Improving Home and Community-Based Services Infrastructure: A Policy Proposal

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Introduction

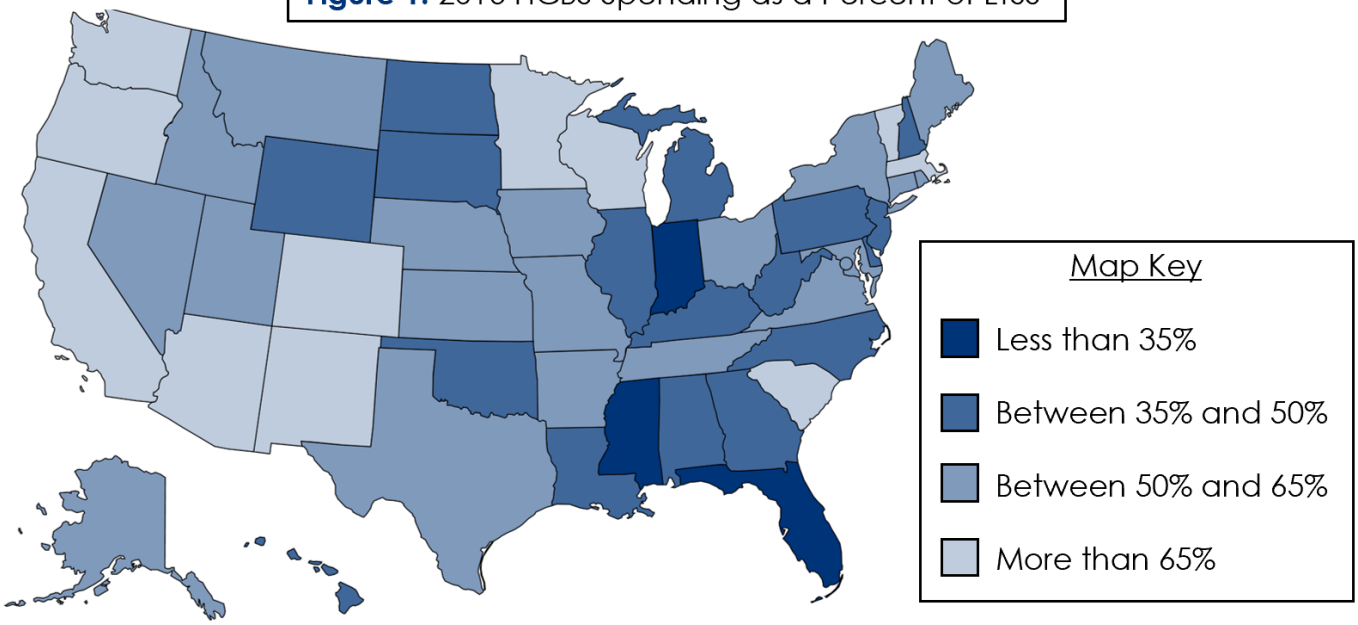
This brief outlines a proposal for an innovative program that assists states with improving their home and community-based services (HCBS) infrastructure. Key goals include strengthening housing, transportation, employment, workforce and caregiver supports in communities across the country with initiatives that address social determinants of health (SDOH), so that persons with disabilities and older adults with disabilities are served where they wish to be served. Specifications for the proposal were developed through a workgroup of the Disability and Aging Collaborative, a coalition of more than 40 national organizations, with additional input provided by associations representing states and other key informants.

Key Proposal Objectives

1. Strengthen HCBS infrastructure to accelerate initiatives that improve integration with Medicare, Older Americans Act programs and others, to better address SDH
2. Assist states with ways to improve access to HCBS, particularly among populations with significant unmet need
3. Leverage evolving state Medicaid information technology (IT) systems to improve HCBS reporting among managed long-term services and supports (MLTSS) and other types of HCBS providers, including outcomes that focus on individual experience of care

In recent years, many states have made significant progress in shifting their Medicaid long-term services and supports (LTSS) systems from heavy reliance on institutional care to a system that includes a range of home and community-based services (HCBS) options and waiver programs. However, significant disparities remain. Nationally, in FY 2016, 57% of total Medicaid LTSS spending was allocated to HCBS,[1] but states ranged from a low of 27% to a high of 81% (Figure 1).

Figure 1. 2016 HCBS Spending as a Percent of LTSS



*California and South Carolina data could not be obtained, data shown is are from estimates

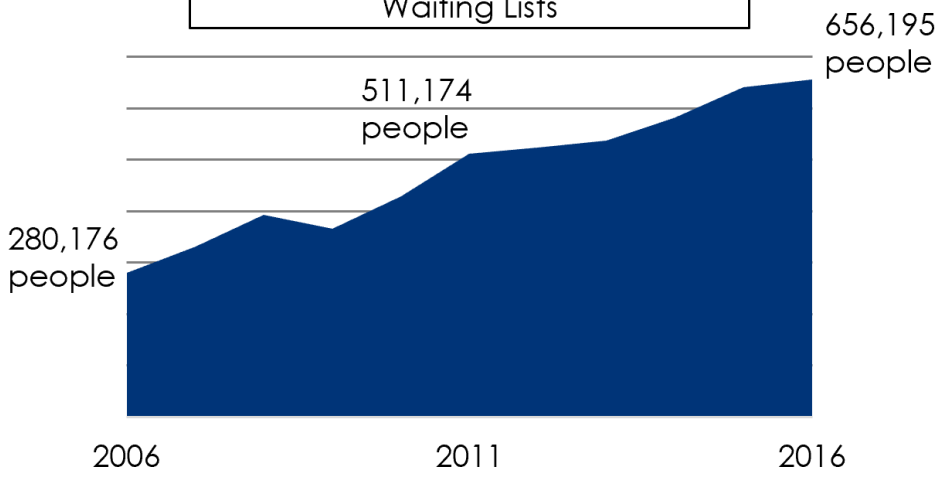
While more than half of all states (27) and the District of Columbia are spending at least 50% on HCBS, this still falls short of the 69% target set by Centers for Medicare and Medicaid Services (CMS). In addition, substantial variation in HCBS spending also exists by population, such that while 78% of total LTSS spending for individuals with intellectual and developmental disabilities (I/DD) was dedicated to HCBS in FY 2016, only 45% was spent on HCBS for older adults and individuals with physical disabilities. Similarly, 46% of Medicaid LTSS spending for individuals with mental health and substance use disorders was for HCBS.

Beyond these disparities are challenges in service accessibility: In 2016, states reported 656,195 individuals were on waiting lists for HCBS 1915(c) or 1115 waiver services (Figure 2).[2] The number of people on HCBS waiting lists has more than doubled over the past decade. Furthermore, this number is likely an undercount, since some states do not maintain waiting lists. Currently, 65% of those on waiting lists are individuals with I/DD, followed by older adults

and individuals with physical disabilities (28%).

Since 2011 when the boomer cohort began turning 65, the U.S. population has been aging at a rapid, historically unprecedented pace. According to the U.S. Census Bureau, the number of adults over the age of 65 is on track to double, reaching 84 million by mid-century. As lifespans lengthen, the number of individuals 85 and older will rise at an even faster rate, from 6 million in 2014 to nearly 15 million by 2040.

Figure 2. Number of People on HCBS Waiting Lists



These known challenges suggest that strengthening states' Medicaid infrastructure today is a worthy policy objective. Improved HCBS state infrastructure would bolster current initiatives that broadly aim to streamline and integrate management of multiple HCBS programs and service delivery arrangements. Better coordination with Medicare to improve outcomes and reduce costs is essential to both federal and state efforts that seek to bend the health care cost curve and identify savings through decreasing avoidable high-cost, low-value care, instead deploying lower-cost community services that can prevent emergency intervention. Accordingly, there is growing recognition that HCBS play an increasingly critical role in addressing social determinants of health and increasing quality of life. This highlights the need for states to improve connections with community-based organizations that deliver services to vulnerable people at home and in the community, including area agencies on aging, independent living centers, local housing authorities, accessible transportation providers and more.

This proposal is informed by the approach taken, and the lessons learned, from the successful five-year program known as the Balancing Inventive Program. That initiative provided states with a temporary enhanced federal medical assistance percentage (FMAP) for Medicaid HCBS in exchange for submitting five-year plans that aimed to make improvements in three areas: (1) No Wrong Door/Single Entry Point (NWD/SEP) information and referral system; (2) standardized needs assessments; and (3) conflict-free case management. States spending less than 50% of their total LTSS spending on HCBS in 2009 were eligible to participate, and the enhanced FMAP was tiered, with a 2% enhanced match for states spending less than 50% on HCBS at baseline, and 5% for states spending less than 25% on HCBS at baseline.

Twenty-one states applied, and ultimately 18 states participated.[3] Process and outcome evaluations conducted by the Assistant Secretary for Planning and Evaluation (ASPE) indicated that the program significantly contributed to enhanced access to HCBS and progress towards structural changes.

- Eight of the ten states with the greatest increase in access to HCBS between 2012-2016 were states that participated in the program: MO, MA, OH, NY, NJ, CT, IL, TX.[4]
- HCBS expenditures as a percentage of total Medicaid LTSS expenditures for states participating in BIP rose from 40.1% of LTSS in FY2009 to 53.9% of LTSS in FY2015.[5]
- Participating states had a greater increase in HCBS spending as a share of total LTSS expenditures than those that were eligible but did not participate. The growth rate was greater during the six years following baseline than during the 5 years preceding the baseline, suggesting that the program enhanced states efforts to shift LTSS spending toward the community .[6]
- All participating states made progress towards the required structural changes.[7] By March 2017, 14 of the 18 states had achieved all of the required infrastructure changes. The most difficult area for four states was NWD/SEP, suggesting additional time and work is needed in this area.[8]

Over the last year, we have received input from key stakeholders, associations representing states, federal and state policy experts familiar with the program, and aging and disability organizations affiliated with the Disability and Aging Collaborative.

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Key Differences in the Design of this Proposal as Compared to the Original Program

- Allowing all states to apply for funding, while maintaining the initial conceptual framework of directing more assistance to states with the greatest need to improve;
- Modifying the existing financing structure from an enhanced FMAP to a structured discretionary grant program that enhances state flexibility, both in devising plans to develop infrastructure programs that best suit their system needs, and expand HCBS access in cost-effective ways. For example, grant funding can be used to provide for investments/innovations in HCBS related infrastructure that do not meet traditional Medicaid funding rules. Like the original balancing incentive program, the amount of funding states would receive would be based on the percentage of their total baseline Medicaid LTSS spending on HCBS;
- Increasing the duration of the program by two years, from five to seven years, to improve the ability of all states that apply to fully implement sustainable infrastructure changes;
- Granting states greater leeway to determine areas of HCBS infrastructure on which to focus;
- Allowing states to determine specific HCBS populations for setting balancing improvement targets, while also calling for equity and inclusion of populations where the percentage of LTSS spending on HCBS is less than the national average;
- Making substantial gains in HCBS data collection and reporting in order to improve state monitoring of HCBS service delivery providers.

Overall Organization of Competitive Grant Program

- Authorize and appropriate funding for a seven-year grant program for states to improve HCBS infrastructure and access;
- Provide CMS with the authority to issue initial short-term planning grants for states that want to seek input and technical assistance in planning and developing a full application;

States would be required to submit applications that include:

- Data on the extent to which the state has already balanced their LTSS system, disaggregated by HCBS populations, including:
- Percentage of total Medicaid LTSS expenditures on HCBS;
- Percentage of total Medicaid LTSS expenditures on HCBS by population:
    - ◊ Individuals with I/DD
    - ◊ Older adults and individuals with physical disabilities
    - ◊ Individuals with mental health and substance use disorders
- Data on the extent to which the state has shifted its HCBS system to emphasize community integration, disaggregated by HCBS populations, including:
    - ◊ Percentage of working age adults in competitive, integrated employment;
    - ◊ Percentage of people with disabilities in non-provider owned or controlled, non-disability specific residential settings;
- Balancing targets -- aggregate and population-specific -- and yearly milestones that provide states with the flexibility to focus on certain populations needing HCBS, while also requiring targets for those populations and inclusion of those populations for which baseline spending is less than the national average;
- Selection of three or more areas for HCBS infrastructure improvement (see allowable areas suggested by stakeholders in next section), including submission of a detailed plan for each area with measurable objectives and annual milestones.

States Must Solicit Stakeholder Input and Select at Least Three of the Following Areas:

Housing Supports

Participating states could direct resources towards development of infrastructure that is designed to assess and expand supply and availability of residential setting options (non-disability specific or provider controlled) for individuals receiving HCBS. States could pursue inclusionary zoning requirements and other types of incentives to accelerate partnerships with state and local housing organizations and developers to create more housing stock that is suitable for lifelong use. Resources could be targeted towards housing that meets the "qualified residence" standard in Money Follows the Person and the new Section 811 program. Participating states could also be authorized to offer a limited rental assistance benefit for individuals transitioning from congregate residential settings into community-based residences (in compliance with the MFP qualified residence standard). This rental assistance benefit could not exceed the cost differential to Medicaid of an individual's current and prior service setting. States would also be asked to establish a plan to maintain housing stability for participating individuals after the demonstration program ended.

Transportation Supports

Development of affordable, reliable, equitable transportation that is highly accountable, and which has a goal of improved community integration. Efforts could include:

- Assessing and supporting development of accessible infrastructure (e.g., sidewalks, audible pedestrian signals, crosswalks and bus stops);
- Assessing and supporting the use of 49 U.S.C. Section 5310 funds, including non-traditional uses that exceed the ADA, e.g. voucher programs, infrastructure improvement, mobility management;
- Assessing public transit accessibility, including elevator access to facilities and bus stop accessibility, and identifying paratransit service and transportation deserts;
- Assessing and supporting the use of 5311 Formula Area for Rural Areas funds for late-night, weekend and off-peak hour services, pedestrian access improvement, mobility management, and Job Access and Reverse Commute activities;
- Assessing the availability of affordable, accessible, reliable transportation within ¾ mile of accessible housing; and

- Assessing the availability of wheelchair-accessible and integrated on demand taxis and application-based transportation, and autonomous vehicle fleets.
- Any contracts going to providers shall require fully accessible vehicles in the fleet or provision of equivalent service as defined in 49 CFR 37.105.

Workforce and Unpaid Caregiver Supports

Development of infrastructure to enhance supply and retention of the direct support workforce, including enhancement of payment rates, contingent on wage increases for direct support professionals, and pipeline programs for direct support professionals; development of infrastructure to support self-direction, including use of matching service registries and training for consumers who want to self-direct; and implementation of expedited and prospective background checks to increase the

population of available direct support workers. For family caregivers, state efforts could focus on broadening use of family caregiver assessments; financial assistance to help with out-of-pocket costs; widening availability of evidence-based supportive services, increased access to (and improvement of) respite care options, and development of new and innovative service offerings that support caregivers and delay or ameliorate the need for more comprehensive HCBS. States could also choose to focus on design, development and implementation of technology (hardware and/or software) that assists family caregivers, including those who work and are remote and to modernize workplace practices vis-à-vis family caregivers.

Employment Supports

Development of statewide infrastructure to support competitive employment for individuals with disabilities and older adults (including both service delivery modifications and expansion). A state would be required to outline measurable objectives and milestones designed to meet or exceed the national average for competitive integrated employment for that HCBS population. To accomplish this, a state could choose to pursue a variety of strategies, including targeted investments in provider network capacity, workshop conversion, pay-for-performance reimbursement structures and expanding the capacity of non-Medicaid infrastructure, such as vocational rehabilitation, Workforce Innovation and Opportunity Act (WIOA) workforce centers, State and Local Education Agencies, to serve individuals with the most significant disabilities.

No Wrong Door—Single Entry Point System

Development of a statewide system to enable consumers to access all LTSS through an agency, organization, coordinated network, or portal, in accordance with such standards as the State shall establish and that shall provide information regarding the availability of such services, how to apply for such services, referrals for services and supports otherwise available in the community, determinations of financial and functional eligibility for such services and supports, and timely assistance with assessment processes for financial and functional eligibility.

States must then submit to CMS plans with measurable objectives and annual milestones for approval.

The amount of funding states would receive would be based on the percentage of their total baseline LTSS spending on HCBS, adjusted annually (Table 1). CMS will determine the baseline year using the most reliable and valid data and provide guidance on data that will be used to calculate the annual change grant awards. For example, CMS could decide to tie adjustments to the CMS-64 forms or use other forms of data reported from other sources for annual enhanced payments.

Table 1. Schedule for State Funding Based on the Current Spending Pattern at the Time of BIP 2.0 Implementation

Percent Increase	Current State HCBS Expenditures
0.25%	65% and above
0.50%	Between 50% and 65%
2.0%	Between 35% and 50%
5.0%	Below 35%

From program inception to the 5th year of the program, state eligibility and payment amounts would hinge on achieving certain percentage targets of HCBS expenditures. Once the Transformed Medicaid Statistical Information System (T-MSIS) is fully operational, adjustments can be tied to this reporting mechanism to enhance accountability. Requirements for increases in both expenditures and percentages of all individuals served in the community may be imposed during the life of the grant to ensure the program is achieving the goal of expanding access to HCBS and not just increasing expenditures (Table 2).

Table 2. Future HCBS Enrollment Criteria
(Beginning in the 6th year or upon a CMS-determined timeframe)

Percent Increase	Percent of People Served in the Community
0.25%	85%
0.50%	75%
2.0%	65%
5.0%	50%

Table 3. Illustrative Annual Grant Funding by State (Millions) Based on 2016 HCBS Expenditures and Proposed Formula

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State	Total	Total HCBS	Total LTSS	Percent	Percent	Projected
Oregon	$439,360	$1,903,310	$2,342,670	81.2%	0.25%	$4758
New Mexico	$303,212	$1,109,023	$1,412,235	78.5%	0.25%	$2,773
Minnesota	$1,174,293	$3,661,192	$4,835,485	75.7%	0.25%	$9,153
Massachusetts	$2,075,580	$4,967,291	$7,042,871	70.5%	0.25%	$12,418
Arizona	$517,388	$1,229,504	$1,746,892	70.4%	0.25%	$3,074
Vermont	$123,754	$293,319	$417,073	70.3%	0.25%	$733
Washington	$1,000,068	$2,168,820	$3,168,888	68.4%	0.25%	$5,422
Colorado	$787,844	$1,553,312	$2,341,156	66.3%	0.25%	$3,883
Wisconsin	$1,107,869	$2,182,360	$3,290,229	66.3%	0.25%	$5,456
Alaska	$194,649	$347,847	$542,496	64.1%	0.50%	$1,739
New York	$9,865,668	$16,588,51	$26,454,179	62.7%	0.50%	$82,943
Missouri	$1,459,620	$2,050,979	$3,510,599	58.4%	0.50%	$10,255
Montana	$201,024	$279,998	$481,022	58.2%	0.50%	$1,400
Texas	$4,514,753	$6,280,550	$10,795,303	58.2%	0.50%	$31,403
Virginia	$1,343,801	$1,841,278	$3,185,079	57.8%	0.50%	$9,206
Kansas	$507,689	$664,326	$1,172,014	56.7%	0.50%	$3,322
Nevada	$302,245	$395,408	$697,654	56.7%	0.50%	$1,977
Maryland	$1,361,800	$1,748,754	$3,110,554	56.2%	0.50%	$8,744
Dist. of Columbia	$358,265	$457,793	$816,058	56.1%	0.50%	$2,289
Idaho	$292,380	$363,896	$656,276	55.4%	0.50%	$1,819
Rhode Island	$380,643	$470,426	$851,069	55.3%	0.50%	$2,352
Maine	$479,175	$558,816	$1,037,991	53.8%	0.50%	$2,794
Tennessee	$1,148,161	$1,314,933	$2,463,094	53.4%	0.50%	$6,575
Connecticut	$1,624,582	$1,836,515	$3,461,098	53.1%	0.50%	$9,183
Nebraska	$418,306	$465,989	$884,294	52.7%	0.50%	$2,330
Ohio	$3,616,958	$4,024,858	$7,641,816	52.7%	0.50%	$20,124
Utah	$275,510	$305,530	$581,040	52.6%	0.50%	$1,528
Arkansas	$999,573	$1,086,255	$2,085,829	52.1%	0.50%	$5,431
Iowa	$1,055,519	$1,076,377	$2,131,896	50.5%	0.50%	$5,382

Data source for HCBS Expenditures: IBM Watson Health (2018). Medicaid Expenditures for Long-Term Services and Supports in FY2016

Table 3. Projected Annual Grant Funding by State (Millions) Based on 2016 HCBS Expenditures and Proposed Formula

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State	Total	Total HCBS	Total LTSS	Percent	Percent	Projected
Wyoming	$141,954	$141,268	$283,222	49.9%	0.50%	$2,825
Illinois	$2,124,434	$2,077,663	$4,202,098	49.4%	0.50%	$41,553
Pennsylvania	$5,050,818	$4,710,413	$9,761,231	48.3%	2%	$94,208
Delaware	$293,119	$268,560	$561,678	47.8%	2%	$5,371
New Hampshire	$390,912	$355,882	$746,793	47.7%	2%	$7,118
South Dakota	$176,677	$160,601	$337,278	47.6%	2%	$3,212
Oklahoma	$722,499	$648,430	$1,370,929	47.3%	2%	$12,969
Georgia	$1,380,579	$1,234,336	$2,614,915	47.2%	2%	$24,687
North Carolina	$2,022,003	$1,658,960	$3,680,964	45.1%	2%	$33,179
West Virginia	$773,925	$624,043	$1,397,967	44.6%	2%	$12,481
Kentucky	$1,133,780	$866,408	$2,000,188	43.3%	2%	$17,328
Alabama	$1,032,698	$769,927	$1,802,626	42.7%	2%	$15,399
North Dakota	$351,756	$252,342	$604,098	41.8%	2%	$5,047
Hawaii	$305,774	$217,041	$522,815	41.5%	2%	$4,341
Michigan	$1,897,657	$1,266,735	$3,164,392	40.0%	2%	$25,335
New Jersey	$2,579,515	$1,634,160	$4,213,676	38.8%	2%	$32,683
Louisiana	$1,458,744	$796,280	$2,255,024	35.3%	2%	$15,926
Florida	$4,096,640	$2,061,694	$6,158,335	33.5%	5%	$103,085
Indiana	$2,637,867	$1,237,211	$3,875,078	31.9%	5%	$61,861
Mississippi	$1,074,197	$398,216	$1,472,413	27.0%	5%	$19,911
South Carolina*	$822,605	$793,556	$1,616,161	49.1%	0.25%	$1,984
California*	$3,874,839	$11,006,830	$14,881,669	n/a	0.25%	$27,517
Total	**$72,272,684**	**$94,407,727**	**$166,680,410**	**56.6%**		**$826.484**

Data source for HCBS Expenditures: IBM Watson Health (2018). Medicaid Expenditures for Long-Term Services and Supports in FY2016

End Notes

1. Eiken, S, Srdel, K., Burwell, B., & Amos, A. (May, 2018). Medicaid Expenditures for Long-Term Services and Supports in FY2016. Prepared by IBM Watson Health for CMS. Available at: https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf
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