have functional or cognitive impairment. Such supports and services must be a part of a person-centered care plan. For audit and verification purposes, MA plans should be required to keep records of payment of claims or other invoices for such services whose costs are included in the “incurred claims costs” calculation.</p>
<p><i>Clarifying ACO Patient Incentive Waivers and Extending Waivers to the CPC Plus Model:</i></p>	<p>CMS should clarify that the Patient Incentive Waiver under the Medicare Shared Savings Program (MSSP) Program and the Next Generation ACO Program will allow for the free or no-charge provision of non-Medicare-covered health-related supports and services that optimize health or functional status for ACO-attributed beneficiaries who are not dually eligible for full Medicaid benefits, have three or more chronic conditions, and have functional or cognitive impairment. The waiver should be limited to supports that are identified in a person-centered care plan, as defined by CMS. CMS should also provide a Patient Incentive Waiver, similar to the waiver applicable for MSSP ACOs and Next Generation ACOs, for participants in “Track Two” of the Comprehensive Primary Care (CPC) Plus Initiative, provided that the in-kind furnishing of supports and services by CPC Plus practices are part of a person-centered care plan, as defined by CMS.</p>
<p><i>Establishing Voluntary Enrollment Pathways within MSSP ACOs.</i></p>	<p>CMS should establish voluntary enrollment processes within the MSSP and make related changes to the underlying attribution and payment reconciliation structures to ensure that ACOs have a more predictable pool of attributed beneficiaries and care expenses, as ACO participants transition to greater risk-sharing.</p>



Appendix B:

STREAMLINED HOME- AND COMMUNITY-BASED SERVICES STATE PLAN AMENDMENT PROPOSALS

Streamlined HCBS State Plan Amendment	Authority/Authorities <i>All citations are from the Social Security Act, unless otherwise noted.</i>	Extension/Expansion or New Proposal
<p>Overall Approach: Establish new consolidated State Plan Amendment, combining existing authority from Medicaid state plan options, Medicaid waivers, and Section 1115 waivers. The 1115 authority has been used by a few states to extend services to a group of “pre duals”, older adults whose incomes are low but not currently eligible for Medicaid. They have LTSS needs and are at risk of spending down to Medicaid. States using the 1115 authority in this context extend a modest benefit to forestall Medicaid eligibility. MN is doing this now under 1115.</p>	<p>Sec. 1915(c) – Home and community-based waiver program</p> <p>Sec. 1915(i) – HCBS Option (Grassley-Bayh bill) – DRA 2005, amended by ACA</p> <p>Sec. 1915(j) – Self-directed services (Grassley) – DRA 2005</p> <p>Sec. 1915(k) – Community Choice Option (Harkin’s MI CASA as a state option) - ACA</p> <p>Other HCBS options used by states.</p> <ul style="list-style-type: none"> • Personal care services (SPA) • Home health (mandatory for those who are eligible for SNF) • EPSDT • Rehabilitation services • Katie Beckett (certain kids who would be eligible if in hospital, SNF or ICF/ID) • Targeted case management (SPA) • Ticket to work • 100 percent of poverty option • Medically needy option • 300 percent of SSI option 	<p>Combining existing waiver and SPA authority, and extending or expanding as noted. Requires legislation to combine existing law requirements into a single SPA.</p>
<p><i>Eligibility</i></p> <ul style="list-style-type: none"> – Income/resources: up to 300 percent of SSI, if states cover institutional care to that level – Functional status: States establish a uniform assessment of functional need, and must be higher for institutional level of care 	<p>Sec. 1915 (k) SSA</p> <p>300 percent option (parity)</p> <p>Sec.1915 (i)</p>	<p>Existing authority</p>
<p>Benefits/covered services</p> <ul style="list-style-type: none"> – Case management – Homemaker/home health aide/personal care – Adult day health – Habilitation – Respite – Such other services as approved by Secretary or other partial hospitalization services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness 	<p>Sections 1915 (i) cross-referencing 1915 (c)(4)(B); 1915(j),</p>	<p>Existing authority</p>

Streamlined HCBS State Plan Amendment	Authority/Authorities <i>All citations are from the Social Security Act, unless otherwise noted.</i>	Extension/Expansion or New Proposal
<p>Additional requirements:</p> <ul style="list-style-type: none"> • Individuals do not need to meet institutional level of care; • State must establish a more stringent needs-based criteria for individuals requiring institutional level of care; • States project the number of individuals expected to receive services, and criteria for receipt of services taking into account inability to perform ADLs and other risk factors; • States may modify the criteria without obtaining prior approval by the Secretary if enrollment exceeds projections; • States must conduct independent assessments, and develop individualized care plans in consultation with providers, caregivers, family, or representatives, and take into account the extent of and need for any family or other supports; • State must identify services to be furnished; • State may allow individuals to choose self-directed services; and • State does not have to meet comparability, or amount, scope and duration of services. 	<p>1915 (i); 1915 (j)</p>	<p>Clarify that states set an enrollment target under 1915(i). When that enrollment target is reached, the state may stop enrollment.</p>
<p>SPAs do not require budget neutrality as do waivers.</p>	<p>Sec. 1915 (i); 1915 (k)</p>	<p>Existing authority</p>
<p>Increased FMAP for Integration of services (Medicaid Health Homes). States receive 90% enhanced FMAP for home health services under Sec. 2703. FMAP is enhanced for first 8 quarters that the program is effective.</p> <ul style="list-style-type: none"> • comprehensive care management, • care coordination and health promotion, transitional care, • individual and family support, • referral to community and social support services, and • use of health information technology to link services where appropriate 	<p>Sec. 1945; Sec. 2703 of the ACA</p>	<p>Existing authority (Expired)</p>



Streamlined HCBS State Plan Amendment	Authority/Authorities <i>All citations are from the Social Security Act, unless otherwise noted.</i>	Extension/Expansion or New Proposal
<p>Make permanent the Money Follows the Person (MFP) demonstration program, and incorporate into the new SPA. 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 4 additional fiscal years after. Any unused grant funds awarded in 2016 can be used until 2020. Eligible individuals include people that live in an institution for more than 90 consecutive days. States receive an enhanced FMAP for covered demonstration and HCBS for the first year the individual receives services in the community after leaving an institution. (Exception: days that a person was living in the institution for the sole purpose of receiving short-term rehabilitation services reimbursed by Medicare don't count toward this 90-day period).</p>	<p>Sec. 6071 of the DRA, as amended by Sec. 2403 of the ACA. Current authorization expires Sept. 30, 2016.</p>	<p>Makes permanent and existing demonstration. Requires legislation. Remove cap on Medicaid expenditures.</p> <p>The ACA extended MFP Program through September 30, 2016, and appropriates an additional \$2.25 billion (\$450 million for each FY 2012-2016).</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 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 Administration. 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, and • State governance and administration 	<p>Sec. 1943</p>	<p>Requires legislation to include coordination and enrollment through Medicaid, ARDCs, the VA, and other agencies identified by ACL.</p> <p>CMS is developing guidance for states on claiming administrative match (50%) for these services. We may want to provide an enhance match (90%) to encourage states to build this infrastructure which will help people in need of LTSS understand their options in getting these needs meet.</p>

Streamlined HCBS State Plan Amendment	Authority/Authorities <i>All citations are from the Social Security Act, unless otherwise noted.</i>	Extension/Expansion or New Proposal
<p>Balancing Incentive Program - increases the Federal Matching Assistance Percentage (FMAP) to states that make structural reforms to increase nursing home diversions and access to non-institutional LTSS. The enhanced matching payments are tied to the percentage of a State's LTSS spending, with lower FMAP increases going to states that need to make fewer reforms.</p> <p>Total funding over 4 years (October 2011 – September 2015) can't exceed \$3 billion in Federal enhanced matching payments. Enhanced FMAP may only be used to provide new or expanded home and community-based LTSS. States are also subject to a maintenance of effort provision prohibiting them from decreasing eligibility below Dec 31, 2010 levels. Eligible states must have less than 50 percent of LTSS spending in non-institutional care.</p>	<p>Sec. 10202 of the ACA</p> <p>The Balancing Incentive Program authorizes grants to states to increase access to non-institutional long-term services and supports (LTSS) as of October 1, 2011.</p> <p>The Balancing Incentive Program will help states transform their long-term care systems by:</p> <ul style="list-style-type: none"> Lowering costs through improved systems performance & efficiency Creating tools to help consumers with care planning & assessment Improving quality measurement & oversight. <p>The Balancing Incentive Program also provides new ways to serve more people in home and community-based settings, in keeping with the integration mandate of the Americans with Disabilities Act (ADA), as required by the Olmstead decision. The Balancing Incentive Program was created by the Affordable Care Act of 2010 (Section 10202).</p> <p>The Balancing Incentive Program increases the Federal Matching Assistance Percentage (FMAP) to states that make structural reforms to increase nursing home diversions and access to non-institutional LTSS. The enhanced matching payments are tied to the percentage of a state's LTSS spending, with lower FMAP increases going to states that need to make fewer reforms.</p> <p>Total funding over 4 years (October 2011 – September 2015) can't exceed \$3 billion in Federal enhanced matching payments.</p> <p>To participate in the Balancing Incentive Program, a state must have spent less than 50% of total Medicaid medical assistance expenditures on non-institutionally based LTSS for fiscal year 2009. States must also submit an application that meets programmatic and structural reform requirements.</p> <p>States that spent 25-50% on non-institutionally-based LTSS are eligible for a 2% enhanced FMAP. These states must reach 50% of total LTSS expenditures on non-institutionally based LTSS by September 30, 2015.</p> <p>States that spent less than 25% on non-institutionally based LTSS are eligible for 5% enhanced FMAP. These states must reach 25% of total LTSS expenditures on non-institutionally based LTSS by September 30, 2015.</p> <p>Currently, the following 21 states are approved: Arkansas, Connecticut, Georgia, Indiana, Iowa, Kentucky, Louisiana, Maryland, Mississippi, Missouri, New Hampshire, New Jersey, New York, Texas, Illinois, Maine, Ohio, Nevada, Massachusetts, Pennsylvania, and Nebraska. Indiana, Louisiana, and Nebraska are no longer participating in the program.</p>	<p>Change or extend increased FMAP.</p> <p>Requires legislation.</p> <p>Extend program for another 4 years at current funding level of \$3 billion and adjust the formula used to determine eligibility for the enhanced FMAP (which is made in the form of a grant payment to the state).</p> <p>Currently, only one state qualified for the 5% enhanced FMAP based on having only 25% of state LTSS spending on HCBS.</p> <p>Since the national average for spending on HCBS v institutional care has exceeded 50%, making adjustments to level of spending on HCBS to qualify for the 2% enhanced match is needed.</p>



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