CONSORTIUM FOR CITIZENS WITH DISABILITIES

2020 Policy Proposals for Improving Medicaid Home and Community Based Services

Co-chairs of the Long Term Supports and Services Task Force

With Updates from 2019 version

Expanding Home and Community Based Services/Addressing Medicaid Institutional Bias

Making Home and Community Based Services (HCBS) a mandatory Medicaid benefit.
Medicaid currently has an institutional bias -- institutional services like nursing facilities are mandatory and home and community based services (HCBS) are optional. As a result, people with disabilities and older adults who prefer to receive services in their own homes and communities often must wait on years-long waitlists for HCBS, while others live in states where the services they need are simply not offered. This institutional bias could be addressed by making HCBS a mandatory Medicaid service under 1905(a) like institutional care. This option was included in a CBO Healthcare Options paper in 2008 (available at https://www.cbo.gov/system/files?file=110th-congress-2007-2008/reports/12-18-healthoptions.pdf).
Status: Ongoing conversations with interested parties.

Incentivizing HCBS over Institutional Long Term Care in Medicaid
States have been working to continue to build capacity for community-based services and are moving away from institutional modes. Medicaid demonstration programs, like the Balancing Incentive Program, and Medicaid authorities like 1915(k), that incentivize HCBS have been helpful. To further incentivize the expansion of states' HCBS, the Federal Medical Assistance Percentage (FMAP) for HCBS authorities could be increased together with a decreased FMAP for institutional care. This would also help to address the Direct Support Professional workforce crisis, thereby reducing waiting lists and improving quality. This option was also included in a CBO Healthcare Options paper in 2008.
Status: On hold due to progress on HCBS mandatory benefit bill.

Expanding Funding for HCBS Infrastructure
The Balancing Incentive Program was a demonstration program that provided grants to states to improve their HCBS systems, with the goal of increasing the balance of HCBS to institutional spending. Thirteen states participated in the program from 2011 to 2015, with the amount of funding tied to the ratio of institutional to HCBS spending. The disability and aging communities are very interested in working with Congress on another program to fund HCBS infrastructure and have specs for a more focused program. Priorities for a new program include funding to assist states with implementing the HCBS Settings Rule, expanding employment opportunities, workforce development,

employment for people with disabilities, case management and assistance with community housing. The bill also includes a focus on quality measures for HCBS.
Status: HCBS Infrastructure Investment Act text has been drafted in both the House and Senate. Working on bi-partisan co-sponsorship in both houses prior to introduction.

Allowing Medicaid to Assist with Housing Costs for People Receiving HCBS
Another institutional bias in the current Medicaid program is that Medicaid pays for room and board in institutional settings but is prohibited from paying for rent in a community residence. As a result, some people with disabilities and older adults end up stuck in institutions due to a lack of affordable housing, not due to their healthcare needs. This huge barrier to community living could be address if Medicaid could assist with rental payments, even if only for a limited time as people transition into new settings. Medicaid assistance with rent could also be ongoing, tied to the amount that local prevailing rents for low income housing exceeds a statutorily determined portion or percentage of a Medicaid HCBS recipient's SSI payment. Questions that would need to be addressed include which entities would bear the responsibility for calculating fair market rents, dealing with waivers, inspecting individual properties, etc. Another option might be to adopt an MFP model in which the Medicaid room and board money follows the individual from the institution into the community. While these are preliminary suggestions, our Task Force and the CCD Housing Task Force would be very interested in pursuing discussions about how best to achieve this policy goal.
Status: Held meetings and heard concerns about using limited Medicaid funding for housing. Ensured that accessible integrated housing was included as a priority for HCBS Infrastructure Investment Act. Otherwise on hold.

Reauthorization of Money Follows the Person and HCBS Spousal Impoverishment Protections
A permanent reauthorization of the Money Follows the Person program is a top priority of the disability and aging communities, hopefully before the latest short-term funding of the MFP program is depleted. Permanently incorporating elements of the MFP program into Medicaid HCBS authorities could be enhanced by expanding on MFP's role in rental assistance by allowing short term "bridge" rental assistance beyond the first month in order to facilitate connection to other rental assistance programs. The disability community has also been working together with the aging community on reauthorization of the HCBS Spousal Impoverishment Protections, which has been paired together with MFP through repeated short-term extensions.
Status: Short-term reauthorization of MFP and Spousal Impoverishment Protections through May 20, 2020. Permanent reauthorization of both programs was included in bi-partisan drug pricing bill from the Senate Finance Committee. The Task Force will be advocating for permanent reauthorization of MFP and Spousal Impoverishment Protections this spring.

Allowing HCBS Payments During Short-Term Hospital Stays
Currently Medicaid HCBS waivers under 1915(c) will not allow an individual to receive both HCBS services and institutional services at the same time. In the situation of a HCBS participant experiencing a short-term hospital stay, this can cause serious problems. When individuals who rely on their support staff provided through an HCBS program -- and in particular on the relationships they have with those staff for things like communication, emotional support, and self-regulation -- lose access to that staff because of a short term hospital stay, the results can be extremely disruptive for the individual and the facility and can cause significant challenges in ensuring the provision of appropriate medical care. Allowing Medicaid waivers to continue to pay for those waiver services deemed necessary to avoid disruption and ensure a successful hospital stay and return home would

address this serious problem. While several HCBS authorities already allow this (including 1915k Community First Choice), the most common authority, 1915(c) waivers, does not. Legislation allowing Medicaid 1915(c) waivers to pay for certain HCBS services during a short-term hospital stay would address this serious problem.
Status: Worked with House and Senate on bi-partisan bill. Bill introduced in the House and soon to be introduced in the Senate.

Creating a single state plan HCBS option
Medicaid's current HCBS programs represent a 35 year incremental approach to system design. Since the early 1980s, Congress has amended the law numerous times, seeking to ameliorate the program's institutional bias by creating new authorities and incentives for states to offer HCBS. While substantially increasing beneficiary access to HCBS, these initiatives also have resulted in a patchwork of options, contributing to administrative complexity for states and confusion for individuals seeking services. A new, single, overarching HCBS authority would alleviate some of the complexity and administrative costs associated with the program and support further progress in increasing beneficiary access to HCBS.

A new authority could align financial eligibility requirements by consolidating some or all of the current eligibility pathways, as well as aligning HCBS eligibility with financial eligibility for institutional care, to avoid incentivizing institutional care over HCBS. Further, this new authority could, for example, borrow from 1915(i) by replacing enrollment caps with functional eligibility criteria, increasing access to HCBS while still giving states some levers to control budgeting. As with the 1915(i), the functional eligibility criteria could be less stringent than what is required to qualify for institutional care. This new authority would also consolidate the services available under existing authorities, allowing access to services based on an individual's functional needs instead of tying eligibility to a particular program or authority. We would recommend including the type of enhanced funding found in 1915(k) for certain services. A consolidated HCBS authority would also align, and could strengthen, quality expectations, and would streamline reporting requirements for states, increasing data availability. This concept has been developed further in a white paper at https://www.kff.org/medicaid/issue-brief/streamlining-medicaid-home-and-community-based-services-key-policy-questions/.
Status: Incorporated into the discussion of a potential mandatory HCBS bill.

DSP Workforce

Pipeline Programs for Direct Service Providers (DSPs)
The disability community has a workforce crisis, specifically for the direct service provider (DSP) workforce. Funded primarily by Medicaid, the DSP workforce is one of the fastest-growing professions in the U.S. due to demographic trends such as the increase in autism diagnoses and longer lifespan of people with disabilities. Despite the ever-growing demand for DSPs, this workforce is experiencing a severe workforce crisis with a national average turnover rate of 45 percent. Turnover can be as high as 60 percent in some states. This has a profound impact on the quality of life of people with disabilities.

To support the DSP workforce and the disability community, enhanced administrative match funding should be made available to states and providers to support pipeline initiates that will train, recruit,

and retain the DSP workforce and improve the likelihood of their beginning, success, and continuation.
Status: Some aspects included as part of the DIRECT CARE Act. Ensured workforce was included as a priority in the HCBS Infrastructure Investment Act. Meeting with other offices on other pipeline programs.

Creation of a Standard Occupational Classification (SOC) for Direct Support Professionals (DSPs)
DSPs support millions of people with disabilities to help them live in the community. DSPs need a federal designation specific to their occupation to recognize the profession and inform policy-making. Currently, "Direct Support Professional" is not recognized as a profession at the federal level because the Bureau of Labor Statistics (BLS) has not given it a SOC. Congressional action is needed to encourage BLS to create a SOC for DSPs because:

- The umbrella SOC that BLS categorizes DSPs under does not accurately reflect the profession. BLS mixes DSPs into an umbrella category that includes home health aides, social workers and camp counselors. While there is some overlap between DSP duties and those professions, DSPs have much higher levels of responsibility not reflected in current BLS descriptions.
- This is problematic because SOCs are heavily used to inform policy-making. SOCs are used to help all levels of government (local, state, federal) identify employment trends and design policies including: state rate setting for Medicaid supports, investment decisions by Workforce Investment Bureaus, and targeted recruitment programs. The current classification does not reflect the true nature of DSP work, preventing policy-makers from making the most informed decisions in these areas.
- Creating a SOC would not cost the federal government anything. BLS already collects data from I/DD agencies which employ DSPs, so this would not be a question of creating a new data collection system – it would simply be adding the DSP data in the data set.

Status: House and Senate bills directing BLS to create a DSP SOC using the definition of a DSP in the HIIA are soon to be introduced.

Technology

Medicaid Directors Letter Encouraging Use of Technology in HCBS
Emerging and innovative technology not only can be one of the solutions to the DSP workforce crisis, but can also help to support individuals in their home and allow reinvestment of cost savings into priorities like waiting lists for services. However, providers serving people with disabilities have not received clear authority from CMS that they can be reimbursed for technology driven services, such as software applications (e.g. phone apps), tablet technology (e.g. IPads), smart home technology, or maintenance of technology solutions. We seek explicit guidance from CMS to confirm Medicaid payments are authorized for the use of innovative technology solutions to deliver HCBS waiver services.
Status: We are currently meeting with offices about legislation that would direct CMS to issue three separate Medicaid Directors letters on each of the following – use of technology in HCBS, use of telehealth in HCBS, and use of augmentative communication devices.

Technology Infrastructure, Adoption, and Training Grants for States and Providers
Improving and maximizing the effectiveness of technology will be key to addressing the challenges facing Medicaid LTSS in the 21st century. As the need for effective quality measures in HCBS and the data collection to support them becomes increasingly more pressing, so does the need for IT infrastructure to support these efforts. Through the Transformed Medicaid Statistical Information System (T-MSIS) and several other initiatives, significant effort and investment has gone into improving state IT systems; however, the It systems used by providers, which must feed into those state systems, have received less attention. Technology can also be used to address the DSP workforce crisis, both through tools that make basic DSP administrative functions more efficient, and through technology that can help meet the service needs of HCBS recipients. Of course, in order to maximize the impact of this technology, providers and their employees must be sufficiently trained in its use. The effort to modernize Medicaid will require more concentrated effort than is supported by administrative claiming. Therefore, we propose a Medicaid Modernization Grant Program through which states can receive grants specifically for developing provider capacity to use technology, in three buckets: 1. building quality reporting infrastructure to feed into the state's data IT systems; 2. purchasing technology that can be used either to modernize employee practices or to improve direct services; and 3. training people on the use of said technology. Funding for training could also be built into awards in the first two buckets, rather than being a separate track. Funding to address this priority could also be folded into a HCBS Infrastructure proposal.
Status: Have held meetings but not much progress yet.

Electronic Visit Verification (EVV)
Poor implementation of EVV continues to across the country. Stakeholders agree that CMS and/or Congress must address biometrics, GPS, dual verification systems, host homes, family caregiving , etc.
Status: Numerous meetings about EVV legislation still working to identify an office to take a strong lead. Have exhausted all efforts for additional CMS guidance on remaining issues.

Other

Medicaid Buy-In
The Medicaid Buy-In program was authorized under the Balanced Budget Amendment of 1997 and the Ticket to Work and Work Incentives Improvement Act (TWWIA) in 1999 These programs offer individuals with disabilities the opportunity to work and access the healthcare services and supports they need, without having to choose between working and qualifying for Medicaid. Through the program, people with disabilities who are working can retain their healthcare coverage through Medicaid, while earning more than the allowable limits for regular Medicaid. Individuals in the program pay a premium to Medicaid in order to participate; the premium amount varies by state. As of 2015, 44 states operate a Medicaid buy-in program; six states, AL FL, HI, MO, OK, and SC do not offer the program. In 2011, nearly 200,000 individuals were enrolled in the program. However, there is considerable variation between state buy-in programs, and individuals participating in a buy-in must reapply if they move between states. We would like to work on creating national standards to improve the utility and adoption of the Medicaid Buy-In programs.

In addition, the Medicaid Buy-In under TWWIA is limited to those between the ages of 16-64 years of age. Once an individual turns 65 they are no longer able to participate and are required to stop working in order to maintain their Medicaid benefits. Individuals with disabilities over the age of 64 should be able to continue work and participate in the TWWIA Medicaid Buy-In program. There should be a statutory change to allow individuals with disabilities over the age of 65 to pursue employment opportunities and maintain their Medicaid benefits.

Status: Senate and House bills introduced to address the 65 and over barrier. Met with offices that have Medicaid Buy-In bills and that are interested in increasing Medicaid HCBS access.

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