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Streamlining and Simplifying Medicaid HCBS Authorities

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Glossary

ACA	AFFORDABLE CARE ACT
ADLs	ACTIVITIES OF DAILY LIVING
CMS	CENTERS FOR MEDICARE & MEDICAID SERVICES
EPSDT	EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT
FMAP	FEDERAL MEDICAL ASSISTANCE PERCENTAGES
FPL	FEDERAL POVERTY LEVEL
HCBS	HOME AND COMMUNITY-BASED SERVICES
IADLs	INSTRUMENTAL ACTIVITIES OF DAILY LIVING
IDD	INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
LTSS	LONG-TERM SERVICES AND SUPPORTS
MFP	MONEY FOLLOWS THE PERSON
PACE	PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY
SPAs	STATE PLAN AMENDMENTS

Executive Summary

Congress is considering legislation to expand the availability of Medicaid home and community-based services (HCBS) by making additional resources available to states as part of a larger reconciliation bill. Although the reconciliation bill does not have bipartisan support, Democrats and Republicans have historically supported efforts to expand HCBS.[a] Policymakers support expansion for several reasons, including a recognition that individuals prefer to receive services at home and in the community. Regardless of the outcome of the pending reconciliation legislation, Congress should consider additional steps beyond funding that would improve the administratively complex and piecemeal structure for HCBS authorities.

This report focuses on streamlining and simplifying states' HCBS waiver and state plan authorities into a single state plan amendment (SPA), with the goal of reducing complexity for states administering the programs and for beneficiaries navigating the system. Streamlining and simplifying the program would make services more uniform from state to state and across populations within a state. Ultimately, this change should improve access to services.

The patchwork of waivers and SPAs that states use to deliver HCBS has created challenges for states and beneficiaries alike and has resulted in divergent levels of access to services both within and between states. Historically, states have relied on 1915(c) waivers to provide HCBS, as these waivers allow states to target services to certain subpopulations and provide states with budget certainty. In 2020, of the 254 active 1915(c) waivers, most targeted individuals with intellectual disabilities (91 waivers), those with physical disabilities (86 waivers), and seniors ages 65 and older (64 waivers).[1] Multiple 1915(c) waivers have enabled states to target different populations or provide different services, with some states relying on up to 11 waivers at once.[2]

The use of multiple waivers or a combination of waivers and state plan amendments creates an enormously complex system for states to manage and beneficiaries to navigate. States often have to administer multiple programs and benefit packages with different eligibility requirements. Beneficiaries must navigate the different sets of requirements to identify the pathway most likely to meet their needs. Additionally, the current structure encourages states to rely

a The Deficit Reduction Act of 2005 (DRA), for example, included provisions to create the state option to offer HCBS. The language was based on bipartisan legislation, S. 1602, the Long-Term Care Choices Act, sponsored by Sen. Chuck Grassley (R-IA) and co-sponsored by Sens. Evan Bayh (D-IN) and Hillary Rodham Clinton (D-NY). The Money Follows the Person Demonstration was also enacted as part of the DRA and was based on legislation introduced by Sen. Tom Harkin (D-IA), and was cosponsored by Republican Sens. Gordon Smith of Oregon and Mike DeWine of Ohio.

heavily on multiple waivers, which can lead to inequitable access to services within a state. For example, two residents of a state may have similar diagnoses and HCBS needs but may not be eligible to receive the same services due to targeting allowed under 1915(c) waivers.

Although most of the national conversation around HCBS expansion is focused on increasing the number of people served and strengthening the infrastructure and workforce that care for them, simplifying and streamlining states' HCBS authorities by creating a single SPA would reduce complexity in the current system. This streamlining would enable states to better design and administer their HCBS programs around the needs of the beneficiary, while also improving the beneficiary experience.

Summary of Recommendations

Streamlining and Simplifying Medicaid HCBS Authorities

A. Congress should streamline and simplify Medicaid HCBS waiver and SPA authorities by creating a single, consolidated SPA that retains much of the flexibility of the existing HCBS waiver authorities and state plan options. Congress should phase out existing HCBS waivers and SPAs and require states to deliver HCBS through the new SPA within five years of enactment.

B. The Centers for Medicare & Medicaid Services (CMS) should provide clarification on the 1915(i) option to phase-in coverage and extend that option to the new consolidated SPA.

C. CMS should provide comprehensive technical assistance to states during the transition to the new state plan authority. During this transition, CMS should collaborate with the Administration of Community Living, and Congress should provide additional resources to CMS for providing technical assistance.

Note: See below for detailed recommendations.

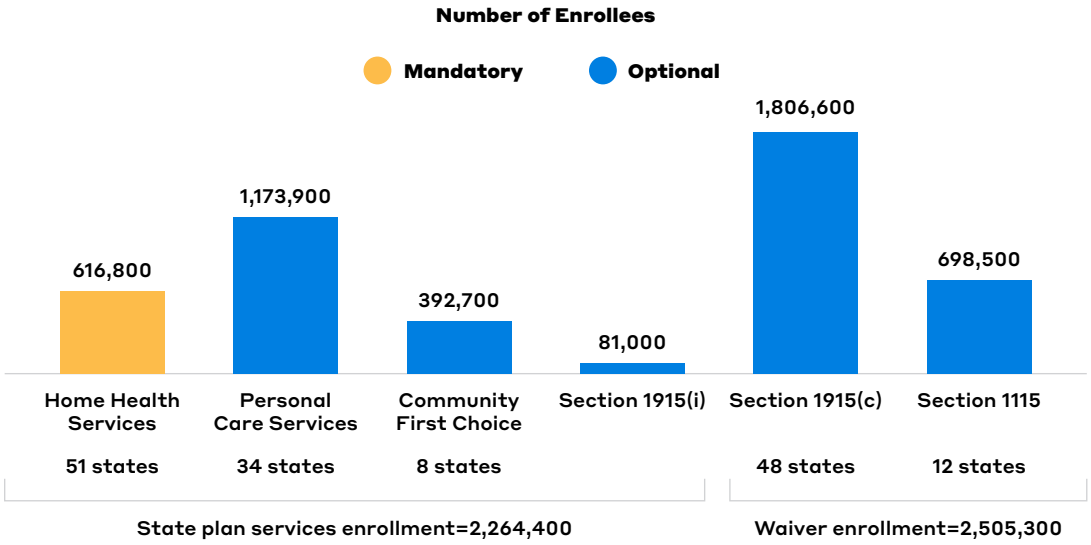
Background

In 2018, an estimated 14 million adults in the United States reported a need for long-term services and supports (LTSS).[3] LTSS refers to a broad range of paid and unpaid medical and personal care assistance that individuals may need when they have difficulty completing self-care tasks due to age, chronic illness, or disability.[4] LTSS includes assistance with activities of daily living (ADLs), such as eating, bathing, and dressing, as well as with instrumental activities of daily living (IADLs), such as medication management and meal preparation.[5] People who need LTSS typically have physical, cognitive, developmental, mental, or chronic health conditions.[6]

The majority of paid LTSS is financed jointly by the federal government and states through the Medicaid program.[7] Medicaid spent $182.9 billion (combined federal and state) on LTSS in calendar year (CY) 2019, the most recent year with data available, accounting for about 43% of the $426.1 billion spent by all payers.[8] LTSS includes institutional care – provided in skilled nursing facilities or other congregate care settings – and services provided at home or in other community-based settings, typically referred to as HCBS.[9] Calculating total HCBS enrollment is difficult, because individuals may receive services under more than one authority. But roughly up to 2.5 million individuals were enrolled in waivers and up to 2.3 million were enrolled in state plan services in fiscal year (FY) 2018 (Figure 1).[10] In FY2016, the last year for which complete state and federal data are available,[b] Medicaid programs (federal and state combined) spent approximately $94 billion on HCBS, which was slightly more than half of total LTSS expenditures.[11]

b CMS released an updated report on Medicaid LTSS expenditures in January 2021, but the report lacks data on managed long-term services and supports (MLTSS) spending in five states. In almost all those states, MLTSS programs account for a large share of overall LTSS expenditures. As a result, we use data from the next most recent report, which includes MLTSS expenditure data in almost all applicable states except California and South Carolina.

Figure 1: Enrollment in Medicaid HCBS by Program Authority, FY2018



Source: Kaiser Family Foundation, Medicaid Home and Community-Based Services Enrollment and Spending

Note: Adding figures across these authorities does not equal total HCBS enrollment, as individuals may receive services under more than one authority.

A Brief History of Medicaid LTSS Coverage

1960s

Since enactment of the Medicaid program in 1965, states have been required to provide LTSS to individuals ages 21 and older in an institutional setting – i.e., nursing homes.

1970s

Home health care services – which are primarily medical services provided by a physician or nurse but which also include home health aide services[12] – were optional under the program until 1970, when Congress required states to cover home health services for those entitled to skilled nursing facility care. Physical and occupational therapy, however, remained optional.[13] Rehabilitation services have been an optional state plan benefit since the start of Medicaid. Additional institutional service options became available to states in the early 1970s; these included intermediate care nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and psychiatric hospitals for adolescents and children under age 21.[14] The secretary of the U.S. Department of Health and Human Services (HHS) established personal care services as an option in the mid-1970s.[15]

1980s

In 1981, Congress expanded states' ability to provide HCBS through section 1915(c) waivers. It provided federal matching dollars for a broad range of HCBS, if the federal spending did not exceed what the federal government would have spent on institutional care for those receiving home and community-based services.[16] Congress also authorized targeted case management as an optional service in 1986.

1990s

Congress established personal care services as an optional state plan benefit in the early 1990s. In 1999, the Supreme Court ruled in *Olmstead v. L.C.*[c] that medically unjustifiable institutionalization of individuals violates the Americans with Disabilities Act. The court said states must administer services in the setting that is most integrated in the community and that is appropriate to meet the needs of the individual.[17] The court also held that states could establish waiting lists if they are cleared at a "reasonable pace,"[18] a standard that was not defined and has not been enforced.

2000s

In 2005, Congress sought to further expand HCBS through state plan options, rather than the use of federal waivers. The Deficit Reduction Act authorized the first HCBS state plan option under section 1915(i); this option provided services to those who do not require an institutional level of care. The act also authorized an option under section 1915(j), which added self-directed care to Medicaid HCBS under the Money Follows the Person demonstration program (MFP).[19] The Affordable Care Act (ACA) included an additional state plan option under section 1915(k), known as the Community First Choice Option.[20] The ACA also established Medicaid Health Homes– an optional state plan benefit to coordinate care for individuals with chronic conditions– and the Balancing Incentive Program.[21,d] For more detailed information on each of the waivers, state plan options, and demonstration programs, see Appendix 1 and BPC's June 2021 white paper, *Streamlining and Simplifying Medicaid HCBS Part I*.

Although not specific to HCBS, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) has become a critical source of HCBS for children with disabilities. EPSDT requires states to offer comprehensive services to children, and to furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions.[22] HCBS covered by the EPSDT benefit may include private duty nursing, personal care services, home health and medical equipment and supplies, and rehabilitative services.[23]

Collectively, the *Olmstead* decision and federal statutory and policy changes resulted in a significant increase in HCBS costs. From FY1999 to FY2018, Medicaid LTSS spending on institutional care decreased from 74% to 44% of total Medicaid LTSS expenditures, while spending on HCBS grew from 26% to 56% (Figure 2).[24] These numbers are averages and do not provide a full picture of access to services in each state. As outlined below, state spending on HCBS as a percentage of LTSS spending varies significantly, contributing to inequitable access to HCBS between states.

HCBS advocates have long viewed the distinction between mandatory and optional services as evidence of a bias toward providing LTSS in institutions, such as nursing homes, versus in the home or community. For many advocates, as long as institutional care is mandatory and HCBS are optional, the state, rather than the individual, ultimately controls where beneficiaries live. Regardless of this distinction, the historically piecemeal approach to expanding HCBS has produced a patchwork of waivers and state plan amendments that is complex for states to administer, encourages inequities in access to services, and confuses beneficiaries needing services.

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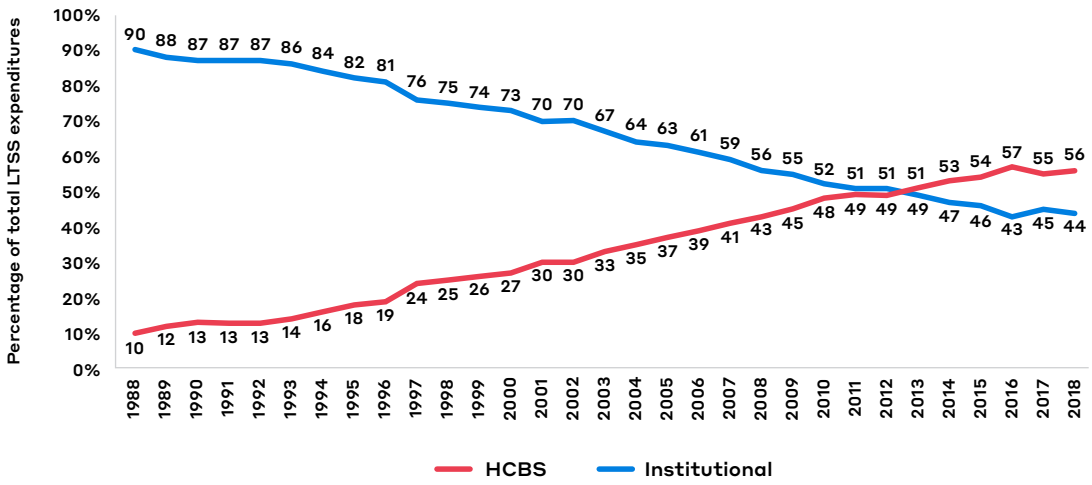
c *Olmstead v. L.C.*, 527 U.S. 581 (1999). In this 1999 opinion written by Justice Ruth Bader Ginsburg, the court held that states must provide community-based services to those with mental illness, when: 1) state professionals have determined that community placement is appropriate; 2) the individual prefers a community-based setting; and 3) community-based care can be reasonably accommodated, considering the state resources and the needs of others with mental disabilities.

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

Figure 2: Changes in Federal Spending on LTSS, FY1988 to 2018



Source: CMS, Long-Term Services and Supports Rebalancing Toolkit, November 2020

HCBS Benefits and Eligibility under Current Law

HCBS Covered Services

Home and community-based services include a wide range of medical and non-medical services designed to support individuals in the community. States often combine mandatory medical services, such as home health, and optional services, such as rehabilitation services, with non-medical services, primarily specified under section 1915(c) of the Social Security Act. HCBS generally may include:

- Home health care services[e] (mandatory for those entitled to skilled nursing facility care);
- Personal care services;
- Private duty nursing services;
- Targeted case management services;
- Program of All-Inclusive Care for the Elderly (PACE) services, which include all Medicare-covered, Medicaid-covered, and other services determined necessary by the interdisciplinary care team to improve or maintain the participant's health;[25]
- Case management services;
- Rehabilitation services, including those related to behavioral health;

e Required home health services that states must cover under the benefit include nursing services; home health aide services; and health care related medical supplies, equipment, and appliances that are primarily and customarily used to serve a medical purpose. Additional services that states may cover under the home health benefit include physical therapy, occupational therapy, or speech pathology and audiology services. 42 CFR § 440.70.

- Services authorized under 1915 (b), (c), (i), (j), or (k); 1115; or 1937 of the Social Security Act.[f] 1915(c) waivers, the most common HCBS waiver, allow states to cover case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and other services requested by the state and approved by the secretary of HHS.[26] States may also cover day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not provided in a facility) for individuals with chronic mental illness;[27]
- HCBS covered through EPSDT.

All states offer HCBS, either through benefits, waivers, HCBS-specific state plan amendments, or a combination of benefits, waivers, and amendments.[28] Often, states combine waiver authorities and state plan amendments to design and administer multiple programs with different sets of services, eligibility rules, federal renewal periods, and other features.

Eligibility for HCBS

States generally define eligibility for mandatory and optional HCBS through financial, categorical, and functional eligibility criteria. Therefore, individuals' ability to receive HCBS depends on their income and assets, their place in one of the categories of covered subpopulations, and their level of functional and clinical need for services.

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

For example, federal rules require states to provide Medicaid coverage to individuals ages 65 and over, and to individuals who are blind or have disabilities who receive cash assistance through the Supplemental Security Income (SSI) program.[29] In 2021, the income limit for SSI for an individual is $794 per month and the resource limit is $2,000.[30] States may rely on the SSI financial eligibility criteria, or they may set more restrictive criteria for individuals who qualify based on SSI.[31] States may also cover other low-income individuals ages 65+ or those with disabilities who are not receiving SSI cash assistance.[32] States may use more generous financial limits for that optional eligibility group.

f See Appendix I for a table describing these authorities.

In placing HCBS participants, subpopulation categories include:

- I/DD (intellectual/developmental disabilities);
- SMI (serious mental illness);
- Individuals ages 65+;
- Individuals under 65 with physical disabilities.[33]

A large majority of HCBS users (63.9%) and almost all users who tend to incur the highest cost (86.6%) were eligible for Medicaid HCBS due to disability in 2012, the most recent year data are available.[34] The most common diagnoses for those with high costs were intellectual disorders and related conditions, mobility impairments, and epilepsy.[35] Those who tend to incur high costs were less likely than all HCBS users (11.4% versus 29.8%) to be eligible due to age.[36]

Functional Eligibility Criteria: In addition to financial and categorical eligibility requirements, individuals generally must meet functional eligibility criteria for HCBS. Functional eligibility criteria for most Medicaid LTSS services, including HCBS, generally mandate that individuals require care that would otherwise be provided in an institutional setting, such as a nursing home. No federal definition for functional eligibility criteria exists. Most states define the need for HCBS through a mix of factors, such as an individual's ability to perform activities of daily living and clinical criteria related to the diagnosis of an injury, illness, or disability.[37]

Recent Action

Although this report focuses on simplifying and streamlining the structure for HCBS authorities, it is important to understand the broader political landscape surrounding HCBS. Policymakers have sought to expand the availability of Medicaid HCBS for more than 40 years to address the growing number of Americans who need assistance with daily activities but who prefer to receive care in their home or community. Notably, home and community-based care is usually less expensive on a per person basis than institutional care.[38] More recently, in the wake of the high mortality rates in nursing homes and other congregate settings during the COVID-19 pandemic, advocates are urging expanded access to HCBS.

Legislation in Response to COVID-19

The American Rescue Plan Act of 2021 contained a 10% increase in the federal share of Medicaid expenditures (FMAP) for certain activities that enhance, expand, or strengthen Medicaid HCBS.[39] In May 2021, CMS released guidance on implementing the enhanced FMAP and detailed the activities eligible for the increased federal match. Examples of the eligible activities include:

- New or additional HCBS;
- HCBS provider payment rate and benefit enhancements;
- Supplies and equipment;
- Caregiver support;
- Support to improve the functional capabilities of persons with disabilities;
- Transition support;
- Mental health and substance use disorder services;
- Outreach; and
- Access to COVID-19 vaccines.[40]

With limited exceptions, the additional federal funding is available to states from April 1, 2021, to March 31, 2022.[41] States must use the money to increase HCBS spending above current levels.[42] Detailed data on how states have used the additional funds to date are not yet available. But according to one preliminary survey, states most often reported plans to increase HCBS provider payment rates and to use the funds for workforce recruitment.[43] The Congressional Budget Office estimates this funding will cost the federal government $12.7 billion over the 12 months it is in effect.[44] Additionally, President Biden has proposed longer-term investments in HCBS through the American Jobs Plan. Specifically, the plan calls for a $400 billion investment in

HCBS over ten years to expand access to services, extend the Money Follows the Person program, and increase wages for caregivers.[45]

Better Care Better Jobs Act

Members of Congress have introduced numerous bills to expand the availability of Medicaid home and community-based services, but these measures have little bipartisan support. In June 2021, Sen. Bob Casey (D-PA) and Rep. Debbie Dingell (D-MI-12) introduced the Better Care Better Jobs Act, which builds on the HCBS funding included in the American Rescue Plan Act. The legislation expands HCBS by making permanent the 10% increase in the federal Medicaid match to states for delivering HCBS and provides a temporary 80% federal match, through 2031, for administrative activities related to improving HCBS.[46] States would have to meet several requirements to receive the increased federal match.

The legislation would provide $100 million to states for HCBS infrastructure improvement planning grants.[47] In line with a previous BPC recommendation, the MFP demonstration program would be made permanent. The program would also receive $450 million in funding each fiscal year. Finally, the state option for impoverishment protections for the spouses of those receiving HCBS waiver services would be made permanent.[48] Under current law, spousal impoverishment protections are permanent for the spouse of those receiving institutional care. However, spousal impoverishment protections for HCBS expire in 2023. Although the Congressional Budget Office has not provided a public estimate of the proposal, proponents want to keep the cost under $400 billion.

Reconciliation

Although the Better Care Better Jobs Act substantially invests in HCBS, the legislation lacks bipartisan support. Given this reality, Democratic members of Congress want to use the upcoming reconciliation bill, where a simple majority is needed to pass legislation, as a vehicle to enact the Better Care Better Jobs Act. However, due to Republican opposition, it is unlikely that all the proposed legislation would be included in the final reconciliation bill. Currently, the Better Care Better Jobs Act has 37 Democratic and two independent Senate co-sponsors.[49]

The House Energy and Commerce mark-up includes a $190 billion investment in HCBS, about half of the $400 billion the president proposed. As of late September, the text includes several provisions from the Better Care Better Jobs Act, such as making MFP and the option for spousal protections for HCBS permanent, while other provisions, such as a permanent 7% enhanced FMAP for HCBS, differ slightly (the Better Care Better Jobs Act calls for a 10% increase).

Challenges under Current Law and Opportunities under a Consolidated SPA

Despite the greater investment in resources, the patchwork of waivers and state plan amendments that states use has created various challenges in meeting the need for HCBS and has led to inequitable access to services both within and between states. The disjointed approach has also led to an administratively complex system for states to manage and beneficiaries to navigate.

Administratively Complex System for States

In determining what authority to use to expand HCBS, states look closely at cost. As outlined above, states that choose to cover optional Medicaid HCBS may deliver these services through a variety of waivers or state plan options. Most often, states rely on 1915(c) waiver authority to deliver these services because of the financial predictability they provide. States may target waiver services to specific populations or regions and cap enrollment for these services. In FY2018, expenditures for Section 1915(c) waiver programs reached approximately $35.7 billion,[g] and accounted for more than half of Medicaid HCBS expenditures.[50] Only a small percentage of HCBS expenditures were for services provided through the 1915(k), 1915(i), or 1915(j) state plan options.[51]

States may rely on multiple 1915(c) waivers simultaneously to target different populations or provide different services, with some states using up to 11 waivers at once.[52] In 2020, of the 254 active 1915(c) waivers, most targeted individuals with intellectual disabilities (91 waivers), those with physical disabilities (86 waivers), and seniors ages 65 and older (64 waivers).[53]

State officials have acknowledged they rely on waivers to control costs and cite this reliance as a challenge to effective administration of their programs. An April 2020 report from the Government Accountability Office found that many state officials reported difficulty meeting the requirement to enroll all eligible individuals when their state opts to cover HCBS under their state plan; the enrollment requirement complicates states' cost control efforts and increases their use of waivers and demonstrations, which allow capping enrollment.[54] To address this problem, the officials suggested allowing states to limit HCBS enrollment through their state plans.[55]

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

States also reported that limitations in their ability to tailor LTSS to certain populations lead to similar challenges. For example, establishing different eligibility criteria for nursing facility services and HCBS, or differentiating services between urban and rural areas, leads to increased use of waivers and demonstrations, which increases complexity.[56] To address this problem, state officials suggested more flexibility in their ability to target LTSS to certain beneficiaries under state plan authority.[57]

The use of multiple waivers or a combination of waivers and SPAs creates an incredibly complex system for states to manage, because the state must keep track of different eligibility rules, benefit packages, and reporting requirements for each waiver. Additionally, each waiver is for only a limited time. If states wish to continue providing HCBS through waivers, states must periodically submit renewal requests to CMS. State officials have noted these waiver application and renewal submissions require significant resources, and the variation in length of each waiver and their renewal processes adds to the burden of administering HCBS through waivers.[58] States may also need to oversee multiple contracts and contractors, manage several waiting lists, and oversee different sets of quality metrics, among other responsibilities that contribute to the complexity of administering multiple HCBS authorities.

A consolidated SPA would provide flexibility to states to customize HCBS programs, while preserving the budget predictability for HCBS that the state plan makes possible. The consolidated SPA would also eliminate the burdensome waiver process for HCBS and other administrative responsibilities that states must manage for each waiver.

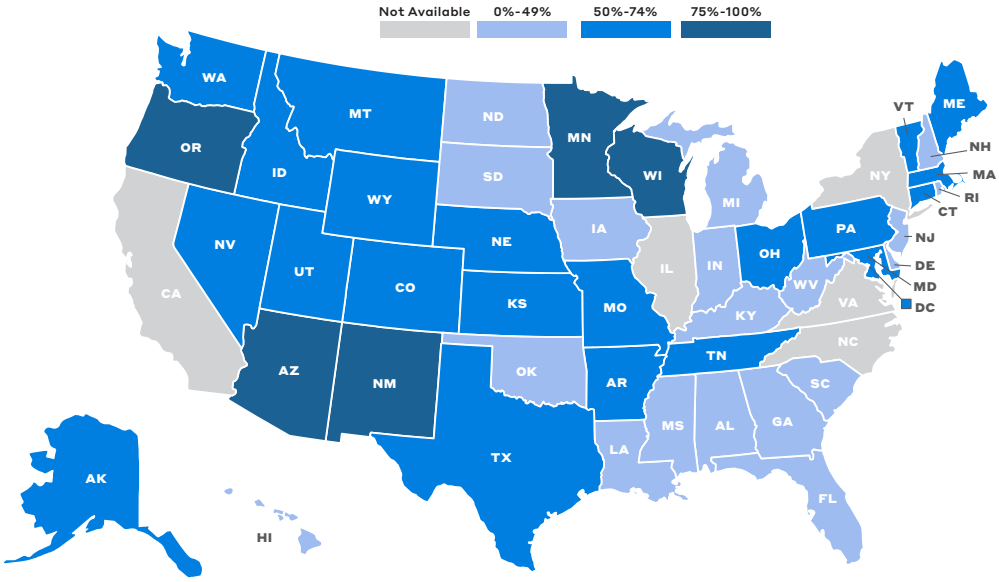
Inequity in Service Availability and Beneficiary Access

Variation in State Spending

Although all states offer HCBS, the services covered, access to those services, and spending varies significantly across states and within states. In 2018, HCBS as a portion of state LTSS expenditures ranged from 30% in Rhode Island to 83.4% in Oregon (Figure 3).[59,h] In 27 states where spending data was available, HCBS accounted for 50% or more of total LTSS expenditures.[60] Generally, spending on HCBS made up a larger portion of total LTSS expenditures in states that provide these services through an MLTSS program.[61]

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

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



Source: MACPAC, April 2021

The availability of waiver slots in Michigan is one example of unequal access to HCBS within a state; certain counties have only one waiver slot for every 58 eligible individuals, compared with one slot for every 20 eligible individuals in the rest of the state.[62] When states administer HCBS through a patchwork of waiver programs with separate benefit packages targeted to certain populations based on, for example, diagnosis or geographic location, beneficiaries with similar needs in the same state may not be able to access the same services in the community.

In addition to certain target groups receiving more or different services within a state, federal cost neutrality formula requirements for waivers can contribute to imbalances in total HCBS spending across populations. In FY2017 and FY2018, states spent almost three-quarters of total 1915(c) waiver program expenditures on individuals with intellectual or developmental disabilities (IDD) or autism spectrum disorder.[63] During that same period, older adults and individuals with physical or other disabilities accounted for the remaining 22% of 1915(c) waiver program expenditures.[64] Since Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) have historically had higher payment rates than nursing homes, the cost neutrality formula generally allows higher HCBS expenditures for waiver programs that target individuals with developmental disabilities.[65] Inequities in allowable HCBS spending between populations could contribute to unmet needs for certain populations.

Unlike waivers, SPAs can provide more equitable access to HCBS both between states and between different populations within a state. Although states would still retain many of the flexibilities that exist under the current HCBS authorities, a single, consolidated SPA would end the practice of states targeting services to specific geographic areas (except in limited circumstances, described below). In addition to reducing inequities in access within a state, a single SPA would not

have to meet federal cost neutrality requirements. Equity in spending on HCBS between different diagnostic groups would therefore likely improve as well.

The consolidated SPA could also help improve equity in access to HCBS across states by reducing administrative complexities that may deter states from modifying or expanding their waiver programs.

Waiting Lists and a Complex System for Beneficiaries to Navigate

Today, about half of 65-year-olds will need LTSS at some point in their life.[66] As the U.S. population ages and the need for LTSS continues to grow, states and the federal government are concerned about the cost of expansion because of the perceived unmet need for services, often referred to as the "woodwork effect." This is the belief that when services become widely available, qualified individuals will come out of the woodwork to seek care.

A report by the Kaiser Family Foundation found that in 2018, nearly 820,000 individuals were on waiting lists across 41 states.[67] However, Kaiser and the Medicaid and CHIP Payment and Access Commission note that the accuracy of waiting lists varies significantly by state, and the estimate should not be considered a precise measure of unmet need for HCBS.[68] For example, some states do not complete eligibility screening before an individual is placed on the state's waiting list.[69] Additionally, while data show that wait times vary greatly based on the state, waiver, and target population, ranging from 1 to 14 years, stakeholders have reported that some of those on waiting lists may be receiving state plan services through Medicaid or from family caregivers.[70] Notably, the IDD population accounts for 72% of those on waiting lists in 2018.[71]

When individuals seek HCBS, they must determine which program will provide the benefit package that best meets their needs. Beneficiaries have several options to choose from, and some waivers may have waiting lists, creating a complex decision for the individual. As mentioned above, some states rely on as many as 11 HCBS waivers at once. Additionally, because of the targeting of services allowed under 1915(c), not all waivers provide the same benefits across the state or to all subpopulations. According to a 2016 policy brief by Kaiser, "If different services are offered through different programs, people with multiple needs may have to choose which services to pursue and which to forgo."[72] Multiple waivers and SPAs operating simultaneously create a complex system for beneficiaries to navigate and in some cases makes it impossible for them to receive all services to meet their needs through a single program.

Consolidating HCBS authorities into a single SPA could help to clear waiting lists, as 1915(i) SPAs – which could provide the foundation for the new consolidated SPA – do not allow for waiting lists or the same targeting of services that occurs under 1915(c) waivers. Additionally, beneficiaries would no longer have to navigate and apply to multiple waiver programs with different eligibility requirements and benefit packages.

Policy Recommendations

Although most of the national conversation surrounding HCBS is focused on strengthening infrastructure and the workforce, simplifying and streamlining the authorities that states use to provide HCBS can also advance the expansion of services and reduce administrative complexity.

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

Streamlining and Simplifying Medicaid HCBS Authorities

A. Consolidated State Plan Amendment

Congress should create a single, consolidated SPA that retains much of the flexibility of the existing HCBS waiver authorities and state plan options. (See Appendix II.) Congress should phase out existing authorities and require states to deliver HCBS through the new SPA within five years of enactment.

Transitioning waivers to an improved state plan option would incentivize infrastructure development for HCBS, promote administrative efficiency and access, and support person-centered care for beneficiaries while providing states with the desired budget predictability. A consolidated state plan option should include requirements or incentives for uniform assessments and person-centered care plans; incentives for states to help individuals transition from institutional to community settings; incentives for streamlined enrollment; and a single entry point to access HCBS.

Key Provisions

Congress should establish a new consolidated SPA that would combine existing authority from Medicaid state plan options, including 1915(i), (j), and (k), and Medicaid waivers, including 1915(c) and Section 1115 (except in limited circumstances). Existing enrollees in each of these options should be grandfathered to prevent a disruption in services. Under this approach, the HHS secretary would develop a template that includes the following information to be provided by the states:

- Eligibility, including income and resource standards, and functional status criteria;
- Benefits covered;
- An estimate of the number of individuals the state projects will be eligible.

Eligibility

Income and resources: Under the consolidated SPA, states should be permitted to cover individuals with incomes up to 300% of SSI, or about 221% of the federal poverty level (FPL). This recommendation does not broaden current income eligibility limits, and it would preserve current eligibility. Under the 1915(i) SPA, states may cover individuals with incomes up to 300% of SSI, who are eligible for HCBS under an approved 1915(c), 1915(d), 1915(e), or 1115 waiver.[73]

Under current law, states have flexibility on income eligibility and resource standards. Examples include the option, under the Katie Beckett provision of the Tax Equity and Fiscal Responsibility Act (TEFRA), to waive the counting of parental income and resources for children under 18 years old who live at home, but would otherwise be eligible for Medicaid-funded institutional care; the option under the Ticket to Work and Work Incentives Act to create a buy-in program for individuals with disabilities; the option to raise the income eligibility level up to 100% of FPL for individuals over age 65 or those under age 65 with disabilities; the option to cover certain individuals with incomes above financial eligibility limits through the medically needy pathway; and the option to cover individuals with incomes up to 300% of SSI who are in an institution or receive HCBS under a waiver. Under this recommendation, states could continue to enjoy these flexibilities.

Functional status: Under the new SPA, states would have to establish functional status criteria that requires an assessment of an individual's support needs and capabilities. This would involve considering the inability of the individual to perform two or more ADLs or the need for significant assistance to perform such activities. Other factors to assess include the need for substantial supervision to protect an individual from threats to health and safety due to severe cognitive impairment, as well as need related to a serious mental illness.

States could modify the criteria without obtaining prior approval by the secretary of HHS if enrollment exceeds projections. However, to ensure transparency when adopting the consolidated state plan, states should be required to describe the process they will use to modify eligibility criteria once the enrollment projection is met. States could also consult their consumer and stakeholder advisory boards when setting enrollment targets and determining eligibility criteria modifications. Although states already can modify criteria to limit enrollment under 1915(i) SPAs, states have not used this authority. They have instead relied on multiple waivers guaranteeing budget predictability by capping enrollment and targeting services. Accordingly, BPC

includes a recommendation below for CMS to work closely with states and provide technical assistance on implementing the consolidated SPA, to ensure maximum flexibility.

Under the consolidated SPA, as under 1915(i), individuals would not need to meet criteria for an institutional level of care. This would permit states to offer services to individuals before their conditions require significant and more costly interventions. To assure equity in the provision of services, states would be required to establish a more stringent needs-based criteria for individuals requiring an institutional level of care.

Individualized Care Plan: Under the consolidated SPA, states would have to conduct independent assessments; develop individualized care plans in consultation with providers, caregivers, family, or representatives; and identify services to be provided. States must allow individuals to choose self-directed services. But states would not be required to meet Medicaid comparability, or amount, scope, and duration of services standards.

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

Spousal Impoverishment Protections: Congress should permanently authorize the state option to extend protection against impoverishment for spouses of individuals receiving Medicaid HCBS.

Covered Benefits

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

- Home health care;
- State plan personal care services;
- Rehabilitation services, including those related to behavioral health;
- Case management;
- Homemaker/home health aide and personal care;
- Adult day health care;
- Habilitation;
- Respite;
- Day treatment or other partial hospitalization services, psychosocial rehabilitation, and clinic services (whether or not furnished in a facility) for

individuals with chronic mental illness;

- HCBS covered through EPSDT;
- Other services approved by the secretary of HHS.

Enhanced Match and Payment for Services

Enhanced Administrative Match: States would be eligible for an enhanced administrative match for activities related to streamlined eligibility and enrollment functions, such as those typically performed by states' No Wrong Door system, as well as for ombudsman activities. An enhanced match would allow states to establish administrative structures that ensure individuals know how to access Medicaid HCBS, furthering efforts to rebalance the LTSS system and promote person-centered care in the community. To help states transition to the consolidated SPA, BPC recommends an enhanced match rate for the administrative services related to streamlined eligibility and enrollment functions, including infrastructure development. To receive the enhanced match, states must comply with a maintenance of effort requirement for HCBS eligibility and benefit standards to ensure federal funding supplements, not supplants, existing state funds expended on Medicaid HCBS, as of the date Congress passes legislation establishing the consolidated SPA.

Additional Enhanced Administrative Match for HCBS Quality Reporting: States that choose to measure and report on an approved set of HCBS quality measures would be eligible to receive an additional 1% FMAP increase beyond the enhanced administrative match. Congress should direct the secretary of HHS to develop recommended core and supplemental sets of HCBS quality measures. In developing these quality measures, HHS should collaborate with the administrator of CMS, the administrator of the Administration for Community Living, the director of the Agency for Healthcare Research and Quality, and the administrator of the Substance Abuse and Mental Health Services Administration. HHS should also solicit feedback from stakeholders and incorporate their suggestions into their recommendations. States would have the option of adopting the core set of HCBS quality measures or another set of HCBS quality measures approved by the HHS secretary.

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

States may also receive a 90% enhanced FMAP for integration and coordination of services, as permitted under current law for eight quarters through the Medicaid Health Homes model.

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

B. CMS should provide clarification on the 1915(i) option to phase-in coverage and extend that option to the new consolidated SPA.

As discussed above, many states provide HCBS through 1915(c) waivers because the waivers give them the ability to target services to specific populations and geographic locations, and to cap enrollment, thus providing budget certainty. Although states may not place caps on enrollment under 1915(i), they can limit participation by estimating the number of individuals they expect to enroll, then modifying eligibility requirements and ending enrollment once they reach that number.

Under current law for 1915(i) SPAs, states do have an additional option to target services to specific populations during the first five-year period the SPA is approved. States can phase in enrollment of eligible individuals or the provision of services under this option.[74] The phase-in can be dependent on the needs of a population, the availability of infrastructure to provide services, or both.[75] In this case, infrastructure is defined as "the availability of qualified providers or of physical structures and information technology necessary to provide any service or set of services."[76] To use this option, the state must submit a plan to CMS for approval that outlines the criteria used for phasing in the benefit. By the end of the period, all eligible individuals must be able to receive services statewide.[77]

The Office of the Assistant Secretary for Planning and Evaluation within HHS previously recommended that CMS clarify that a state can use the phase-in option to test new HCBS approaches in a specific geographic location before it makes these approaches available statewide.[78] This option means the state can study the impact of the policy change, determine whether current infrastructure is adequate to support the policy changes, and potentially modify the policy before implementing it statewide.[79] As states continue to develop their HCBS programs, flexibilities such as these can help them make changes to their programs to best serve beneficiaries. A phase-in approach can be useful as states implement the consolidated state plan option. The ability to phase in enrollment and the provision of services should apply to the new consolidated SPA as well.

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

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

In addition to providing direct technical assistance, CMS could implement an HCBS technical assistance initiative similar to the Integrated Care Resource Center, which helps states develop integrated care programs for dual eligible Medicare-Medicaid beneficiaries. CMS could also provide states with planning grants and create a learning collaborative, so states can learn best practices from each other.

Longer-Term Pathway to a More Comprehensive HCBS Reform

Although consolidating HCBS authorities into a single SPA will likely reduce administrative burdens and increase equity in access to services, more comprehensive reforms are necessary to meet the growing need for LTSS in the United States. In September 2021, BPC released a report, *Bipartisan Solutions to Improve the Availability of Long-Term Care*. The report included recommendations for Congress on establishing a refundable tax credit for caregivers to help with out-of-pocket costs for paid LTSS-related care and on expanding access to HCBS for middle-income individuals who are ineligible for Medicaid. Specifically, BPC recommended that Congress establish a buy-in to HCBS for Medicare-only beneficiaries. BPC also recommended that Congress create a transitional program to support the expansion of integrated delivery models and build caregiver capacity until the new HCBS buy-in is fully implemented.

The buy-in would be made available to Medicare beneficiaries with LTSS needs who do not qualify for Medicaid. Services would be offered through a fully integrated care model, such as a Medicare Advantage Dual Eligible Special Needs Plan or the PACE program. The services would be fully subsidized for those who are under 221% of FPL (about $2,372 per month for an individual in 2021),[80] and sliding scale subsidies would be available for those between 221-400% FPL. Those who are ineligible for subsidies would still be able to access the services by paying for them.

The proposal included one of three service packages for beneficiaries to choose from:

- A set of services with a fixed dollar amount to be used by beneficiaries to address their individual needs (similar to the CAPABLE program);[i]
- Up to 10 hours per week of personal care assistance services; or
- Services covered under Section 1915(c) of the Medicaid program.[j]

BPC intends to further refine this proposal through future study. BPC would focus on developing a model of administration within Medicare that permits income-based targeting of services and builds on existing state-level expertise in the delivery of HCBS.

Conclusion

The growing need for LTSS, coupled with the impact of COVID-19 on congregate settings and individuals' preferences to receive care in the home or community, has brought national attention to the need for HCBS reform. However, many of the congressional proposals to expand HCBS lack bipartisan support. BPC believes streamlining HCBS into a single state plan option strikes a balance between simplifying administrative complexity and providing states with budget predictability, while helping to advance the goal of expanding access to services.

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

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

Appendix I

HCBS Waivers and State Plan Amendments

HCBS Authorities	Eligibility	Limits and Flexibilities	Population Targeting (Comparability)	Geographic Targeting (Statewideness)	Self-Direction
Section 1915(c)	Individuals who meet the state's institutional level of care (meaning individuals could be admitted to a nursing facility, hospital, ICF/IID); the need for services must be based on an assessed need and identified in a state-approved service plan.	States may cap enrollment. In the aggregate, program services must not cost more than what would have been incurred to care for participants in an institution, referred to as "cost neutrality."	States may target based on age or diagnosis, including children, adults with physical disabilities, individuals with intellectual or developmental disabilities, individuals with traumatic brain injuries, individuals with MH/SUD, and older adults, among others.	States may limit a program geographically.	States can choose to offer self-directed HCBS under this benefit.
Section 1915(i)	Individuals who are eligible for medical assistance under the state plan, meet state-defined needs-based criteria, and reside in the community.	No cost neutrality requirement. States may not cap enrollment or maintain waiting lists. States may limit participation through needs-based eligibility criteria.	Option to target the benefit to a specific population based on age, disability, diagnosis, and/or Medicaid eligibility group. The lower threshold of needs-based criteria must be "less stringent" than institutional and HCBS waiver program level of care.	Benefit must be offered statewide.	States can choose to offer self-directed HCBS under this benefit.
Section 1915(k) Community First Choice Optional State Plan Benefit	Individuals who meet the state's institutional level of care (meaning individuals could be admitted to a nursing facility, hospital, ICF/IID, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the state plan) can qualify for services under section 1915(k).	States cannot limit the number of eligible individuals served.	States cannot target the benefit to a particular population.	Benefit must be offered statewide.	States can choose to offer self-directed HCBS under this benefit.

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

Research and Demonstration Programs

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

Appendix II

Consolidated State Plan Amendment

***Note**: The policy recommendation for a consolidated SPA is explained in the left column of the table below. References to existing statutory authority are in the center column as a point of reference, and how BPC's proposal would affect current law is in the right column.*

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

Consolidated SPA Defined	Drawing from Existing Authorities	Proposed Change from Current Law
Eligibility: • **Income and resources**: States may cover individuals with incomes up to 300% of SSI, or 221% of FPL. States could continue to adopt flexibilities related to income eligibility and resource standards, such as options under the Katie Beckett provision of TEFRA, TWWIA, etc. • **Functional status:** States must establish functional status criteria that requires an assessment of an individual's support needs and capabilities. States must take into account the inability of the individual to perform two or more activities of daily living or the need for significant assistance to perform such activities, or the need for substantial supervision to protect an individual from threats to health and safety due to severe cognitive impairment, and such other risk factors as the state determines to be appropriate. • States may modify the functional criteria without obtaining prior approval by the secretary of HHS if enrollment exceeds projections. However, when adopting the consolidated state plan, states are required to describe the process they will use to modify eligibility criteria once the enrollment projection is met, to ensure transparency. States may engage their consumer and stakeholder advisory boards when setting enrollment targets and determining eligibility criteria modifications. • Individuals do not need to meet criteria for an institutional level of care, and the state must establish a more stringent needs-based criteria for individuals requiring an institutional level of care.	• The 300 percent option (parity). • The following sections of the SSA: » 1915 (k). » 1915 (i) – including the option for states to limit participation by modifying the needs-based criteria once actual enrollment exceeds the state's projected enrollment. This effectively limits enrollment growth to those in greater need of services, while allowing the state to continue to serve those who enrolled at the less stringent level of care. » 1915 (j). • States have an obligation under *Olmstead* to make services available in the most integrated setting appropriate to the Medicaid beneficiary's need. • Section 2404 of the ACA modified the definition of "institutionalized spouse" in Section 1924 of the SSA, which provides impoverishment protections for spouses of individuals in institutional settings, to include individuals receiving services through 1915 (c), (i), or (k) and 1115 waivers providing HCBS. » Originally set to expire in 2018, Congress has extended these protections through 2023 from subsequent legislation.	• Current law. *Note: BPC addressed HCBS expansion in our September 2021 report, Bipartisan Solutions to Improve the Availability of Long-Term Care.* • Clarify that states set an enrollment target under 1915(i). When that enrollment target is reached, the state may modify the needs-based criteria for LTSS by using more stringent criteria. Extend this to the new consolidated SPA. • Legislation establishing the consolidated SPA should require states to conduct independent assessments and develop individualized care plans; require states to allow individuals to choose self-directed HCBS; allow states to waive comparability, amount, duration, and scope standards; and should include a maintenance of effort requirement. • Requires legislation to make permanent the existing state option, which will sunset in 2023, to extend protection against impoverishment for spouses of individuals receiving Medicaid HCBS.

Consolidated SPA Defined	Drawing from Existing Authorities	Proposed Change from Current Law
• **Individualized Care Plan**: States must conduct independent assessments; develop individualized care plans in consultation with providers, caregivers, family, or representatives; and identify services to be furnished. • **Self-Directed Services**: States must allow individuals to choose self-directed services. • **Comparability, amount, duration, and scope**: States are not required to meet Medicaid comparability, or amount, scope, and duration of services standards. • **Maintenance of Effort**: To receive an enhanced administrative match under the consolidated SPA, states must comply with a maintenance of effort requirement for HCBS eligibility and benefit standards to ensure federal funding supplements, not supplants, existing state funds expended for Medicaid HCBS, as of the date Congress enacts legislation establishing the consolidated SPA. • **Spousal Impoverishment Protections**: Congress should permanently authorize the state option to extend protection against impoverishment for spouses of individuals receiving Medicaid HCBS		

Consolidated SPA Defined	Drawing from Existing Authorities	Proposed Change from Current Law
Optional Covered Services: • Home health care (remains mandatory as under current law). • State plan personal care services. • Rehabilitation services, including those related to behavioral health. • Case management. • Homemaker/home health aide and personal care. • Adult day health care. • Habilitation. • Respite. • Day treatment or other partial hospitalization services, psychosocial rehabilitation, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness. • HCBS covered through EPSDT. • Other services approved by the HHS secretary.	• Sections 1915 (i) cross-referencing 1915 (c)(4)(B); 1915(j); 1905(a) of the SSA.	• Current law.
• SPA does not require cost neutrality as do waivers.	• Sections 1915 (i) and 1915 (k) of the SSA.	• Current law.

Consolidated SPA Defined	Drawing from Existing Authorities	Proposed Change from Current Law
Enhanced Match and Payment for Services: • **Enhanced Administrative Match**: States are eligible for an enhanced administrative match for activities related to streamlined eligibility and enrollment functions, such as those typically performed by states' No Wrong Door system, as well as for ombudsman activities, and infrastructure development. To receive the enhanced match, states must comply with a maintenance of effort requirement for HCBS eligibility and benefit standards to ensure federal funding supplements, not supplants, existing state funds expended for Medicaid HCBS, as of the date Congress enacts legislation establishing the consolidated SPA. • **Additional Enhanced Administrative Match for HCBS Quality Reporting**: States that choose to measure and report on an approved set of HCBS quality measures would be eligible to receive an additional 1% FMAP increase beyond the enhanced administrative match.	• Section 1943 of the SSA. • **No Wrong Door**: The ACA allowed individuals to apply for Medicaid through any means, whether through state or federal marketplaces, state Medicaid agencies, by phone, or by fax. The No Wrong Door single entry point system builds on collaborative efforts of CMS, the Administration for Community Living, and the Veterans Health Administration to support states' efforts to streamline access to LTSS options for all eligible populations. The program promotes: » Public outreach and coordination with key referral sources. » Person-centered counseling. » Streamlining access to public LTSS programs. » State governance and administration. States may receive administrative match for administrative activities performed through No Wrong Door systems, including Medicaid outreach; referral, coordination, and monitoring of Medicaid services; facilitating Medicaid eligibility; and other Medicaid administrative functions such as training, program planning, quality improvement, and information technology.[81] • **Balancing Incentive Program** (BIP): Section 10202 of the ACA established the BIP. The program authorized grants to states to increase access to noninstitutional LTSS. Total funding over the four-year program (October 2011 – September 2015) was $2.4 billion in federal enhanced matching payments.	• Requires new legislation to: » Establish the enhanced administrative match for activities related to streamlined eligibility and enrollment functions; » Direct the secretary of HHS to develop a recommended core set and supplemental set of HCBS quality measures; and » Establish an additional 1% FMAP increase for states that choose to measure and report on an approved set of HCBS quality measures.

Consolidated SPA Defined	Drawing from Existing Authorities	Proposed Change from Current Law
	• States with HCBS spending that accounted for less than half of total LTSS expenditures were eligible to participate in the program.[82] Participating states received an enhanced FMAP for HCBS, and were required to meet certain HCBS spending and infrastructure goals, including creating a No Wrong Door single-entry point for those seeking LTSS.[83] Eighteen of 21 participating states continued the program from 2011 to 2015, and most states received extensions through 2017 to complete the work.[84] • The enhanced FMAP was tied to the percentage of a state's LTSS spending, with lower FMAP increases going to states that needed to make fewer reforms. States spending less than 25% of LTSS dollars on HCBS at baseline received a 5% enhanced FMAP, and were required to increase HCBS spending to at least 25% of total LTSS spending. States spending between 25% to 50% of LTSS on HCBS at baseline received a 2% enhanced FMAP, and were required to spend at least 50% of LTSS dollars on HCBS. • States were required to use the enhanced FMAP to provide new or expanded HCBS, and were also subject to a maintenance of effort provision prohibiting them from decreasing eligibility below December 31, 2010 levels. • Sections 1139A and 1139B of the SSA– related to core measurement sets for adults and children in Medicaid and CHIP.	

Consolidated SPA Defined	Drawing from Existing Authorities	Proposed Change from Current Law
Maintaining Existing Initiatives: • The 6% enhanced FMAP for 1915(k) and the enhanced FMAP available for the Money Follows the Person (MFP) demonstration extend to the consolidated SPA. • Permanently reauthorizes the MFP demonstration. • Through the Medicaid Health Homes model, states may receive a 90% enhanced FMAP for integration and coordination of services, as permitted under current law for eight quarters. • States may develop payment rates for services in accordance with applicable state plan requirements.	• Section 1915(k) of the SSA. • **The Money Follows the Person (MFP) Demonstration**: Section 6071 of the Deficit Reduction Act of 2005, as amended by subsequent legislation. Extended through September 30, 2023, by Section 204 of the Consolidated Appropriations Act, 2021 (P.L. 116-260), which also appropriated $450 million for FY2021 - FY2023. • The program provides incentives to states to move individuals from institutional settings to HCBS. Grant awards are available to states for the fiscal year they got the award and four additional fiscal years after. Eligible individuals include people who live in an institution for more than 90 consecutive days. States receive an enhanced FMAP for covered demonstration and HCBS for the first year the individual receives services in the community after leaving an institution. (Exception: Days that a person was living in the institution for the sole purpose of receiving short-term rehabilitation services reimbursed by Medicare do not count toward this 90-day period.) • **Medicaid Health Homes**: Section 1945 of the SSA; Section 2703 of the ACA. • Under this state plan option, states receive a 90% enhanced FMAP for Health Home services. The enhanced FMAP is available for the first eight quarters that the program is effective. Required Health Home services include: » Comprehensive care management; » Care coordination; » Health promotion; » Comprehensive transitional care/follow-up; » Patient and family support; and » Referral to community and social support services. • Use of health information technology to link services where appropriate is strongly encouraged.	

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9 Centers for Medicare & Medicaid Services, "Medicaid Long Term Services and Supports Annual Expenditures Report, Federal Fiscal Years 2017 and 2018," January 7, 2021, 9. Available at: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures-2017-2018.pdf.

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