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Key Issues in State Implementation of the New and Expanded Home and Community-Based Services Options Available Under the Affordable Care Act

EXECUTIVE SUMMARY

The Affordable Care Act (ACA) provides a number of new and expanded options for states to offer home and community-based services (HCBS) to Medicaid beneficiaries. While states have made overall progress in rebalancing their long-term care systems in favor of HCBS, state adoption of the new and expanded ACA HCBS options has been relatively slow to date, despite the growing need for HCBS among beneficiaries and the enhanced federal funding associated with several of these options. To explore these issues, the Kaiser Commission on Medicaid and the Uninsured convened a roundtable meeting on July 16, 2013 with a group of federal and state officials and experts. This brief summarizes the key issues identified and discussed by the invited participants.

States are interested in increasing access to Medicaid HCBS, but participants agreed that designing and implementing the new and expanded ACA HCBS options presents administrative complexities. In addition, adoption of the ACA HCBS options is competing with state efforts to implement the ACA's Medicaid eligibility and enrollment changes in 2014, and taking place in an environment of state budgetary pressures. While beneficiary need for HCBS is growing, more information is necessary to determine which services are needed and whether current programs are providing the proper type and amount of services.

The needs assessment process is a fundamental part of HCBS access, and participants discussed consolidating and standardizing this process and incorporating elements such as beneficiary goals and needs in the critical areas of housing and employment and quality of life. States and beneficiaries recognize the importance of being able to provide services when beneficiaries have a need for HCBS, even if their needs have not yet risen to an institutional level of care. In addition, some states are interested in integrating HCBS into their managed care programs, particularly in the absence of other options to coordinate services across all populations receiving LTSS. The opportunity for beneficiaries to self-direct services also was cited as an important element of HCBS.

Participants identified several areas for additional inquiry to further the expansion of HCBS and state adoption of the new ACA options. Coordination between the aging and disability communities and among various subpopulations within the disability community is a critical part of expanding access to HCBS. Looking ahead, participants agreed that future work is needed to better understand beneficiary needs, evaluate service quality, improve the needs assessment process, facilitate the provision of services before beneficiaries require institutional care, and streamline the various Medicaid HCBS authorities. Extending options that currently have statutory expiration dates also could facilitate state adoption of the ACA options. Continued attention to these issues can help to realize the ACA's promise of expanded access to Medicaid HCBS and increased community integration for people with disabilities.

INTRODUCTION

States have various opportunities to use Medicaid funds for home and community-based long-term services and supports (LTSS), and the Affordable Care Act (ACA) provides a number of new and expanded options for states to offer home and community-based services (HCBS) to Medicaid beneficiaries. State adoption of the new and expanded ACA HCBS options has been relatively slow despite the growing need for HCBS among beneficiaries and the enhanced federal funding associated with several of these options. Currently, all but three states are pursuing at least one HCBS option newly created or expanded under the ACA, most notably the Money Follows the Person (MFP) demonstration grant program. However, to date, fewer than half the states have taken up the Balancing Incentive Program (BIP) or the Community First Choice (CFC) or HCBS state plan options.[1]

Despite the relatively slow take-up of the ACA options, state spending on Medicaid HCBS delivered through the home health and personal care services state plan benefits and § 1915(c) waivers grew at a much faster rate than spending on institutional services from 2000 to 2009, with overall spending on those HCBS moving closer to the level of spending for institutional services during this period.[2] While the majority of Medicaid LTSS dollars still goes toward institutional care, the national percentage of Medicaid LTSS spending on HCBS has more than doubled from 20 percent in 1995 to 45 percent in 2010.[3] In addition, between 2000 and 2009, the total number of individuals receiving Medicaid HCBS grew steadily each year by an average of five percent, with the exception of the 2005-2006 period when there was a decline of one percent.[4] From 2000 to 2009, however, there was great inter-state variation in both average total Medicaid HCBS participant enrollment annual growth rates and per person spending on Medicaid HCBS.[5]

State adoption of the various Medicaid HCBS options is driven by beneficiary preferences, the desire to reduce costs relative to institutional long-term care spending, and states' obligation to serve individuals in the community consistent with the Americans with Disabilities Act and the Supreme Court's *Olmstead* decision.[6] States considering adopting the new and expanded ACA HCBS options also may encounter administrative challenges and budgetary constraints. Further, states face the competing priorities of preparing to implement the ACA's Medicaid expansion and new streamlined eligibility and enrollment procedures that take effect on January 1, 2014.[7]

To explore issues related to state adoption of the new and expanded ACA HCBS options, the Kaiser Commission on Medicaid and the Uninsured convened a roundtable meeting on July 16, 2013 with a group of federal and state officials and experts. This brief summarizes the key issues identified and discussed by the invited participants. A companion paper, *Medicaid Long-Term Services and Supports: An Overview of Funding Authorities,* provides additional background about the various LTSS provisions, including key ACA HCBS options, available to states through the Medicaid program.[8]

KEY ISSUES

1. STATE DECISIONS ABOUT WHETHER TO ADOPT THE ACA OPTIONS TO EXPAND ACCESS TO HCBS ARE TAKING PLACE IN A CHALLENGING ENVIRONMENT.

- **States are interested in increasing access to Medicaid HCBS, but designing and implementing the new ACA HCBS options presents administrative complexities**.

Roundtable participants observed that the new and expanded ACA options are helping to meet the growing need for, and increasing beneficiary interest in, HCBS. For example, participants believe that Money Follows the Person, with its enhanced federal funding for beneficiaries transitioning from institutional to community-based settings, has expanded the availability of HCBS. Participants observed that beneficiary wait times for an open waiver slot can be months or years long, although there are not waiting lists in all states or for all waivers within states.[9]

Participants remarked that the new ACA options enable states to offer beneficiaries greater access to HCBS and to make the type and level of services more equitable regardless of the Medicaid authority under which services

are provided. In many cases, participants said that HCBS waivers have become the "gold standard" for access because these waivers may be the only means to obtain assistive technology, home modifications, and the ability to self-direct services, which are important elements of independent community living. The ACA's Community First Choice (CFC) benefit now makes these supports available through a state plan option with enhanced federal funding that is not time-limited and may offer some administrative simplification compared to waivers.

At the same time, states are finding that significant time is required to navigate among the various HCBS options, and it often is necessary to combine multiple authorities to accomplish the goals of increasing services (e.g., § § Community First Choice (1915(k)), HCBS state plan option (1915(i)), offering beneficiary self-direction (§ 1915(j)), and implementing managed care (§ § 1115, 1915(b)). Participants discussed the desirability of being able to offer beneficiaries the services they need no matter where they live or in which program they are enrolled. Participants also voiced their wish to focus service provision on meeting beneficiary needs while making the particular waiver program or benefits category through which services are authorized transparent to beneficiaries. Participants noted that the current system is complex and believe that "people should not feel like they have to understand the system to advocate for what they need."

- **Adoption of the new and expanded ACA HCBS options is competing with state efforts to implement the ACA's Medicaid eligibility and enrollment changes in 2014 and taking place in an environment of state budgetary pressures.**

Several roundtable participants cautioned that there are limited state agency personnel and staff time, information technology (IT) resources, and funding to be shared among various competing initiatives. While states are considering the new ACA Medicaid HCBS options, they also are working to implement the new streamlined Medicaid eligibility and enrollment processes required in 2014. State HCBS programs were described as "waiting in line," especially for state IT staff time and resources to develop the systems needed to administer the programs. In addition, requests for funding to implement the new and expanded HCBS options are competing with the need for funds to implement the ACA's Medicaid expansion in states that are moving forward, as states look ahead to 2017, when federal funding will begin to decline from 100% to 90%. Participants also pointed to the potential restriction of HCBS eligibility, with the expiration of the ACA's Medicaid maintenance-of-effort requirement for adults (when state Marketplaces are certified, expected in January 2014). They noted that there is a need for HCBS programs to be sustainable and that, because of budgetary constraints, states need the ability to control program enrollment.

Participants observed that implementation of new Medicaid eligibility and enrollment systems may present particular challenges for beneficiaries with disabilities who rely on HCBS. The establishment of new Medicaid eligibility pathways, potentially with different benefits packages associated with each, creates the need to ensure that beneficiaries with disabilities are able to access the benefits package that is most appropriate to their needs and to which they are entitled.[10] The extent to which the benefits package offered to the Medicaid expansion population differs from the traditional state plan benefits package and any additional benefits packages available through waivers, especially in terms of HCBS coverage, will be an important factor.

2. The needs assessment process is a critical part of HCBS access.

- **Beneficiary need for HCBS is growing, but more information is necessary to determine exactly which services are needed and whether current programs are providing the proper type and amount of services.**

Participants observed that Medicaid continues to be the "only game in town" for vulnerable beneficiaries who require HCBS and suggested focusing more attention on whether needed services are available from current program options. Some participants noted that beneficiaries know what services they need, but those services are not always available due to gaps in the current care delivery system. Participants also believed that not enough attention has been paid to evaluating outcomes when providing HCBS. As discussed more below, participants suggested that needs assessments focus on beneficiary goals and outcomes, not just the services that will be provided, and suggested that beneficiaries' overall quality of life, not just their medical needs, be

considered. The tension inherent in implementing program reforms that seek to provide person-centered assessments and comprehensive care plans while at the same time achieving cost savings also was raised.

- **The needs assessment process is a fundamental part of HCBS access, and work is required to consolidate and standardize this process and incorporate consideration of elements such as beneficiary goals and quality of life.**

Participants agreed that the assessment process is an essential part of meeting beneficiary need for HCBS and that improvements in this area are desirable. Participants observed that the current assessment process and resulting service plans can be subjective and noted the desirability of consistency across programs and beneficiary subpopulations. Participants suggested that assessments move to a more "rules based" system and that service determinations be based on beneficiary needs rather than diagnoses. There was consensus among participants to have assessments evaluate a beneficiary's functional needs and to determine how to provide necessary services in the setting of the beneficiary's choice instead of having the setting determine whether certain services can be accessed.

Participants also cited the need to consolidate the various assessments currently in use. States are presently required to apply different needs-based criteria when determining eligibility for different HCBS options (i.e., an institutional level of care for CFC services; less than an institutional level of care for HCBS state plan option (§ 1915(i)) services; and medical necessity without necessarily determining level of care for state plan personal care services). Participants also noted the administrative burden associated with having to establish that a beneficiary requires an institutional level of care in order for the state to qualify for the enhanced federal funding associated with CFC services. Prior to CFC, states have been providing personal care services to this population through the state plan option, which does not require a level of care determination.

Participants also discussed the challenges presented by assessments in the context of capitated managed long-term care. They observed that managed care organizations (MCOs) may have an incentive to assess beneficiaries at higher levels of care to obtain an associated higher capitation rate. Participants also noted MCOs' relative lack of experience in assessing beneficiaries' need for LTSS and in coordinating services for special populations, such as people with developmental disabilities. They suggested that, as part of the state oversight process when implementing capitated managed care, states may wish to prescribe the assessment tool and care coordination standards to be used by MCOs.

- **Participants suggested that beneficiary goals and needs in the critical areas of housing and employment be incorporated into the assessment and service planning process.**

Participants suggested that housing and employment options for people with disabilities be included among the outcomes considered in the HCBS assessment process. Participants distinguished among various types of housing options, such as a beneficiary's own home versus a small group home, which may provide different levels of community integration. States reported devoting additional resources to expanding housing options for beneficiaries with disabilities who wish to live in the community, and they cited housing access and affordability as among the most difficult challenges associated with providing HCBS.

3. States and beneficiaries see certain administrative and programmatic features in HCBS programs as beneficial.

- **States and beneficiaries recognized the importance of being able to provide services when beneficiaries have a need for HCBS, even if their needs have not yet risen to an institutional level of care.**

Participants agreed that offering HCBS as a "preventive measure" before an institutional level of care is required is both desirable for beneficiaries and cost-effective. Providing services earlier could help prevent beneficiaries from developing higher-intensity and more expensive care needs, including potentially avoidable inpatient admissions and emergency room visits. Participants cited the § 1915(i) HCBS state plan option as a needed cost-effective alternative that enables states to offer services to beneficiaries before their needs rise to

an institutional level of care. Participants emphasized the importance of having appropriate services available to support beneficiaries wherever they are living, regardless of the care setting. They also noted the relationship between level of care criteria and access to services. For example, when states tighten nursing facility functional eligibility criteria, they also effectively restrict access to § 1915(c) home and community-based waiver services, which are tied to meeting a nursing facility level of care.

- **Some states have included HCBS in their capitated or managed fee-for service managed care programs.**

States are interested in improving care coordination, whether through capitated managed care or the addition of care management to the fee-for-service delivery system, and some states are taking steps to provide additional Medicaid benefits, including LTSS, through managed care arrangements.[11] For example, some states are including nursing facility services in their managed care programs and providing financial incentives for MCOs to transition beneficiaries to the community. Some states also are including behavioral health services, such as targeted case management and mental health rehabilitative services, and medical transportation in their managed care systems. Participants also indicated interest in the ability to combine under a single authority separate § 1915(c) HCBS waivers that historically have served distinct populations to provide care management across all populations receiving LTSS. In the absence of such an option, states may look to managed care as a way to streamline administrative complexities and include a multitude of existing programs within a single care plan. Participants also noted there may be a financial incentive for managed long-term care: whereas states receive the 50 percent federal matching rate for Medicaid administrative costs when they perform care management themselves, they receive their regular federal matching rate (which exceeds 50 percent in most states[12]) for capitated payments when they contract with MCOs to provide services, including care management, to beneficiaries. Participants also noted that if states are implementing managed care, it is important to integrate both Medicaid acute and long-term care services to achieve cost savings and avoid creating separate systems such as those that face beneficiaries who are dually eligible for Medicare and Medicaid today.

- **The opportunity for beneficiaries to self-direct services is an important element of HCBS.**

Participants agreed that beneficiaries' ability to self-direct services through administering individual budgets and the autonomy to select, supervise, and dismiss care attendants is critical to meeting beneficiaries' needs for HCBS. Participants also cited the importance of beneficiaries being able to choose among MCOs where managed care is offered and providing adequate information and supports to assist beneficiaries in comparing different health plans and making enrollment decisions.

4. There are several areas in which future work is needed to support expanded access to HCBS.

- **Coordination between the aging and disability communities and among various subpopulations within the disability community is a critical part of expanding access to HCBS.**

Participants observed that expanding HCBS access requires understanding the similarities and differences between the aging and disability populations and among different disability subpopulations. Historically, programs and responsibilities for these populations have resided in separate and siloed state government agencies. Implementing and administering the new Medicaid HCBS options frequently requires coordination among various parts of federal and state agencies that separately focus on aging, disability, eligibility, benefits, and managed care, among other areas. Participants also discussed the need to bring together various constituencies representing people with developmental, mental health, and physical disabilities and the aging community to determine common goals and ways to create an integrated HCBS system that offers expanded access to all populations.

- **Additional work is needed to develop appropriate quality measures for HCBS.**

Participants agreed that there is a need to develop additional quality measures to evaluate HCBS and questioned whether existing measures focus on the right questions. Participants also expressed interest in having a common standardized set of quality measures to evaluate HCBS. One participant suggested making enhanced federal funding contingent upon states meeting certain quality standards related to outcomes. CMS recently announced a funding opportunity for states to test new quality measures, including those focused on functional capacity and beneficiary experience, in HCBS programs, which may lead to further developments in this area.[13]

- **Developing ways to streamline the various HCBS authorities could facilitate state adoption of the new options.**

Participants discussed how the ACA options can be used in a complementary fashion to expand access to HCBS and expressed interest in exploring ways to streamline and/or blend the existing HCBS authorities. They noted that different programs currently have different eligibility criteria, IT systems, and quality measures associated with them. For example, states may have an interest in combining the services that they currently offer through different authorities, such as the personal care services state plan option and § 1915(c) HCBS waivers, under one authority, such as CFC or the § 1915(i) HCBS state plan option. However, eligibility for CFC services does not extend to beneficiaries who meet less than an institutional level of care, a limitation that requires states to maintain a personal care services state plan option to continue serving that population. Participants emphasized that efforts to streamline HCBS must not leave in place or replicate the complexities that underlie the current system. The no wrong door/single entry point system that BIP requires was viewed as a positive development with the potential to facilitate information sharing across the LTSS system and alleviate the burden on beneficiaries to "tell their story" repeatedly. Participants also discussed the desire of some states to more easily incorporate the use of managed long-term care, whether capitated or managed fee-for-service, and beneficiary self-direction within the existing authorities. The idea of keeping BIP and MFP operational past their statutory expiration dates to preserve these options for states also was raised.

CONCLUSION

The ACA's new and expanded Medicaid HCBS options present opportunities to increase beneficiary access to these services. Several of the ACA options offer enhanced federal matching funds, and the addition of these new services presents states with a broader array of Medicaid HCBS from which to choose than ever before. Nevertheless, state adoption of the ACA HCBS options may be hindered by administrative complexities, budgetary pressures, and the competing demands of preparing for the ACA's 2014 Medicaid eligibility and enrollment changes. At the same time, additional work is needed to better understand beneficiary needs, evaluate service quality, improve the needs assessment process, facilitate the provision of services before beneficiaries require institutional care, and streamline the various Medicaid HCBS authorities. Continued attention to these issues can help to realize the ACA's promise of expanded access to Medicaid HCBS and increased community integration for people with disabilities.

This brief was prepared by MaryBeth Musumeci, Erica Reaves, and Julia Paradise of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured and Henry Claypool of the American Association of People with Disabilities. The authors acknowledge Mike Nardone of Health Management Associates for moderating the roundtable and thank the discussion participants for sharing their time and expertise.

ENDNOTES

[1] Kaiser Commission on Medicaid and the Uninsured, *How is the Affordable Care Act Leading to Changes in Medicaid Long-Term Services and Supports (LTSS) Today? State Adoption of Six LTSS Options* (April 2013), available at http://www.kff.org/medicaid/issue-brief/how-is-the-affordable-care-act-leading-to-changes-in-medicaid-long-term-services-and-supports-ltss-today-state-adoption-of-six-ltss-options/. BIP is only available to states that devoted less than half of their long-term care spending to HCBS in FY 2009.

[2] Kaiser Commission on Medicaid and the Uninsured, *Medicaid Spending Growth Over the Last Decade and the Great Recession, 2000-2009* (February 2011), available at http://www.kff.org/medicaid/upload/8152.pdf.

[3] Distribution of Medicaid spending on long-term care, FY 2010, Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on CMS-64 data as of December 2011, available at http://www.kff.org/medicaid/state-indicator/spending-on-long-term-care-fy2010/.

[4] Kaiser Commission on Medicaid and the Uninsured, *Medicaid Home and Community-Based Services Programs: 2009 Data Update* (December 2012), available at http://www.kff.org/medicaid/report/medicaid-home-and-community-based-service-programs/.

[5] Id. at 6, 7.

[6] In *Olmstead v. L.C.*, the Supreme Court held that people with disabilities have the right to live at home or in the community if they are able and do not oppose doing so, rather than to be institutionalized. 527 U.S. 581 (1999), available at http://www.law.cornell.edu/supct/html/98-536.ZS.html.

[7] For more information, see Kaiser Commission on Medicaid and the Uninsured, *Medicaid Eligibility, Enrollment Simplification, and Coordination Under the Affordable Care Act: A Summary of CMS's March 23, 2012 Final Rule* (December 2012), available at http://www.kff.org/medicaid/issue-brief/medicaid-eligibility-enrollment-simplification-and-coordination-under-the-affordable-care-act-a-summary-of-cmss-march-23-2012-final-rule/.

[8] Available at http://kff.org/medicaid/fact-sheet/medicaid-long-term-services-and-supports-an-overview-of-funding-authorities.

[9] For information about state waiver waiting lists, see Kaiser Commission on Medicaid and the Uninsured, *Medicaid Home and Community-Based Services Programs: 2009 Data Update* (December 2012), available at http://www.kff.org/medicaid/report/medicaid-home-and-community-based-service-programs/.

[10] For background, see Kaiser Commission on Medicaid and the Uninsured, *Medicaid Eligibility and Enrollment for People With Disabilities Under the Affordable Care Act: The Impact of CMS's March 23, 2012 Final Regulations* (December 2012), available at: http://www.kff.org/health-reform/issue-brief/medicaid-eligibility-and-enrollment-for-people-with/.

[11] For background, see Kaiser Commission on Medicaid and the Uninsured, *Medicaid Long-Term Services and Supports: Key Considerations for Successful Transitions from Fee-For-Service to Capitated Managed Care Programs* (April 2013), available at http://www.kff.org/medicaid/issue-brief/medicaid-long-term-services-and-supports-key-considerations-for-successful-transitions-from-fee-for-service-to-capitated-managed-care-programs/; Kaiser Commission on Medicaid and the Uninsured, *People with Disabilities and Medicaid Managed Care: Key Issues to Consider* (February 2012), available at http://www.kff.org/medicaid/issue-brief/people-with-disabilities-and-medicaid-managed-care/; Kaiser Commission on Medicaid and the Uninsured, *Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider* (October 2011), available at http://www.kff.org/medicaid/issue-brief/examining-medicaid-managed-long-term-service-and/.

[12] States' regular federal matching rates range from 50% to over 73% in FY 2013, depending upon a state's per capita personal income relative to the national average. Kaiser Commission on Medicaid and the Uninsured, *Medicaid: A Primer: Key Information on the Nation's Health Coverage Program for Low-Income People* (March 2013), available at http://www.kff.org/medicaid/issue-brief/medicaid-a-primer; see generally Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP)* (September 2012), available at http://kff.org/health-reform/issue-brief/medicaid-financing-an-overview-of-the-federal/.

[13] Dep't of Health & Human Servs., Amended Announcement, *Planning and Demonstration Grant for Testing Experience and Functional Tools in Community-Based Long Term Services and Supports* (June 27, 2013), available at https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=15699.