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Examining the Potential for Additional Rebalancing of Long-Term Services and Supports

Final Report

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Executive Summary

Background

Medicaid is the primary payor for long-term services and supports (LTSS) needed by older adults and people with disabilities (Watts, Musumeci, and Chidambaram 2020). Although the program has historically relied on institutional settings to provide LTSS, over the last two decades, federal and state policymakers have focused on rebalancing or shifting LTSS away from institutional settings and toward home and community-based services (HCBS). States have made considerable progress toward rebalancing LTSS, although some states have been more successful than others. In 2018, six states spent under 40% of their LTSS expenditures on HCBS, whereas five states spent over 75% (Murray et al. 2021). The COVID-19 public health emergency (PHE) has accelerated federal and state interest to promote the use of HCBS over institutional services.

To better understand the factors that affect states' efforts to rebalance their LTSS systems, including the barriers and potential opportunities to address those barriers, MACPAC contracted with RTI International (RTI) to conduct case studies of five states with low levels of rebalancing (Louisiana, Mississippi, New Jersey, North Dakota, and West Virginia) relative to the national average. This report reviews the findings from interviews with federal officials, state officials, and other stakeholders involved with Medicaid LTSS systems and beneficiaries. We used the following questions to guide our study:

1. What factors have limited rebalancing in the states where HCBS spending remains under 50% of total LTSS spending?
2. How can the federal government promote further rebalancing in these states?
3. Do any of the flexibilities introduced by states to respond to the COVID-19 pandemic help expand access to HCBS in states with less developed HCBS systems?

State Efforts to Rebalance LTSS

Despite relatively low spending on HCBS, state officials from all case study states reported engaging in rebalancing efforts, including:

- Increasing waiver slots among Section 1915(c) waivers,¹
- Expanding services available under Section 1915(c) waivers,
- Increasing Medicaid payment rates for community-based services,
- Increasing opportunities for education and awareness among Medicaid beneficiaries with LTSS needs about community-based options,

¹ Section 1915(c) waivers, also referred to as HCBS waivers, are programs states can develop, within federal guidelines, to meet the care needs of individuals receiving LTSS at home or in the community, instead of institutional settings. There are over 300 1915(c) waiver programs operating across most states and DC (<https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html>).

- Updating and centralizing LTSS intake systems to facilitate consumer education and access, and
- Targeting HCBS state plan options to Medicaid beneficiaries not eligible for HCBS waiver services.

Although state officials cited several examples of improved access to HCBS, beneficiary advocates and HCBS providers generally disagreed with state officials about rebalancing progress. For example, one state had recently increased waiver slots available for several of its HCBS waivers, yet beneficiary advocates in the state noted that access remained difficult. And several stakeholders emphasized that lawsuits and *Olmstead* settlements led to many of the efforts to rebalance LTSS systems rather than state leadership prioritizing increasing access to community-based services.

Barriers to HCBS and Opportunities to Address These Barriers

Federal officials, national-level stakeholders, state officials, and state-level stakeholders reported a variety of barriers that affect states' efforts to increase access to HCBS for Medicaid beneficiaries. These barriers exist across all states, even those that have made significant progress toward rebalancing. Interviewees also identified potential opportunities that federal and state governments can consider when trying to address these barriers. While states with higher levels of rebalancing have considered many of these opportunities, several stakeholders emphasized the importance that federal investments and incentives can provide to states with lower levels of rebalancing to encourage their consideration of these opportunities.

(1) Federal statute prioritizes institutional care. Although legislative and regulatory changes have expanded Medicaid support for HCBS, long-standing structures continue to bias the Medicaid program toward institutional care. Interviewees identified opportunities to address this barrier:

- Change federal statutes to prioritize HCBS such as allowing presumptive eligibility for HCBS as is done for institutional services or addressing Medicaid financial eligibility for HCBS
- Provide more federal support for state rebalancing efforts, including making programs like Money Follows the Person (MFP) and the Balancing Incentive Program (BIP) permanent
- Improve communication around care transitions, particularly for individuals dually eligible for Medicare and Medicaid
- Use managed LTSS programs to support rebalancing efforts
- Provide incentives for innovation from federal or state programs to create solutions to workforce shortages or lack of housing

(2)Limited state support and expertise. Several interviewees cited the lack of state leadership encouraging and supporting efforts to increase HCBS as a common factor among their states with relatively low levels of rebalancing. Stakeholders also mentioned states having few staff with the expertise to implement HCBS programs as a barrier. Although interviewees did not identify any unique opportunities or actions that states could consider to address these challenges, the lack of state champions highlights the importance of federal leadership and development of opportunities to encourage rebalancing efforts.

(3)Nursing facility industry influence on state LTSS policy. Most of the national-level stakeholders interviewed cited the influence of the nursing facility industry as an ongoing political barrier to rebalancing efforts across the country. Interviewees identified opportunities to address this barrier:

- Engage nursing facilities to create mutually beneficial partnerships
- Encourage nursing facility diversification of services

(4)Lack of affordable and accessible housing. The lack of affordable and accessible housing is a barrier for residents of institutions attempting to transition back to the community and for some individuals at risk of nursing facility placement. Interviewees identified opportunities, including federal-level opportunities and possible cross-agency and cross-sector collaborations, to address this barrier:

- Use federal programs such MFP, the Balancing Incentive Program, and the Innovator Accelerator Program, as well as other federal funding flexibilities to increase accessible and affordable housing
- Use managed care programs to address housing challenges
- Develop alternative housing settings

(5)LTSS workforce challenges. All stakeholders highlighted persistent and growing LTSS workforce shortages as a primary barrier to increasing HCBS, with many emphasizing the unique challenges in recruiting and retaining direct care workers (home health aides, personal care aides, certified nursing assistants). Interviewees identified opportunities to address this barrier:

- Increase payment rates and other incentives, such as additional training opportunities, for workforce retention
- Leverage Medicaid managed LTSS programs to address workforce challenges by including provider network requirements in contracts

(6)Limited public awareness and understanding of HCBS options. Some stakeholders mentioned community and many families' traditional beliefs about where care should be provided and long-standing medical practice patterns as impeding rebalancing efforts. For example, the hospital-to-nursing facility pipeline is difficult to overcome, and the referral process to the nursing facility is much easier than the multi-step process involved for HCBS referral and access. Interviewees identified opportunities to address this barrier:

- Support shifts in cultural norms and increase awareness among Medicaid beneficiaries and providers about HCBS options

Effects of the COVID-19 Public Health Emergency

The COVID-19 PHE has highlighted several inefficiencies and challenges associated with providing care in institutional care settings and has been motivation for states to increase their efforts to rebalance their LTSS systems. Many of the interviewees noted that the pandemic has highlighted ways in which the HCBS system can expand beneficiary access to HCBS. All of the case study states had applied for and received temporary flexibilities for HCBS waiver and state plan services. Stakeholders reported on which flexibilities had been most helpful in maintaining and expanding access to HCBS, including:

- Expanding telehealth,
- Expanding self-directed services and allowing family members to be in-home paid caregivers,
- Flexibilities associated with HCBS payment,
- Flexibilities associated with addressing provider capacity and facilitating providers to practice at the top of their licenses,
- Flexibilities associated with beneficiary eligibility and enrollment, and
- Flexibilities associated with provider trainings.

Future Considerations

This study includes several opportunities that require additional examination as the federal government and states consider next steps to addressing barriers to states' efforts to provide more HCBS.

- **MFP.** Several stakeholders raised concerns about the temporary nature and administrative requirements associated with the MFP program. Further examination of areas where the MFP program can be updated, or administrative requirements can be reduced may encourage states to continue their MFP programs and increase their rebalancing efforts.

- **Nursing facility diversification.** While several nursing facility industry stakeholders discussed the opportunities for nursing facilities to diversify their services to offer HCBS, they also identified federal and state policies that may impede facilities from offering HCBS.
- **Opportunities for testing innovations in HCBS care service delivery in rural areas.** Because the barriers to increasing HCBS are more pronounced in rural areas, policymakers may consider working with rural providers to determine alternative strategies to deliver HCBS.
- **Recruitment and retention of direct care workers.** Several stakeholders noted that increased investments in the direct care workforce, such as payments and training, are needed to address barriers to increasing HCBS. Investments could also include improvements in direct care workforce data collection and monitoring.
- **Effects of COVID-19 PHE.** Additional examination of the flexibilities granted to states during the COVID-19 PHE can determine whether the flexibilities improved access to HCBS, and which flexibilities should be extended in the future.

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1. Background

1.1 The Shift of Medicaid LTSS Spending Towards HCBS

Medicaid is the primary payor for long-term services and supports (LTSS) needed by older adults and people with disabilities (Watts, Musumeci, and Chidambaram 2020). At the start of the Medicaid program in 1965, states were required to guarantee coverage of nursing facility services to eligible individuals, but there was essentially no mechanism to cover home- and community-based services (HCBS).² This reflected a historical reliance on institutionalization of older adults and people with physical, functional, or cognitive disabilities (MACPAC 2019).

Medical advancements and shifts in societal perspectives on institutional-based care slowly led to a national movement toward providing LTSS in less restrictive settings (MACPAC 2019). In 1981, Congress passed legislation allowing states to provide HCBS to eligible individuals who would otherwise require institutional services through the Section 1915(c) waiver authority, but in 1989 over 90% of Medicaid LTSS funding was still being used to provide institutional care (CMS 2020b; Watts, Musumeci, and Chidambaram 2020). The enactment of the American Disabilities Act in 1990, and the landmark case *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999), began to drive investments in HCBS. By the late 1990s, policymakers began to talk of purposely rebalancing or shifting LTSS away from institutional settings and toward community-based care.

Over the last two decades, states have made considerable progress toward rebalancing LTSS. In 2013, for the first time, state Medicaid expenditures for HCBS were on average greater than for institutional care. As of 2018, 56% of Medicaid LTSS funds went toward HCBS (Murray et al. 2021). Although rebalancing progress has been made overall, some states have been more successful than others. In 2018, six states spent under 40% of their LTSS expenditures on HCBS, whereas five states spent over 75% (Murray et al. 2021). This report examines

Defining and Measuring Rebalancing

Rebalancing is often defined as achieving a more equitable balance between the share of spending and use of services and supports delivered in HCBS settings relative to institutional care or shifting LTSS away from institutional settings and toward community-based care (CMS 2020). Medicaid HCBS spending as a share of total LTSS spending is often used to gauge a states' progress in rebalancing their LTSS systems. However, relying only on HCBS spending to measure rebalancing progress does not account for the variations that exist across states, such as the differences in population demographics (e.g., states that have rapidly aging populations who are more likely to be nursing facility residents) or resources (e.g., large number of nursing facilities in a state that has reduced long-term bed capacity) (Lipson 2019).

² States were required to provide home health services and had the option to provide personal care services, but they severely restricted the use of these services to a narrow range of circumstances such as providing in-home skilled nursing care (Shirk 2006).

barriers to states' rebalancing efforts as viewed through the lens of five states. It also explores potential opportunities to overcome those challenges through policy and programmatic changes.

1.2 Overview of Federal Support for State Rebalancing Efforts

States have flexibility in deciding on HCBS coverage, including eligibility criteria, benefit packages, and scope of benefits. The most widely used vehicle for providing these services is through HCBS waivers (Section 1915(c) waivers or Section 1115 research and demonstration waivers), with all states offering at least one HCBS waiver (Musumeci, Watts, and Chidambaram 2020). States may also provide HCBS as part of state plan services. As of fiscal year (FY) 2018, all states offer home health services as a state plan service, while only 34 states offer personal care services, and even fewer offer Section 1915 (i) and Community First Choice services (11 and 8 respectively) (Musumeci, Watts, and Chidambaram 2020). While variations in states' fiscal and policy priorities and HCBS infrastructure largely shape the types and degree of HCBS offered, federal policies also affect HCBS coverage including where these services may be provided. A 2014 Centers for Medicare & Medicaid Services (CMS) final rule establishes new requirements for HCBS settings and defines the qualities of community-based settings that distinguish them from institutional settings.³ Additionally, the federal government has supported state efforts for rebalancing through several initiatives and development of resources.

1.2.1 Money Follows the Person Program

The Money Follows the Person (MFP) program, established by Congress through Section 6071 of the Deficit Reduction Act of 2005, enables state Medicaid programs to help Medicaid beneficiaries who live in institutions to transition into the community and expands options for older adults and individuals with disabilities deciding where to live and receive LTSS. In addition to facilitating transitions into the community, the MFP program provides states with financial support for HCBS infrastructure development (e.g., improving housing supports, expanding the number of waiver slots, workforce training). Congress extended the MFP program through federal fiscal year (FY) 2016 through the Patient Protection and Affordable Care Act (2010 Affordable Care Act), with flexibility to use funding through 2018. Since then, Congress has passed six short-term extensions of MFP to sustain the program, with the most recent extension of \$450 million per year through 2023 signed into law in

³ The HCBS settings rule requires HCBS settings to (1) be integrated in and supports full access to the greater community; (2) be selected by the individual from among setting options; (3) ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint; (4) optimize autonomy and independence in making life choices; and (5) facilitate choice regarding services and who provides them (CMS, 2014). States have until early 2023 to bring their HCBS programs and settings into compliance (CMS, 2020a).

December 2020.⁴ The most recent funding extension also includes changes to the program requirements, such as lowering the number of days someone must spend in an institution before qualifying for MFP from 90 days to 60.

States are required to invest their MFP funds in programs or initiatives that help shift the balance toward HCBS. From the time transitions began in 2008 to the end of 2019, states had transitioned 101,540 people to community living through MFP (Liao and Peebles 2019).

1.2.2 Balancing Incentive Program

The Balancing Incentive Program (BIP), authorized in the 2010 Affordable Care Act, offered a higher federal medical assistance percentage (FMAP) to participating states to support their efforts to increase the total percentage of LTSS expenditures on HCBS. Participation was limited to states that, as of 2009, had less than 50% of their Medicaid LTSS spending going toward HCBS. As part of the program, participating states were required to undertake structural changes (i.e., establishing no wrong door systems, using core standardized assessment instruments, and implementing conflict-free case management), spend program funds to enhance community LTSS, and meet the “balancing benchmark,” (i.e., spend a certain percentage of total LTSS dollars on community LTSS⁵) (CMS n.d.(a), CMS n.d.(b)). States taking part in BIP had a greater increase in HCBS spending as a share of total LTSS expenditures than did states that were eligible but did not participate in the program (Karon et al. 2019).

1.2.3 Additional Federal Support

In July 2014, CMS launched the Medicaid Innovation Accelerator Program (IAP).⁶ Through IAP, CMS provides technical support, tool development, and cross-state learning opportunities to support states’ payment and delivery system reforms. CMS targeted Promoting Community Integration through Long-Term Services and Supports (CI-LTSS) as one of the four program areas to provide technical support. Through CI-LTSS, the IAP

⁴ Medicaid Extenders Act of 2019, Pub. L. No. 116-3 (January 25, 2019) provided \$112 million; Medicaid Services Investment and Accountability Act of 2019, Pub. L. No. 116-16 (April 18, 2019) provided \$20 million; Sustaining Excellence in Medicaid Act of 2019, Pub. L. No. 116-39 (August 6, 2019) provided \$122.5 million; Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94 (December 20, 2019) provided \$176 million; Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-127 provided \$337.5 million through Nov. 30, 2020. Consolidated Appropriations Act, Pub. L. No. 116-260 (December 27, 2020) provided \$450 million per year through 2023, with states allowed to use funds through 2027.

⁵ 25% or 50% depending on the 2009 starting point.

⁶ The Medicaid Innovation Accelerator Program (IAP) is a federal program that has helped many states further rebalancing efforts. In 2016, eight states received support to develop or increase public and private partnerships between Medicaid and housing systems to increase community living opportunities for Medicaid beneficiaries. Some specific examples of activities include updating data systems and improving data integration of Medicaid and housing data (CT, KY, MI, NJ), increasing knowledge of the affordable housing gap (AK, KY), building housing partnerships for the development of more affordable housing (MN, NE, NV, TX), and reducing chronic homelessness (CA, HI, MA).

offered program support to states in housing-related services and partnerships as well as value-based payment (VBP) in community-based LTSS programs. An evaluation of IAP indicated that states participating in the CI-LTSS program had formed or strengthened intra-state health and housing staff partnerships, applied for Medicaid waivers to support the provision of housing-related services, engaged providers in strategic discussions about VBP for HCBS, and gained foundational knowledge to support early development of VBP HCBS strategies (Witgert, Bertrand, and Caughlan 2020).

CMS also released the *Long-Term Services and Supports (LTSS) Rebalancing Toolkit* in November 2020, to support states in their efforts to expand HCBS (CMS 2020b). The toolkit identifies promising state models and practices as a resource for states strengthening their HCBS infrastructure. It also provides strategies that states can consider when trying to increase the share of LTSS provided in the community.

1.3 State Variation with Rebalancing

Despite federal support and overall progress nationally, states vary in their progress on rebalancing LTSS. In 2018, six states spent under 40% of their LTSS expenditures on HCBS, whereas five states spent over 75% (Murray et al. 2021). HCBS expenditures as a proportion of total Medicaid LTSS expenditures increased steadily for more than a decade, but they have recently begun to plateau. The share of HCBS as a total of LTSS was 56% in 2018, which was just slightly lower than in 2016 (57%).

The percentage of LTSS spending on HCBS is influenced by state systems and policies, which help shape HCBS access and benefits (i.e., who receives services and what services are received by each recipient). States control access by defining eligibility requirements to receive services (which are defined in terms of functional criteria and are separate from the financial criteria necessary to qualify for Medicaid). States also decide which benefits to provide and the level of intensity (reflected in spending) of services provided to each recipient (Segelman et al. 2017; Segelman et al. 2019; Wenzlow, Schmitz, and Shepperson 2008).

In addition to variation among states in LTSS spending, variation exists by LTSS subpopulation. Most LTSS spending is focused on three groups: older adults and individuals with physical disabilities, individuals with intellectual disabilities or developmental disabilities (ID/DD), and individuals with behavioral health conditions. Yet the balance between HCBS and institutional care differs across these three populations. For older adults and people with physical disabilities, in 2018 states spent slightly under a third (32.9%) of their LTSS expenditures for HCBS, compared to 49.2% for people with behavioral health conditions and 78.9% for people with ID/DD (Murray et al. 2021). These differences also vary considerably across states.

1.3.1 State Focus on Rebalancing During COVID-19

The COVID-19 public health emergency (PHE) has recently accelerated state interest and efforts in promoting the use of HCBS over institutional services. Individuals residing in nursing facilities or receiving LTSS in general may have chronic conditions, be immunocompromised, or be older adults (Watts, Musumeci, and Chidambaram 2020). Individuals with these very characteristics have been disproportionately infected by the novel coronavirus. Relatedly, there has been significant attention on congregate housing settings, such as nursing facilities, as incubators for the virus, creating an impetus for states and beneficiaries alike to avoid greater risk related to being in institutional care settings and instead opt for home-based care (Musumeci 2020; CMS 2020c).

For states, the PHE has led to increased investments in HCBS. At the same time, the pandemic highlights current limitations in their LTSS systems.

To mitigate some of these challenges, CMS granted both 1135 waivers and 1915(c) Appendix K waivers to states that will continue at least through the duration of the PHE. Section 1135 waivers, authorized under Section 1135 of the Social Security Act (the Act), allow the federal government to waive certain requirements related to Medicare, Medicaid, and the State's Children's Health Insurance Program (CHIP) during an emergency or disaster declared by the President or PHE declared by the Secretary (MACPAC 2020). In response to COVID-19, state-specific 1135 waivers were made available to address five key areas and facility continuity of programs and services throughout the public health emergency period: Medicaid prior authorization requirements, LTSS, fair hearings, provider enrollment, and reporting and oversight. States could also request Section 1135 waivers for other flexibilities not listed, such as relaxing requirements for need and timing of public notice of state plan changes related to cost sharing, alternative plan benefits, and payment (MACPAC 2020). Some examples of provisions states are waiving to ensure continuity and access to services include waiving preapproval and preauthorization requirements for particular benefits, suspending preadmission screening and annual resident review Level I and Level II assessments for 30 days, and relaxing provider enrollment requirements. Appendix K is a standalone appendix that states can request in emergency situations to amend Section 1915(c) waivers.⁷ Specific provisions of Appendix K waivers vary across states and have included efforts intended to bolster the HCBS workforce by paying for personal care services provided by family caregivers, providing retainer payments to

⁷ Section 1915(c) waivers, also referred to as HCBS waivers, are programs states can develop, within federal guidelines, to meet the care needs of individuals receiving long-term care services and supports at home or in the community, instead of institutional settings. There are over 300 HCBS Waiver programs operating across most states and DC (<https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html>).

support HCBS providers at risk of closure, and increasing direct care workforce payment rates (ATI Advisory 2020).

To help states finance the costs incurred from these and other policy changes related to COVID-19, the Families First Coronavirus Response Act (Public Law No. 116-127) provides states with a temporary 6.2% enhanced FMAP for all Medicaid-covered services.

Increased demand for home-based care to help mitigate COVID-19 spread in institutional care settings is likely to keep LTSS rebalancing in focus, but it is unclear whether states will consider long-term expansion of access to HCBS in light of significant budget pressures.

1.4 Project Purpose

To better understand the factors that affect states' efforts to rebalance their LTSS systems, including the barriers and potential opportunities to address those barriers, MACPAC contracted with RTI International (RTI) to conduct case studies of five states (Louisiana, Mississippi, New Jersey, North Dakota, and West Virginia). This report reviews the findings from interviews with federal officials, case study state officials, and national and case study state stakeholders involved with Medicaid LTSS systems and beneficiaries. We used the following questions to guide our study:

1. What factors have limited rebalancing in the states where HCBS spending remains under 50% of total LTSS spending?
2. How can the federal government promote further rebalancing in these states?
3. Do any of the flexibilities introduced by states to respond to the COVID-19 pandemic help expand access to HCBS in states with less developed HCBS systems?

2. Methods

2.1 State Selection

To determine state-specific factors that create barriers to HCBS, we conducted case studies of five states with low levels of HCBS spending. In consultation with MACPAC, RTI identified five study states (Louisiana, Mississippi, North Dakota, New Jersey, and West Virginia) that, in addition to low rates of HCBS spend, varied in use of HCBS state plan and waiver options, population density, participation in BIP or MFP, and adoption of Medicaid managed LTSS (MLTSS). Case study states were selected using FY 2016 HCBS expenditure data, but as **Table 1** shows, HCBS spending as a proportion of total LTSS spending was also less than 50% in FY 2018 across all study states, compared to the national average (56.1%).

Table 1. Characteristics of Selected Study States

State	HCBS Spending as Percent of Total LTSS, FY 2018				HCBS Waivers and State Plan Options	BIP and/or MFP Participation	Adoption of MLTSS
	Overall	Services for Older Adults and People with Physical Disabilities	Services for People with ID/DD	Services for People with Behavioral Health Conditions			
Louisiana	34.2	21.6	56.4	0.2	1915(c)	BIP & MFP	No
Mississippi	32.6	29.1	33.1	40.5	1915(b), 1915(c), 1915(i)	BIP & MFP	No
New Jersey	34.4	20.9	55.9	4.9	1915(c), 1115	BIP & MFP	Yes
North Dakota	41.7	17.5	68.6	26.0	1915(c), 1915(i)	MFP	No
West Virginia	41.4	22.6	81.5	50.8	1915(c), 1115	MFP	No

Notes: HCBS = Home- and community-based services; ID/DD = individuals with intellectual disabilities or developmental disabilities; BIP = Balancing Incentive Program; MFP = Money Follows the Person program; MLTSS = Medicaid managed long-term services and supports. West Virginia Section 1115 demonstration is the Substance Use Disorder Waiver.

Sources: Murray et al. 2021; CMS 2021; CMS n.d.(a); CMS n.d.(b); Integrated Care Resource Center 2021.

2.2 State Profiles

RTI reviewed the most current publicly available data on each selected state's LTSS spending, HCBS state plan and waiver options, HCBS waiver waiting list data, supply of

HCBS providers, participation in rebalancing initiatives such as MFP and BIP, and other information needed to identify or describe barriers to rebalancing across case study states. RTI also researched selected states' uptake of recent flexibilities granted by CMS in response to the COVID-19 pandemic (e.g., allowing paid caregivers under Section 1915(c) waivers to include family members and legally responsible individuals).

2.3 Federal and State Stakeholder Interviews

RTI, Center for Health Care Strategies (CHCS), and MACPAC staff sought insights, experiences, and expertise from a variety of stakeholders to better understand the barriers to HCBS rebalancing and potential opportunities to support further rebalancing at the federal and state levels. For each selected state, the project team conducted structured interviews with staff from the Medicaid agency as well as the aging and ID/DD agencies. Similarly, the project team interviewed representatives from state provider associations (nursing facility and HCBS), beneficiary advocates, and managed care plans. The team also targeted stakeholders who interact with and provide services to older adults and people with physical disabilities because these populations have lower rates of HCBS use. Interviewees responded to a series of questions regarding overall efforts and barriers to rebalancing, as well as specific challenges and opportunities around provider supply, affordable housing, and rebalancing efforts in rural areas. Questions also probed rebalancing challenges that might be specific to certain populations including older adults, people with physical disabilities, individuals with ID/DD, and individuals with severe mental illness.

To supplement the state interviews, RTI also interviewed CMS and Administration for Community Living (ACL) officials to gain federal perspectives on barriers and opportunities for further rebalancing, especially via MFP and other federally funded LTSS programs; representatives from national provider associations offering industry perspectives to rebalancing; and representatives from national organizations that advocate for the various subpopulations who use HCBS. In total, RTI conducted 28 interviews. A listing of organizations interviewed is in **Appendix A**.

3. Findings

The findings synthesize the information gathered from the interviews. After an overview of recent state efforts to rebalance their LTSS systems, this section includes the factors that create barriers for states trying to rebalance their LTSS spending as identified by the interviewees. This section also includes the interviewees' suggestions of opportunities to address the barriers to increasing HCBS.

3.1 States' Efforts to Rebalance

Despite relatively low spending on HCBS, each of the case study states reported engaging in some rebalancing efforts. These efforts included:

- Two states reported increasing waiver slots among their Section 1915(c) waivers.
- One state expanded the types of services available in its HCBS waiver programs for older adults and people with physical disabilities, drawing from successful experiences with benefit design for people with ID/DD.
- Two states increased their Medicaid payment rates for community-based services provided through HCBS waivers. In one state, the HCBS rates had been reduced in 2008 and the state recently increased the rates to restore them back to pre-2008 levels.
- Two states reported increasing opportunities for education and awareness among Medicaid beneficiaries with LTSS needs about community-based options as alternatives to going into a nursing facility. For example, one state's legislature mandated an informed choice process for Medicaid beneficiaries accessing LTSS. The state also includes a follow-up process for beneficiaries who initially prefer a nursing facility setting to reassess their interest in transitioning back to the community.
- Two states have focused on updating their LTSS intake systems.⁸ In one state, the state legislature had recently passed legislation to turn its aging and disability resources web portal into a centralized intake system for HCBS.
- One state discussed relying on its HCBS state plan options, such as personal care assistance, to help Medicaid beneficiaries remain in the community before they become eligible for LTSS available through waivers.

Publicly available data and the percentage of LTSS expenditures spent on HCBS do not fully demonstrate the extent of state efforts. State officials mentioned that their efforts, including updates to their LTSS systems, allowed for more beneficiaries to access HCBS and were more nuanced than increasing expenditures for HCBS. One state official noted that programmatic changes the state implemented to try to improve access to HCBS

⁸ LTSS intake systems function as an LTSS information hub for individuals who need to learn about LTSS available in their state and how to access those services (e.g., eligibility criteria, application process, etc.). They can also be used to screen individuals for services, conduct needs assessments, and develop service plans.

were not well represented in their overall HCBS expenditures as a share of total LTSS spending, which continued to remain low: “Initiatives like single point of entry and informed choice and consumer direction...are truly wonderful things in terms of giving people access to the community, but they don't necessarily much alter the expenditure picture.”

Beneficiary advocates and HCBS providers generally disagreed with state officials about how successful rebalancing efforts have been. Officials in two of the case study states reported that they have recently targeted reducing the HCBS waiver enrollment waiting list. While one state had increased the waiver slots available for several of its HCBS waivers, beneficiary advocates in the state noted that although more people were enrolled in the waiver programs, it remained difficult for beneficiaries to access the waiver services. “Yes, they did clear the wait list, but I don't know that they see that in the form of rebalancing anything.” Officials in the other state implemented a waiting list reduction program that included reducing the overall wait for the state’s Section 1915(c) waivers for older adults and people with physical disabilities and assisting people who are on the waiting lists in accessing state plan HCBS. However beneficiary advocates in the state were less enthusiastic about the state’s efforts to increase HCBS waiver slots without addressing other needed structural reforms, such as improving workforce supply by increasing HCBS payment rates. And in one state that had reported increased HCBS payment rates, an HCBS provider representative in the state noted that the largest barrier to increased access continued to be the low payment rates for HCBS providers. To highlight the low rates, the HCBS provider mentioned that people could earn more by working at gas stations compared to providing direct care services. “Even prior to COVID, the largest barrier in the state is the pay because the reimbursement rate versus what you can pay your caregiver, puts you out of competition with like a gas station.”

Several efforts to rebalance state LTSS systems result from lawsuits and state settlements with the Department of Justice. Beneficiary advocates emphasized that efforts to rebalance were primarily driven by lawsuits and *Olmstead* settlements rather than state leadership prioritizing increasing access to community-based services. For example, beneficiary advocates in one state discussed how a lawsuit over services provided to individuals with ID/DD sparked the state’s efforts to provide more services to this population. “I think that that lawsuit is the one reason that it ... transitioned into what we're seeing today.” In two states, beneficiary advocates and state officials cited their *Olmstead* settlements as leading to increased efforts to develop informed choice process for people needing LTSS. Another state developed a diversion and transition program that specifically targets people with serious mental illness who are in nursing homes or at risk of nursing home placement as a result of the state’s agreement with the U.S. Department of Justice.

3.2 Barriers to HCBS and Opportunities to Address These Barriers

Federal officials, national-level stakeholders, state officials, and state-level stakeholders reported a variety of barriers that affect states' efforts to increase access to community-based services for Medicaid beneficiaries. These barriers exist across all states, even those that have made significant progress toward rebalancing. Interviewees also identified potential opportunities that federal and state governments can consider when trying to address these barriers. Although states with higher levels of rebalancing have considered or used many of these opportunities, several stakeholders emphasized the importance of federal investments and incentives for states with lower levels of rebalancing to encourage their consideration of these opportunities.

3.2.1 Federal Statute Prioritizes Institutional Care

From its inception, the Medicaid program has prioritized institutional care over home and community-based options for LTSS. Although states were required to cover nursing facility benefits for eligible individuals, there was essentially no standard vehicle for coverage of non-institutional LTSS until enactment of the Section 1915(c) waiver authority in 1981 (Engquist et al., 2010). Over time, legislative and regulatory changes have expanded Medicaid support for HCBS, but long-standing structures still bias the program toward institutional care. For example, when states must cut funding or cut programs to balance their budgets, it is more likely to be among HCBS rather than institutional services because HCBS are optional and institutional services are mandatory.

Interviewees discussed several opportunities to overcome this barrier.

Opportunity: Change Federal Statutes to Prioritize HCBS

Changes to various federal statutes could prioritize providing HCBS. National and state-level interviewees suggested changes, including:

- Allowing presumptive Medicaid eligibility for HCBS as is done for institutional care would provide individuals with the freedom to choose HCBS over institutional care without fear of incurring costs for home-based care that they cannot pay.⁹
- Addressing Medicaid financial eligibility for LTSS services, including raising the income limit criteria for accessing HCBS waiver services, and raising the cap on home equity that excludes individuals from Medicaid coverage of LTSS if the equity in their home exceeds \$603,000 (or up to \$906,000 at state

⁹ Medicaid programs can assume eligibility and provide coverage of institutional services for up to three months prior to the month a beneficiary submits a Medicaid eligibility application, but presumptive eligibility and retroactive coverage does not apply to HCBS. Eligibility and coverage of HCBS is prospective-only from the date on which the Medicaid program approves the beneficiary's HCBS service plan (Justice in Aging, 2015).

option) except when a spouse or child with a disability is residing in the home (CMS, 2021a).

- Providing beneficiaries greater flexibility to pay for alternative providers and settings such as providing family caregivers a monthly allowance to help keep individuals at home instead of requiring billing for each individual service provided, and allowing Medicaid to pay for room and board in community settings and not just institutional settings.
- Leveraging the Program for All-Inclusive Care for the Elderly (PACE) by expanding the program to younger populations including individuals with ID/DD, allowing individuals to enroll in PACE at any point during the year, and revising PACE marketing guidelines to allow these organizations to reach more individuals who could potentially benefit from the program.
- Developing a unified program that would provide fully integrated Medicare and Medicaid services for dually eligible individuals to support home and community-based care for this population more effectively.¹⁰

Opportunity: Provide More Federal Support for State Rebalancing Efforts

MFP and BIP have provided valuable federal support for state rebalancing efforts.

There was broad consensus among both national- and state-level interviewees that MFP and BIP helped states to advance rebalancing efforts. Officials from all case study states emphasized that their MFP programs were critical to addressing their states' goals to transition people back to the community. As one official noted, "it really is a fundamental element of our program and our rebalancing." Although the overall numbers and effect of MFP transitions on an individual state can be limited, state officials all highlighted the ability to use MFP funding to support infrastructure and administrative development as key to their rebalancing efforts. One federal official also described states' ability to use MFP to fund administrative costs as very important because moving forward with rebalancing required more infrastructure and staffing than states could build out within their regular budgets. Another federal official thought that MFP and BIP also helped states to implement *Olmstead* settlements by providing additional money for funding for community-based services.

All the case study states that participated in BIP mentioned the usefulness of the program. One state emphasized the importance that BIP had in allowing the state to develop the systems needed to improve access to HCBS, including supporting the development of the state's no wrong door system. While the other states that participated in BIP acknowledged the important support that the program provided to improving their LTSS systems, they also mentioned that they already had ongoing efforts to improve their LTSS infrastructure in addition to their BIP participation.

¹⁰ Several stakeholders, such as the Bipartisan Policy Center and the Dual Eligible Coalition convened by Leavitt Partners, have proposed unified programs that fully integrated systems for dually eligible individuals (MACPAC, 2021).

Another important aspect of both MFP and BIP was the stakeholder engagement that took place around these efforts.¹¹ Medicaid officials in one state attributed its success with BIP to this upfront relationship-building and said that it allowed them to implement several large-scale projects across different Medicaid programs. This was also true for MFP. Even though the state decided not to renew its MFP grant because of uncertainty of whether the program would be reauthorized, Medicaid officials reported that associated stakeholder meetings had helped them identify areas for improvement and provided the catalyst for conversations about how to move forward with rebalancing.

Interviewees noted two opportunities around broadening federal supports for rebalancing efforts.

Making programs like MFP and BIP permanent would facilitate state-level planning and more consistently advance rebalancing.

The federal officials and national-level stakeholders interviewed believed that, although MFP and BIP offered states much-needed support for rebalancing infrastructure, there is a need for ongoing federal support. One national-level interviewee thought that the slowing in rebalancing progress in the last several years, particularly in states with limited resources, could be linked back to the sunset of these programs. They believed that, although MFP has continued to exist through piecemeal extensions, this approach lacks the predictability that both state Medicaid staff and HCBS providers need to continue to invest in rebalancing efforts.

Money Follows the Person HCBS Capacity Building Initiative

On September 23, 2020, CMS announced the MFP HCBS Capacity Building Initiative. This supplemental funding opportunity provides support to the 33 MFP demonstration states currently operating MFP programs for planning and capacity building activities to accelerate LTSS rebalancing efforts. The funds are available to the states for the federal fiscal year in which they are awarded and four additional fiscal years (CMS, n.d.(b)).

State Medicaid officials agreed that MFP had helped them to successfully transition individuals to the community, but they also expressed frustration with the temporary nature of the program. Officials from one state reported that although they plan to extend their MFP program and even apply for new supplemental funds through MFP's HCBS Capacity Building Initiative, they struggle each year as they wait to find out whether program funding has been reauthorized, which creates budgeting challenges. Officials from another state said that uncertainty around future funding contributed to their state's decision not to continue its participation. Another national-level interviewee noted that MFP has been helpful for MLTSS plans' efforts to rebalance, and that MLTSS plans had expressed their desire to see the program continue with more permanency.

¹¹ MFP and BIP included requirements that states develop stakeholder engagement processes and strategies (Deficit Reduction Act of 2005 P.L. 109-171; Mission Analytics Group, 2013).

Federal officials interviewed recognized that, because of uncertainty in MFP funding, states have had to create more sustainable infrastructures to support transitions outside of the MFP program. They noted that states have used MFP funding to build out their transition capacity and then used that capacity to support expanded transition efforts under HCBS waiver programs or other activities. In that way, states would have something tangible remaining if MFP funding does not continue. Three of the case study states specifically mentioned incorporating their MFP program services into their HCBS waiver programs as community transition services.

The programmatic and administrative requirements of federal supports can be burdensome and at times at odds with state-level structures and capacity.

Stakeholders at multiple levels reported that MFP's grant-based funding structure can be an administratively burdensome way for states to access funding. Federal officials acknowledged that some states may have been reluctant to continue participating in MFP because of the requirements associated with grant funding, including grant and budget approvals to access funding, and that an advantage of BIP was that it was funded through an enhanced FMAP, which was easier to administer for states.

Medicaid officials in one state said that MFP's reporting requirements were cumbersome and required them to hire additional staff. They indicated that they would have preferred to use their MFP grant money to serve more beneficiaries rather than spend it on program administration. They noted that BIP was an easier program for them to administer because they had more flexibility in how they accessed and used program funds, and it did not have as many reporting requirements. Officials in another state said they had difficulty capturing and reporting costs as required by the MFP program.

MFP's requirements around participant eligibility are also challenging. When MFP started in 2007, an individual was required to be institutionalized for a minimum of 180 days to be eligible for transition under the program (Irvin et al., 2015). The 2010 Affordable Care Act reduced the length-of-stay requirement to 90 days, and with the recent passage of the Consolidated Appropriations Act 2021 that requirement is further shortened to 60 days (P.L. 116-260). Medicaid officials in two states noted that the 90-day requirement was a barrier to transitioning some facility residents because, by 90 days after admission, they may have given up their housing and other possessions or supports that could help to sustain them in the community. One noted that Medicare-covered days in the nursing facility—which can be up to 100 days—did not count toward the 90-day requirement, creating an even higher barrier to transition. This official welcomed the shortening of the length-of-stay requirement to 60 days, but again believed that Medicare-covered rehabilitation days should count toward the length-of-stay requirement under MFP.

Federal requirements for rebalancing programs can sometimes be at odds with a state's structures or political capacities. Officials in one state reported that they dropped out of BIP

because the state struggled to meet BIP's rebalancing expenditure target required to access the enhanced FMAP.¹² The state officials said that while the state had made progress in serving more people in home- and community-based settings under BIP, their state's legislatively mandated nursing facility rate increases prevented it from meeting BIP's expenditure-based metrics of success. The influence of the nursing facility industry on state rebalancing efforts are further discussed below.

Opportunity: Improve Communication Around Care Transitions

Improved communication around care transitions could bolster community-based care, particularly for individuals dually eligible for Medicare and Medicaid.

Stakeholders noted that most rebalancing efforts, including MFP and BIP, have helped to provide needed resources, but fundamental issues around poor communication remain. One interviewee cited the example of a Medicare beneficiary who is discharged from a hospital to a facility-based post-acute rehabilitation program. This individual may stay in the facility for some time, spending down their income and assets. Only then does Medicaid become aware of this individual's existence, but by that point it is often difficult to help them return to the community.

When Medicare beneficiaries become eligible for Medicaid, they may still face challenges with communication and care coordination, even if they are enrolled in managed care plans for both their Medicare and Medicaid services. Oftentimes a Medicare Advantage (MA) plan covering the individual's hospital or skilled nursing facility stay may be unaware of how that individual receives Medicaid-covered LTSS (e.g., through a Medicaid managed care plan operated by a different organization or a Medicaid HCBS waiver that is carved out of the individual's Medicaid managed care plan and is part of the state's Medicaid fee-for-service system). The opportunity for care coordination is lost if there is no point of communication between Medicare and Medicaid.

An MLTSS plan association representative said plans would like to see more coordination and more integration between Medicare and Medicaid and to have greater access to Medicare data so that they could identify their members who may be at higher risk for needing long-term institutional care. New requirements for dual eligible special needs plans—which are MA plans serving dually eligible individuals—to share information on high-risk members' hospital and skilled nursing admissions with states or states' designees may help improve communication around care transitions (CMS, 2019a). Similarly, new rules to improve health information exchange between health plans, providers, and patients may

¹² States participating in BIP were required to meet certain rebalancing targets for HCBS expenditures to receive the enhanced FMAP. By October 1, 2015, states that had been spending less than 25 percent of their LTSS expenditures for community-based services were expected to reach a 25 percent expenditure target, and states that had been spending 25 to 50 percent of their LTSS expenditures for community-based services were required to reach a 50 percent expenditure target (Barth, Klebonis, and Archibald 2011).

support more efficient care coordination (CMS, 2020a). On March 9, 2020, CMS issued the Interoperability and Patient Access final rule (CMS-9115-F), which is designed to improve patient access to their health information, improve interoperability and encourage innovation, and reduce burden on payers and providers (CMS, 2020d).

Opportunity: Use MLTSS Programs to Support Rebalancing Efforts

MLTSS programs are incentivized to prioritize rebalancing. National-level interviewees and stakeholders from one case study state noted that MLTSS programs have been a key driver in state rebalancing efforts. The managed care plans in these programs often have the financial incentive to transition enrollees from institutional settings to community-based care or to divert enrollees away from facilities before their admission, such as including institutional services in the capitated payment rate to plans.¹³

One nursing facility association representative believed that there are opportunities to use value-based payments and other more flexible contract provisions to align incentives between managed care plans and nursing facilities and promote rebalancing. However, a managed care industry representative noted that managed care plans' greatest barrier to providing care in the community is their ability to find and pay for housing outside of an institution.

Beneficiary advocates, however, were concerned that MLTSS programs hinder access to HCBS by authorizing fewer services than beneficiaries require based on their level of need. One national-level stakeholder mentioned that rather than improving access to quality HCBS, MLTSS programs had generally cut services and focused more on engagement with providers rather than beneficiaries.

Opportunity: Provide Incentives for Innovation

The advancement of LTSS rebalancing may benefit from incentives for innovation that come from outside the Medicaid program. Other programs, agencies, or departments could unlock solutions to barriers like workforce shortages or the lack of housing. One federal official believed that rebalancing would only be possible if improvements were made in areas such as discharge planning processes and aligning financial incentives between Medicare and Medicaid. This official called for more efforts similar to ACL's direct support professional workforce challenge (DSP Challenge) that will award a prize for solutions to strengthen the direct support professional workforce and improve the overall quality of HCBS for individuals with ID/DD (ACL, 2021).

¹³ As of 2017, 30 MLTSS programs had carved some type of institutional care out of the managed care capitation rate, including 25 programs that excluded ICF/IID services, two programs that excluded ICF/IID and nursing facility stays of more than 180 days, and three programs that excluded all ICF/IID and nursing facility services (Lewis et al., 2018).

Other ideas include additional federal investment to improve access to supportive services within housing and examining eligibility requirements for programs like MFP that may limit states' ability to serve a variety of populations with LTSS needs. One state Medicaid official noted that there are opportunities to address the siloed nature of housing resources, such as the United States Department of Housing and Urban Development (HUD) Section 8 voucher program that relies on multiple public housing authorities to identify eligible beneficiaries with disabilities and often faces challenges in providing supportive services.

3.2.2 Limited State Support and Expertise

Several interviewees cited the importance of champions among state leadership to encourage rebalancing efforts as well as state staff with the expertise to implement HCBS programs. However, conversations with the interviewees did not identify any specific opportunities that states could consider to address the challenges of when states lack leadership support and the expertise needed to support efforts to increase HCBS.

State leadership's commitment to rebalancing, particularly from the governor's office, is a key factor to a state's success with increasing HCBS. As one federal official noted, "Having leadership at the state level is first and foremost, one of the most important factors, and that shouldn't be really underestimated." A beneficiary advocate from one state noted that the recent commitment from state leadership had been a big part of the state's improved movement towards rebalancing. The advocates noted that recently the state legislature tied funding to revamping the state's intake process, including streamlining assessments and creating a no wrong door system to ease access to services for Medicaid beneficiaries in need of LTSS.

Conversely, the lack of executive and legislative champions is a barrier to increasing access to community-based services. In one state, beneficiary advocates noted that they had never heard state officials publicly discuss rebalancing as a priority. Although state officials had noted recent efforts to rebalance their LTSS systems, the beneficiary advocates in that state attributed all of those efforts to *Olmstead* settlements rather than specific state policy priorities. "I've never heard the word rebalance used by state government here." The lack of state champions of rebalancing highlights the importance of federal leadership and development of opportunities to encourage rebalancing efforts.

States have a limited number of staff available with expertise to administer complex HCBS programs. One national-level stakeholder noted that many states' infrastructures were depleted during the recession in 2007 and some have not since been rebuilt. Therefore, it can be difficult for states to operate HCBS programs that are primarily based on staff knowledge and community connections. Rebalancing initiatives require a consistent pool of state staff that have lot of knowledge and expertise in the various parts of the LTSS system, including payment and service delivery. And with the implementation of

no wrong door systems, states require case management staff who can respond quickly when individuals identify that they want to move out of a nursing facility. Several stakeholders cited the MFP program as particularly helpful in providing the resources necessary for states to establish staff with relevant knowledge and expertise.

3.2.3 Nursing Facility Industry Influence on State LTSS Policy

The nursing facility industry has strong political clout compared to HCBS advocacy groups. The influence of nursing facility industry advocates was cited by most of the national-level stakeholders interviewed as an ongoing political barrier to rebalancing efforts across the country. In two of the five states examined in this study, state-level stakeholders also perceived nursing facility industry advocates as being strongly resistant to rebalancing away from institutional care. Stakeholders described the HCBS provider advocates as being less organized or influential in comparison to nursing facility industry advocates, particularly when budgetary pressures create an immediate need for advocacy around potential reductions in Medicaid LTSS budgets or related legislative proposals.

A primary source for this political influence was discussed in Section 3.2.1 of this report – namely that federal statute prioritizes institutional care. Interviewees described how the requirement that state Medicaid programs make long-term institutional care available to all qualifying beneficiaries, combined with Medicare and Medicaid payment structures (i.e., accessing higher Medicare payment rates for the first 100 days of care) that have historically incentivized providers to keep institutional capacity full and maximize their reimbursement creates a disincentive for the nursing facility industry to shift its business model to include HCBS, and impedes state progress toward rebalancing efforts.¹⁴

Stakeholders cited several other factors as generating political clout for nursing facilities. Nursing facility provider taxes often finance a large portion of a state’s LTSS budget, which is also often a significant percentage of the state’s overall budget (Kaiser Family Foundation, 2017). In addition, in rural areas, nursing facilities can be the largest employers, and rebalancing efforts may cause concern about job loss. Moreover, as discussed previously in this report, nursing facility positions often have better pay, benefits, and working conditions than direct care HCBS positions, creating greater incentives for states and local regions to preserve them. Similarly, beneficiary advocates in one state noted that the state-based institutional facilities for ID/DD populations also provide a level of pay and benefits that community-based HCBS providers serving this population generally cannot match.

As a result, stakeholders perceived institutional providers of LTSS as having few incentives to cooperate with rebalancing efforts. When LTSS system reforms are proposed, nursing

¹⁴ Recent changes to Medicare skilled nursing facility payment structures, discussed below, may change this dynamic.

facility industry advocates often use their influence to help further secure their position. Interviewees provided an example of how in one case study state, the legislature passed a series of laws that essentially guaranteed continued rate increases for nursing facilities without requiring the same rate enhancements for HCBS providers. In the past several years, nursing home provider payment rates increased, while the state cut payment rates for HCBS providers.

Interviewees cited possible opportunities to address the barrier created by the nursing facility industry's political influence.

Opportunity: Create partnerships with nursing facilities

Engaging nursing facilities in mutually beneficial collaborations may be one way of harnessing the industry's political strength. Federal officials cited an example of this in Minnesota's Return to Community Initiative (RTCI), a successful public-private collaboration that assists low-acuity, private-pay nursing home residents to return to the community early (i.e., 60-90 days) after facility admission (Hass et al., 2019). These individuals then receive care in the community and may not need to convert to Medicaid coverage. Although initially nursing facilities and industry representatives were threatened by the plan to discharge private-pay residents, they recognized the benefit of freeing up beds for higher acuity patients whose care would bring higher reimbursement rates (Buttke et al., 2018). While this effort is similar in design and approach to the national MFP initiative, this program provides earlier intervention for individuals who have not converted to Medicaid coverage. The federal officials suggested that the RTCI could be scaled up or replicated in other states.

Opportunity: Encourage nursing facility diversification

Assisting nursing facilities to diversify the services they provide may help overcome resistance to rebalancing efforts. Diversification of the nursing facility business model was cited by several interviewees as another opportunity for states to create a mutually beneficial partnership with the industry. This may be an attractive option for nursing facilities facing solvency issues related to declines in patient census or more generally, for nursing facilities that operate in markets where LTSS system reforms either have or are projected to significantly shift the LTSS system towards a greater reliance on HCBS.

Nursing facility industry representatives in a case study state spoke of wanting to create something similar to Georgia's Section 1915(c) waiver that operates the Service Options Using Resources in a Community Environment (SOURCE). This type of HCBS waiver program, designed to serve older adults and people with disabilities who need a nursing home level of care, allows participants to live in their homes or other community-based settings (e.g., assisted living facilities) and provides HCBS, care management, and links to

primary care providers, and is commonly employed by states (Paying for Senior Care, 2020). SOURCE sites have included hospital systems, Area Agencies on Aging, and other community-based organizations as well as nursing home providers (Lind, Gore, & Sommers, 2010).

The nursing home industry representatives in one state said that a SOURCE-like model would allow nursing facilities to provide HCBS, including home-delivered meals. They said that while there was interest from state officials in such a model, the state's moratorium on issuing new licenses for home health providers, which nursing facilities would also need to be licensed as, was a barrier to further development of this idea.

Some stakeholders mentioned one barrier to diversification is Medicaid's HCBS settings rule that prohibits providing Medicaid HCBS in buildings, on the grounds of buildings, or adjacent to buildings that provide institutional LTSS (CMS, 2017). While the intent of the rule was for HCBS program participants to receive services in the most community-integrated settings possible, it may prevent creative repurposing of nursing home facility spaces that would further rebalancing efforts. As one national-level stakeholder noted, the HCBS settings rule hindered nursing facilities that were considering revamping certain areas of their facilities into adult day centers or turning some of their beds into assisted living beds.

Medicaid officials in one state also mentioned the HCBS settings rule as inhibiting their rebalancing efforts. This state applied to CMS to implement assisted living in its Medicaid 1915(c) waiver before the HCBS settings rule was issued. The state's approach to assisted living would have allowed for nursing facility conversion to make it more politically feasible to implement Medicaid-funded assisted living, but their approach was not approved by CMS. As a result, the state does not have a 24/7 option to provide HCBS in assisted living facilities, which state officials believed has led some potential HCBS recipients to opt to receive care in a nursing facility instead.

3.2.4 Lack of Affordable and Accessible Housing

Stable housing is critical for individuals seeking to access HCBS. However, these individuals often find themselves in situations that make maintaining or acquiring stable, suitable housing challenging. Some individuals lose their housing unit as a result of nursing facility placements that last longer than anticipated and longer than are permitted for maintaining their personal residency. For others, the cost-of-living becomes prohibitively expensive, or their home is no longer safe enough for them to remain, and thus the need for supportive services is met by the added challenge of needing new housing. Most stakeholders mentioned barriers to HCBS posed by the lack of affordable or accessible housing, and the ways in which states are trying to address these issues.

The lack of affordable housing is a barrier for residents of institutional care facilities attempting to transition back to the community and for some individuals

at risk of nursing facility placement. Federal and state stakeholders noted that a lack of affordable housing is an ongoing and significant challenge to rebalancing efforts across LTSS populations. According to a federal stakeholder, this is especially problematic for beneficiaries requiring LTSS, since they tend to have much lower incomes than other low-income populations. Stakeholders in one state shared that as a result of the increased living costs, housing in areas where beneficiaries could better access HCBS services are now prohibitively expensive, while stakeholders in another state explained that affordable housing options are at capacity, and the waiting list for a HUD voucher can take over a year. In a different state, stakeholders said that the main challenge is a lack of housing options for individuals who would like to transition back into the community but did not previously have stable housing.

In addition to affordability, the lack of accessible housing was noted as a significant issue by several stakeholders. According to one national stakeholder, affordable housing that is available to LTSS beneficiaries often lacks one or more of the necessary characteristics that would make the housing option accessible for them (e.g., access ramp, wheelchair or walker friendly entrances and halls). In one state, a stakeholder explained that more adequate and up-to-date housing was necessary to meet the needs of lower acuity residents of nursing facilities to transition back into the community, including technological accessibility. In another study state, an advocate pointed out that appropriate community residence options are lacking for people with serious and persistent mental illness. Describing the experience of individuals with severe and persistent mental illness and the Housing Choice Voucher Program Section 8 program, the beneficiary advocate explained “[A] lot of times people who have mental health issues are kicked out pretty quickly from the Section 8 housing. It seems like no one has any kind of training with dealing with someone with mental health in the state. And they would rather deal with people that have acquired injuries or were born with them.”

Issues of housing accessibility are more acute in rural settings. According to state officials and a beneficiary advocate in one state, individuals requiring LTSS that continue to live in their rural homes often live in spaces that are older and not appropriate for their LTSS needs. The houses are also located far from available HCBS providers.

One of the biggest barriers to increasing the availability of affordable and accessible housing is a lack of consistent and sufficient funding. Officials in one state explained that although state legislation had been passed to allow the establishment of a rental assistance program, no funds were designated to support its implementation. Additionally, the existing funding to expand access to affordable housing was described as below the necessary levels to meet demand, and decisions about how to allocate and execute the funds have in the recent past inadvertently kept those in need of accessible housing out of the developed units.

One managed care industry stakeholder noted that current Medicaid policy does not allow for the payment of room and board for individuals eligible for HCBS. According to the stakeholder, this is “the number one barrier that MLTSS plans have experienced [...] the inability to fund or pay for accessible housing through the Medicaid program outside of an institution.”

Siloed affordable housing systems within a state can result in inconsistent data about available housing placements. One beneficiary advocate explained that “the access to affordable housing programs where low-income individuals could apply for assistance is a segmented maze” in the state and information regarding available affordable housing units is often inaccurate. According to the advocate, there is no statewide or regional depository to track occupancy of low-income senior apartments or buildings and individuals are forced to apply individually to each building. As a result, “management of those lists is difficult because someone could find a place and then they’re still on the list for another place and the person in that building doesn’t know.”

Interviewees discussed several opportunities to address housing barriers.

Opportunity: Use federal programs and other federal funding flexibilities to increase accessible and affordable housing

Several stakeholders indicated that federal programs, such as MFP and BIP, have been helpful for improving access to affordable and accessible housing. According to one national-level stakeholder federal opportunities like MFP, allowed flexible and creative use of funds to address other issues related to HCBS access, such as access to affordable housing, and these efforts can help ensure that individuals have access to safe and structurally sound community-based placements. One of the states used their MFP funds to partner with a housing consultant and state housing authorities to move individuals transitioning from facilities to the community up the waiting list for HUD affordable housing. Similarly, another study state has used MFP funds to enter several partnership arrangements with the housing finance and mortgage agencies to provide development incentives for developers to build or transform housing units that are specifically for MFP transitions or younger individuals with disabilities. In another study states, MFP participation has been leveraged to bring together social services, beneficiary advocates, and housing advocates to brainstorm ways of improving housing access.

Separate from the federal programs, one of the study states mentioned using incentives in the IRS low-income housing tax credit to set aside units for individuals with LTSS needs. This state also pointed out that if federal agencies, namely the US Department of Health and Human Services (HHS) and HUD, “truly want housing resources to go to people with disabilities,” one way to ensure this would be to review and address structural problems of

Federal and State Partnerships to Address Housing Challenges: Louisiana Permanent Supporting Housing Program

The Louisiana Permanent Supportive Housing (PSH) program was founded in 2005 as part of the LA Road Home plan after Hurricanes Katrina and Rita. Through partnerships among several state health and housing agencies as well as local service partners, and homeless and disability advocates, low-income individuals with disabilities can access rental subsidies as well as state plan rehabilitative services and Section 1915(c) waiver program services. The program also addresses rural housing challenges by increasing the number of tenant-based vouchers in the program and state-funding rental subsidies (Louisiana Department of Health, 2021).

According to an evaluation of the program in 2012, 58% of the households served were homeless or at risk of being homeless before being housed, and 95% of the households served remained in the program. The evaluation also determined a 24% reduction in average monthly Medicaid costs per person served in PSH households (TAC, 2012). As of 2017, the program had provided more than 3,500 individuals with housing and services (CHCS 2018).

the current housing voucher program “that channels those resources for people with disabilities.”

Opportunity: Use managed care programs to address housing challenges

In one case study state, officials and industry representatives discussed MLTSS plan contract requirements that focus on addressing housing challenges. The state contract requires the MLTSS plans to employ housing specialists to identify and locate housing options for members to move them back out into the community or to keep them in the community. The plan’s housing specialists develop established relationships with local housing authorities and low-income housing landlords so that the plan is notified directly when housing is available.

Managed care industry representatives also discussed how several states and MLTSS plans have developed programs that focus on providing more affordable and accessible housing. In Minnesota, the state has a housing stabilization services program where MLTSS plans pay for a variety of tenant services for older adults and people with disabilities (Minnesota Department of Human Services, 2021). Florida implemented a housing assistance waiver in collaboration with several managed care plans that targets Medicaid beneficiaries with behavioral health conditions

(Florida Agency for Health Care Administration, 2021).

MA supplemental benefits flexibilities could provide examples for MLTSS programs. The enactment of the Bipartisan Act of 2018 included the introduction of Special Supplemental Benefits for the Chronically Ill and new guidance issued by CMS that included a reinterpretation of “primarily health related.” These changes allow MA plans to cover a

wider array of extra benefits than previously allowed, and as of 2020, MA plans can cover benefits that target social determinants of health (CMS, 2019d). One managed care industry representative pointed out that the MA supplemental benefits flexibilities, which give MA plans the authority to pay for subsidies for rent, assisted living communities, and utilities, could be used as an example and way to develop Medicaid parameters where MLTSS plans could pay for some of those costs. The flexibilities do not, however, provide additional funding for the new supplemental benefits and value-add across plans has been small: the average value-add across MA plans and D-SNPs in 2018 was \$62 per D-SNP member per month (Rizer, 2018).

Opportunity: Develop alternative housing settings

One industry stakeholder offered that investing in the development of more residential care settings for Medicaid beneficiaries could create a community-based care option for individuals who are unable to care for themselves but could potentially receive care and services in the community. Although Medicaid does not pay for room and board in residential care settings, states can support Medicaid beneficiaries' access to residential care settings by using a variety of Medicaid authorities (e.g., Section 1915(c) HCBS waivers, Section 11115 demonstrations, HCBS state plan options) to pay for services in these settings. States can also implement policies that make room and board costs for Medicaid beneficiaries more affordable, such as offering monthly supplements to Supplemental Security Income or limiting the amount residential care settings can charge Medicaid beneficiaries for room and board (MACPAC, 2016). In another state, a beneficiary described a county-based organization that is implementing home-sharing as a housing option that provides hosting individuals with economic support and individuals in need of affordable housing with a placement.

3.2.5 LTSS Workforce Challenges

Persistent and growing LTSS workforce shortages are a primary barrier to increasing HCBS. All interviewees discussed workforce shortages across all long-term care settings and among different provider types (e.g., physical therapists, behavioral health, RNs), but emphasized unique challenges in recruiting and retaining direct care workers (e.g., home health aides, personal care aides, certified nursing assistants). Employed by HCBS provider agencies or, increasingly, through independent arrangements with beneficiaries and their families, direct care workers drive the delivery of home and community-based care, providing beneficiaries assistance with activities of daily living (ADLs) (e.g., eating, bathing, getting dressed, toileting, mobility).

Direct care workers providing HCBS typically receive low wages. National industry experts, state officials, beneficiary advocates, and provider representatives highlighted that direct care workers are compensated poorly, earning significantly less than the median wage for all U.S. workers (PHI, 2011). Contextualizing these realities, one representative from an HCBS provider organization shared, “Honestly, you can work at a Target, and you can take the bus to that Target and work an 8-hour shift, and you get paid more than you get paid as a home health aide.” As a result, turnover rates are high, and recruitment and retention of these workers is a persistent challenge.

Direct care workers often have difficulty getting to clients in the community. State officials from all five case study states, federal officials, representatives from provider associations (national and state-specific), and beneficiary advocates, highlighted challenges with transportation for HCBS providers. These providers, including direct care workers, are often responsible for their own transportation to and from the home and community settings where beneficiaries reside and are not compensated for travel times. State officials from all of the states mentioned that rural or more remote settings exacerbated challenges with transportation among providers. As one HCBS provider described, “I have nurses that go out on four wheelers to get [to] a client's home in some of the counties.”

A lack of data makes it difficult for states to understand the magnitude of their workforce needs. Access to state-specific data on the direct care workforce is crucial to understanding and addressing workforce challenges, according to industry experts. Specifically, states need access to comprehensive data on full versus part-time employment among direct care workers, as well as retention, turnover, and vacancy rates. However, a national HCBS provider advocate shared that one of the challenges of measuring statewide provider supply adequacy is that “most states don't collect data on direct care workers in a way that would allow us to measure whether there's enough workers to meet unmet need.” Additionally, states must understand the level of care needed for beneficiaries who may vary in the amount of support needed (i.e., 20-30 hours a week of services and supports versus 2-4 hours) to determine the magnitude of LTSS workforce shortages.

Direct Care Workforce Challenges Exacerbated in Rural Areas

Direct care workforce challenges exist in urban and rural settings alike. However, these challenges are exacerbated for HCBS providers and direct care workers operating in rural areas. Sparse in population and development, rural areas often lack the infrastructure (e.g., public transit systems, internet and/or broadband access for telehealth optionality, adequate labor supply) necessary to support direct care workers.

According to several state stakeholders, HCBS operators often cannot afford to reimburse or pay for their direct care staff to drive several hours into rural areas to service clients. Direct care employers often do not compensate employees for transportation, meaning workers are typically responsible for their own transportation time and costs.

Inadequate training may contribute to high rates of direct care worker turnover.

State stakeholders also emphasized improved training requirements as critical to preparing and maintaining the direct care workforce. Beneficiary advocates in one state noted that existing training requirements for direct care staff should be strengthened beyond what they considered to be checkbox training: cardiopulmonary resuscitation (CPR), first aid, nonviolent crisis intervention. Elaborating further, the advocate explained, “training requirements should be more because [HCBS operators] can say, ‘look, we trained because we did all that checkbox stuff,’ but there’s no requirement for that shadowing part, which for me is the most important part.” In other words, new direct care workers often lack in-the-field, hands-on training to adequately prepare them for working with beneficiaries.

ACL Innovations to Transform the Direct Support Professionals Workforce

In November 2020, ACL announced a new cash prize competition to incentivize solutions to strengthen the direct care workforce providing HCBS to individuals with ID/DD. *Blazing New Trails for Community-Based Direct Support Professionals* seeks to challenge the direct support professional industry to re-imagine how the direct care workforce is recruited, developed, and grown to ensure that individuals with disabilities have access to the services they need (ACL, 2021).

Beneficiary advocates as well as a national HCBS provider advocate shared that without proper training, direct care staff often feel unprepared and overwhelmed, contributing to the high turnover among direct care workers.

Interviewees discussed several opportunities to address workforce barriers.

Opportunity: Increase payment rates and incentives for workforce retention

Wage increases and added benefits, strengthened training supports, and non-wage incentives (e.g., loan forgiveness and tax credits) can help with recruiting and retaining staff. A provider

representative suggested that states could enhance wages for direct care staff through pass-through

provisions for Medicaid provider rates,¹⁵ whereby HCBS providers would be required to use a portion of their rates to increase staff wages. A managed care industry representative noted that one of the case study states required the increase in wages go to direct care staff but did not indicate whether the increased payment rates had affected direct care worker supply. Another state shared that during the PHE, they had implemented an HCBS provider rate increase to address workforce challenges. However, these rate increases did not result

¹⁵ Pass-through payments have historically been used to ensure funding for providers largely serving Medicaid beneficiaries. For additional information and discussion of pass-through payments, please see <https://us.milliman.com/en/insight/pass-through-payment-guidance-in-final-medicaid-managed-care-regulations-transitioning-to>.

in higher wages for direct care workers themselves, which diminished the state’s efforts to attract and retain direct care workers during the COVID-19 PHE. Beneficiary advocates in one state and a national HCBS provider representative suggested that more support is needed for HCBS agencies to develop training programs for direct care workers. Investing in direct care workers through additional training opportunities can address turnover rates by encouraging providers to consider their efforts as a career rather than a job. According to beneficiary advocates in one state, “Agencies are missing out on trying to build that bigger picture kind of thing of how important these jobs are, how vital you are in the life of another human being”. Another provider representative suggested states consider encouraging partnerships among high schools, providers, and other sponsors to help identify those students who may not be immediately college bound but rather may be interested in being trained to be certified nursing assistants, home health aides or food service workers.

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States can consider strategies specific to addressing workforce challenges in rural areas. A national HCBS provider advocacy organization recently launched rural workforce interventions in two states (Wisconsin and Minnesota), to experiment with scalable best practices for states to adopt. These interventions emphasize training (e.g., enhanced communication skills, dementia care competency) for direct care workers so that they may play a more expansive role in care. Additionally, these interventions explore ways to support HCBS infrastructure. For example, to address rural transportation challenges, provider organizations in Minnesota provided transportation vouchers to direct care workers, enabling them to reach clients in hard-to-reach places, while also ensuring that workers were not bearing the transportation cost. Workers using their own vehicles were compensated for travel-related expenses, such as gas and tolls. One of the case study states mentioned making some headway in getting certain HCBS providers out into rural areas through a rural rate incentive. However, the types of providers that have taken this up do not include certain much-needed providers, such as occupational therapists or physical therapists.

Opportunity: Leverage MLTSS Programs to Address Workforce Challenges

MLTSS plans and the state can address provider shortages through state contract requirements for provider network adequacy. State officials highlighted the opportunity for states to include in contracts with MLTSS plans requirements to ensure adequate provider networks and access to HCBS. Industry representatives also discussed

how MLTSS plans can help with training and retention of direct care workers. One industry representative discussed MLTSS plans working with HCBS providers to train and certify additional direct care workers. And in return, the MLTSS plan would encourage members to go to that provider by identifying them as a preferred provider. The industry representative also discussed using the MLTSS plans' care managers to work with HCBS providers to improve efficiencies of care. For example, a plan's care manager can work with a personal care attendant agency to connect the agency to a group of enrollees who live near each other and coordinate their schedules so one attendant can serve more than one member.

MLTSS programs can help address disparities in network adequacy between urban and rural areas. For example, an industry representative suggested states could set different network adequacy standards for urban versus rural areas, allowing payers to build networks that provide greater access to LTSS. And as some states consider increasing self-directed services¹⁶ as a strategy to address provider shortages in rural areas, an industry representative suggested that states should use distinct network adequacy standards that acknowledge and account for differences between agency-directed and self-directed attendant services. Increased beneficiary control (i.e., self-direction) can present benefits, but it also shifts control over resources and staffing, which creates challenges for network adequacy standards that assume an agency-directed model.

3.2.6 Limited Public Awareness and Understanding of HCBS Options

The medical community and many families' beliefs about where care should be provided for older adults impede rebalancing efforts. As one federal official noted, the hospital-to-nursing home pipeline is difficult to overcome, and the referral process to the nursing home is much easier than the multi-step process involved for HCBS referral and access. "It's easier to make a referral to a nursing home than it is to coordinate the community supports and services needed." Moreover, as one state official pointed out, nursing homes can accept a hospital patient immediately and then work on eligibility. Conversely, a beneficiary cannot start accessing community services until after the state has worked through the entire eligibility process and eligibility and a plan of care has been determined. One state beneficiary advocate mentioned that many families in the state need to better understand the community-based options available for older adults with LTSS needs. "I think people are continuing to wake up to the fact that there are options other

¹⁶ Under self-directed services, beneficiaries, or their representatives if applicable, can make decisions about waiver and state plan services and are responsible for managing those services. For more details, see: <https://www.medicaid.gov/medicaid/long-term-services-supports/self-directed-services/index.html>.

than just, if you get old, you need nursing home care, and I think that's a philosophical change that we've had ingrained in our society forever.”

Interviewees cited a possible opportunity to address the barrier created by the limited public awareness and understanding of HCBS options.

Opportunity: Support shifts in cultural norms and increase awareness among Medicaid beneficiaries and providers about HCBS options

Many of the stakeholders interviewed for this report believed that a combination of market forces, policy changes, and shifting cultural norms were beginning to change long-standing power dynamics in long-term care. Federal officials and beneficiary advocates acknowledged that societal expectations for where people access LTSS are changing. For example, a federal official highlighted that among parents of children living with disabilities, “we would be remiss in not mentioning that the expectation of parents, of children with disabilities...is much different today than it was, for instance, two decades ago. And their expectation is not institutionalization.” This shift is reinforced by state efforts to better inform LTSS consumers of their HCBS options, such as the previously mentioned effort in one state to promote an informed choice process among Medicaid beneficiaries accessing LTSS. Beneficiary advocacy stakeholders noted that educating beneficiaries and their family caregivers about their HCBS options not only promotes a cultural shift toward HCBS, but it also empowers these individuals to build relationships with state officials and advocate for their HCBS needs, thereby building up political influence of their own. Another national-level stakeholder believed that the nursing home industry’s deeply entrenched opposition to HCBS and transitioning people home is beginning to shift with the realization that both community-based care and managed care is the future of long-term care. The experiences during the COVID-19 pandemic may have also accelerated this shift in attitude.

4. Effects of COVID-19 on Rebalancing LTSS Efforts

The COVID-19 PHE has focused attention on Medicaid LTSS, including the beneficiaries with LTSS needs, the types of services offered, and how the services are delivered and financed. All stakeholders discussed how the pandemic has changed federal and state rebalancing LTSS efforts, and how adaptations to these efforts have provided opportunities to meet the needs of beneficiaries during the challenging time.

4.1 Momentum for Rebalancing Efforts Across States

The COVID-19 PHE highlighted several inefficiencies and challenges associated with providing care in institutional care settings and has provided motivation for states to increase efforts to rebalance their LTSS systems. As one national-level stakeholder said, “The pandemic has brought to light weaknesses in the HCBS system and in the nursing home infrastructure.” A beneficiary advocate mentioned that the pandemic has also helped bring awareness about HCBS options, and they had noticed an increasing number of individuals accessing them. “And then I think the third factor is just simply a greater awareness. And I think that to be blunt, I think the pandemic has helped a greater awareness of what are the inherent risks and challenges of all options.” Federal officials cited the pandemic as the main impetus for providing additional resources and support to states in efforts to rebalance their LTSS systems, including the CMS Long-Term Services and Supports Toolkit and the extension of the MFP program.

4.2 Negative Impacts Due to COVID-19 Pandemic

All stakeholders described the negative impact that the COVID-19 pandemic has had on beneficiaries and the state LTSS systems. Overall, institutionalized Medicaid beneficiaries interested in transitioning were limited in their ability to move back to the community due to COVID-19 restrictions.

Several challenges developed for the LTSS workforce, especially community-based direct care workers. State officials in one state mentioned that the pandemic exacerbated direct care worker shortages. An HCBS provider representative cited a study that showed that in the first three months of COVID-19, the direct care workforce contracted by 280,000 workers (Espinoza, 2020). State officials and HCBS provider representatives described how some HCBS agencies had trouble hiring direct care providers because the COVID-related stimulus relief and unemployment benefits were more than the Medicaid rates and what home care agencies pay direct care workers.

A national-level stakeholder noted that home care staff were particularly affected as many of the federal and state efforts to support providers did not include home care providers. “[Home care providers] were often kind of secondary, or not named at all in any kind of relief funding that was coming at the federal level and ultimately down [at] the state level;

that it was going to hospitals, to emergency care clinics, to nursing homes.” Managed care industry representatives and HCBS provider representatives noted that direct care workers—including professional and personal care attendants serving populations in the home and community—were not given priority access to personal protective equipment.

The nursing facility industry has experienced adverse financial effects. Several nursing facility industry representatives mentioned that occupancy rates have been much lower due to the pandemic. In February 2021, one industry representative estimated that the state’s nursing homes had been at 65% to 70% occupancy for the last 9 months. Nursing homes are not just faced with financial constraints due to declining census but also the tremendous cost associated with providing care for COVID-19 patients and keeping staff safe. One HCBS provider representative was concerned that nursing home closures may put pressure on HCBS to begin taking a large influx of individuals with nursing home level of care needs, but that community providers do not currently have the resources or capacity to take on that level of need.

Medicaid beneficiaries with LTSS needs have had increased access challenges. A beneficiary advocacy group noted that, in addition to the negative impacts of social isolation, beneficiaries were finding it difficult to access services due to regional office closures and state staff working from home. The closure of regional Medicaid offices and other social support offices had made it very difficult or impossible to submit applications for waiver services.

4.3 Temporary Flexibilities Enabled States to Support Further Rebalancing Efforts

Despite the overwhelming challenges associated with the pandemic, many of the interviewees noted that the pandemic has highlighted potential HCBS system innovations that could have positive effects on beneficiary access to HCBS. All of the case study states had applied for and received temporary flexibilities for HCBS waiver and state plan services. Stakeholders reported on which flexibilities had been most helpful in maintaining and expanding access to HCBS, including which flexibilities they thought should remain permanent.

Several stakeholders cited the expansion of telehealth services as key when serving Medicaid beneficiaries. Federal officials and provider representatives mentioned that using telehealth enabled providers to continue serving beneficiaries that needed care, and helped to combat social isolation among beneficiaries. One national-level stakeholder highlighted some particularly effective technological adaptations that adult day centers had implemented, such as the remote delivery of evidence-based health and wellness programs to Medicaid beneficiaries. Stakeholders also described how the use of telehealth technology expanded the reach of HCBS to those populations who were in rural settings or had trouble accessing HCBS. For example, two HCBS providers suggested that the use of technology

indicated that PACE could potentially be expanded to more rural areas or different populations that do not typically access adult day centers, like younger populations with disabilities. One state mentioned they were considering making certain flexibilities permanent around the telehealth activities, including eligibility and assessment processes to enroll beneficiaries.

Although many stakeholders welcomed the opportunities introduced by telehealth, some were cautious of its expanded use. One HCBS provider mentioned that although the ability to conduct virtual assessments and discuss care planning over the phone had been helpful during the pandemic, they did not plan to continue any virtual activities after the pandemic because it is more beneficial to see the clients. "You need to see the environment, you need to make sure that they're safe...I think that's great for COVID purposes, but it definitely, it would not be that policy outside of COVID for our agency." A managed care representative also noted that there were not as many standards for accessibility within telehealth, or even the ability for caregivers to participate in telehealth appointments. The representative noted that although continuing some telehealth flexibilities was valuable, there should be parameters implemented to ensure that the technology does not compromise beneficiaries' access or care.

Federal officials and national-level experts mentioned that the flexibilities to expand self-directed services and allow care from family members was helpful in addressing the direct care workforce shortage. One national-level expert observed that several states that did not have many self-direction options or allow family members to be paid caregivers before the pandemic had included those flexibilities during the PHE. Federal officials noted that support for states enhanced ability to pay family caregivers helped build up the capacity of the states' HCBS infrastructure and create more options for beneficiaries and their families. With appropriate training requirements and background checks, the federal officials thought states should consider supporting family caregivers through Medicaid authorities after the pandemic.

One state noted that the most effective temporary flexibilities included rate increases, hazard pay, and retention payments for HCBS providers. Federal officials also supported some of the flexibilities associated with HCBS payment, including retainer payments to home-based caregivers while a beneficiary is temporarily institutionalized, in quarantine, or otherwise unable to receive services on an ongoing basis due to COVID-19. The federal officials encouraged states that expanded the availability or duration of retainer payments during the PHE to incorporate these expansions into HCBS authorities on an ongoing basis to support HCBS recipients who may require short-term institutional stays related or unrelated to COVID-19.

Federal officials and several HCBS providers cited flexibilities in Medicaid rules that addressed provider capacity as helpful to increase access to care during the

PHE and that states could consider making permanent. Some of these flexibilities include Medicaid out-of-state provider enrollment and licensing reciprocity.

Federal officials highlighted state actions to allow for easier Medicaid application and enrollment as helping to improve access to HCBS. Some of the state actions have included time-limited self-attestation of income and assets, relaxation of resources limits, and the expansion of presumptive eligibility for older adults and individuals with a disability trying to access HCBS.

While HCBS providers were generally supportive of some of the training flexibilities, other interviewees noted that these flexibilities should not remain permanent because they may adversely impact beneficiary quality of care and safety. One HCBS provider cited the flexibilities that allow remote supervisory nurse visits for certified home health aides and annual skills competency evaluations as helpful and suggested that they be made permanent. HCBS provider representatives and federal officials both mentioned the relaxed training requirements for home care workers as policies that should end. Some states have waived required background checks, CPR and First Aid certification for caregivers through approved Appendix K waivers. CMS has also waived nurse aide training requirements in nursing facilities via Section 1135 waivers. As the HCBS provider representative observed, the relaxed training requirements may have been necessitated by the pandemic, but at “the cost of safety, skill, and quality.”

5. Future Considerations

The findings from this study highlight several barriers that states have encountered when trying to serve more beneficiaries with LTSS needs in the community. The study also presents several opportunities that require additional examination and research as the federal government and states consider next steps to addressing these barriers.

5.1 Money Follows the Person

Although almost all stakeholders acknowledged the critical importance of the MFP program for states' rebalancing efforts, several stakeholders raised concerns about the temporary nature and administrative requirements associated with the program. Further examination of areas where the MFP program can be updated, or where administrative requirements can be reduced, may encourage states to maintain their MFP programs and increase their rebalancing efforts. For example, one state official noted that the restrictions on where a beneficiary can transition back to in the community (e.g., not to residential care settings with more than four beds), can be a barrier to increasing the number of transitions from institutions.

The most recent funding extension of the MFP program contained updates to program eligibility criteria, such as a decrease in the number of days an individual must spend in an institution from 90 days to 60. Analysis of how this change has affected the number of successful transitions back to the community may provide further insight into how federal and state officials can develop and further support programs that encourage more transitions to the community. The research may also help inform the nature and parameters of a potentially permanent MFP program. Legislation was introduced in Congress on March 12, 2021, to amend the Deficit Reduction Act of 2005 and make the MFP demonstration permanent.¹⁷ The legislation is also responsive to stakeholder concerns regarding the temporary nature of the program.

5.2 Technical Assistance to States

States that have not made as much progress with rebalancing their LTSS systems may benefit from additional and targeted technical assistance to support expanding access to HCBS. As previously noted, states' experience with expanding access to HCBS varies, and the opportunities and available policy levers to rebalance LTSS systems may not be uniformly understood among states with lower levels of rebalancing that have the greatest potential to expand access to HCBS. Providing direct technical assistance to states could be an important adjunct to any additional federal investments in HCBS and would further encourage state rebalancing efforts and improve their capacities to expand access to HCBS.

¹⁷ See <https://www.congress.gov/bill/117th-congress/house-bill/1880/all-info>.

5.3 Nursing Facility Diversification

Nursing facility industry stakeholders discussed the opportunities for nursing facilities to diversify their services to offer HCBS. However, they identified federal and state policies that may impede the facilities from offering HCBS. For example, discussions with industry stakeholders highlighted that the HCBS settings rule deterred interested nursing facilities from offering HCBS, such as adult day services, at their facilities. Further consideration of these federal and state policies may determine opportunities for supporting nursing facilities in their diversification efforts to offer HCBS.

5.4 Testing Innovations in HCBS Care Service Delivery in Rural Areas

National-level experts noted that rural communities offer an opportunity for innovation in care delivery. Small nursing facilities can be one of the biggest employers in rural areas, and so there is a concern about the loss of jobs if more beneficiaries receive HCBS. However, because the barriers to increasing HCBS are more pronounced in rural settings, policymakers may consider offering targeted support (e.g., demonstration programs) to rural communities to test and encourage rural nursing facilities to provide alternative ways to deliver care in the community. For example, a demonstration program could test and support the nursing facility as a hub for LTSS in a rural area and offer HCBS such as adult day services, and the nursing facility staff could be trained to go out into the community to provide care.

5.5 Recruitment and Retention of Direct Care Workers

Several stakeholders noted that increased investments in the direct care workforce are needed to address barriers to increasing need for HCBS. Although some states had raised payment rates for HCBS providers, the payment rates overall were below other industries (e.g., retail, restaurants). An HCBS provider representative also noted that more data collection with better measures are needed to capture the experiences among these workers. Improvements in direct care workforce data collection and monitoring could include developing standard workforce data collection systems and including direct care workforce quality measures.

5.6 Effects of COVID-19 PHE

The flexibilities granted to states during the PHE will have long-lasting effects on how states, plans, and providers consider LTSS delivery and financing. Most recently, the newly passed federal COVID relief package included a provision to increase the federal matching rate (FMAP) for spending on Medicaid HCBS by 10 percentage points from April 1, 2021,

through March 31, 2022.¹⁸ This increase is in addition to the 6.2 percentage point temporary FMAP increase for most Medicaid services, including HCBS, provided to states under the Families First Coronavirus Response Act (P.L. 116-127).¹⁹ This increase States could potentially use the enhanced FMAP to support the HCBS provider workforce, offer new or expanded HCBS benefits, or increase the number of individuals receiving HCBS (Chidambaram & Musumeci, 2021). Additional examination of these flexibilities can determine whether they improved access to HCBS and whether quality of care was maintained. Policymakers could consider which flexibilities should be extended in the future and possibly made permanent.

¹⁸ The American Rescue Plan was signed into law on March 11, 2021. To receive the enhanced FMAP, states must maintain their level of spending as of April 1, 2021, and states are required to use their funds to “implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen” Medicaid HCBS. Full language of the bill may be accessed at: <https://www.congress.gov/bill/117th-congress/house-bill/1319/text>.

¹⁹ The Families First Coronavirus Response Act (P.L. 116-127) provides temporary enhanced FMAP for allowable Medicaid expenditures, which include expenditures defined in Section 1905(b) of the Act, that were incurred on or after January 1, 2020 and through the end of the quarter in which the COVID-19 PHE, including any extensions, ends (CMS, 2021c).

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Appendix A: Stakeholder Interviews

The authors would like to express our appreciation to the individuals from the following organizations who were willing to be interviewed and shared their time, expertise and valuable insights:

State Agencies

- Louisiana Department of Health
- Louisiana Office of Aging and Adult Services
- Mississippi Division of Medicaid
- Mississippi Department of Rehabilitation Services
- Mississippi Department of Mental Health
- New Jersey Division of Medical Assistance and Health
- New Jersey Aging Services
- North Dakota Medical Services Division
- North Dakota Adults and Aging Services
- West Virginia Bureau for Medical Services

Beneficiary Advocates

- Justice in Aging
- The Arc
- AARP Louisiana
- AARP Mississippi
- AARP North Dakota
- AARP West Virginia
- Disability Rights Mississippi
- Disability Rights West Virginia
- New Jersey Advocates for Aging Well

Home and Community-Based and Nursing Home Providers

- PHI National
- American Health Care Association
- Homecare Association of Louisiana
- Help at Home
- Homecare and Hospice Association of New Jersey
- Northland PACE
- Simplura Health Group
- Louisiana Nursing Home Association
- New Jersey Hospital Association

Managed Care Organizations

- National MLTSS Health Plan Association
- Horizon New Jersey Health

Additional Experts

- The Centers for Medicare & Medicaid Services
- Administration for Community Living
- ADvancing States