Bipartisan Policy Center

Written Testimony of Lisa Harootunian
Before the U.S. Senate Special Committee on Aging Hearing:
An Economy That Cares: The Importance of Home-Based Services
March 23, 2022

Good morning, Chairman Casey, Ranking Member Scott, and distinguished members of the committee. Thank you for inviting me to testify today about a bipartisan pathway to improve the availability of Medicaid home and community-based services (HCBS). I commend the committee for considering this critical issue through a bipartisan lens.

My name is Lisa Harootunian, and I am an associate director of the Health Program at the Bipartisan Policy Center, a non-profit organization that combines the best ideas from both parties to promote health, security, and opportunity for all Americans.[i] BPC drives principled and politically viable policy solutions through the power of rigorous analysis, painstaking negotiation, and aggressive advocacy.

Democrats and Republicans have historically supported efforts to expand Medicaid HCBS,[1] and Congress has made meaningful progress toward improving the availability of those services since the inception of the program; however, the need for these services persists and will continue to grow as 10,000 baby boomers turn age 65 each day until 2030, at which point the youngest of the generation will reach that age. In recent years, COVID-19 has exacerbated the need for home and community-based care options as an alternative to congregate care settings, which experienced high rates of infection and mortality. Additionally, for individuals with functional limitations or cognitive impairment, HCBS have long played a critical role in allowing Medicaid beneficiaries to live independently and to work.

To address the growing number of Americans who need assistance with daily activities, but who prefer to receive care in their home or community, continued bipartisan collaboration is necessary.

As described in BPC's report, *Streamlining and Simplifying Medicaid HCBS Authorities* (October 2021), Congress should consider a bipartisan pathway forward that would improve the administratively complex and piecemeal structure for HCBS authorities. To this end, **BPC**

[1] The Deficit Reduction Act of 2005 (DRA), for example, included provisions to create the 1915(i) state option to offer HCBS. The language was based on bipartisan legislation, S. 1602, the Long-Term Care Choices Act, sponsored by Sen. Chuck Grassley (R-IA) and co-sponsored by Sens. Evan Bayh (D-IN) and Hillary Rodham Clinton (D-NY). The Money Follows the Person Demonstration was also enacted as part of the DRA and was based on legislation introduced by Sen. Tom Harkin (D-IA), and was cosponsored by Republican Sens. Gordon Smith of Oregon and Mike DeWine of Ohio. The Balanced Budget Act of 1997 (BBA) included the PACE Coverage Act, which permanently established the PACE model under both Medicare and Medicaid. The PACE Coverage Act was introduced in the Senate by Sen. Chuck Grassley (R-IA), and originally co-sponsored by Sens. Bill Frist (R-TN), Daniel Inouye (D-HI), and Bob Graham (D-FL).

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

Historically, states have relied on 1915(c) waivers to provide HCBS, as these waivers allow states to target services to certain subpopulations and provide states with budget predictability. States often use multiple 1915(c) waivers–with each state using an average of five waivers and some states relying on up to 11 waivers at once–to target different populations or provide different services.[ii] States also provide HCBS through 1115 waivers and state plan options, including 1915(i), (j), and (k) state plan amendments.

The patchwork of HCBS waivers and state plan amendments that states use have led to three key barriers to the availability of Medicaid HCBS, including:

1. A system that is extremely complex and burdensome for states to administer;
2. HCBS programs that are challenging for beneficiaries to navigate; and
3. Inequities in access to HCBS both within and between states.

The use of multiple waivers or a combination of waivers and state plan amendments creates an enormously complex system for states to manage, because they must administer multiple programs and benefits packages with different eligibility and other requirements.

When beneficiaries seek HCBS, they must navigate the different sets of requirements to determine which program will provide the benefit package that best meets their needs. Beneficiaries often have several options to choose from, and some waivers may have waiting lists. Additionally, because of the targeting of services allowed under 1915(c), not all waivers provide the same benefits across the state or to all subpopulations. Multiple waivers and SPAs operating simultaneously create a challenging system for beneficiaries to navigate and in some cases could make it impossible for them to receive all necessary services through a single program.

The current structure of HCBS authorities encourages states to rely heavily on multiple waivers, which can lead to inequitable access to services within and between states. For example, two residents of a state may have similar diagnoses and HCBS needs but may not be eligible to receive the same services due to the geographic targeting allowed under 1915(c) waivers. Although all states offer HCBS, the services covered, access to those services, and spending varies significantly across states.

Simplifying and streamlining states' HCBS authorities by creating a single SPA would improve the availability of HCBS by reducing administrative complexity in the current system. This would reduce administrative burden for states administering HCBS programs, make it easier for beneficiaries to navigate the system, and help to address inequities in access to HCBS within and

between states. States could better design and administer their HCBS programs around the needs of the beneficiary, while also improving the beneficiary experience.

Streamlining and simplifying HCBS waivers and state plan options could be addressed independently, or as part of other efforts to reform the system.

Policy Recommendation: Simplify and Streamline Medicaid HCBS Authorities

Congress should establish a new consolidated SPA, combining existing state plan options and waivers. Current enrollees should be grandfathered to prevent a disruption in services.

The administrative complexity and inequities in the current system could be addressed by replacing the complex patchwork of state plan amendments and waivers with a single, consolidated state plan amendment that draws from authorities that exist under current law. Ideally, the SPA would provide necessary services to those in need and retain much of the flexibility of existing HCBS waiver and SPA authorities to give states budget predictability for HCBS. Transitioning waivers to an improved state plan option would promote administrative efficiency, make programs more accessible to beneficiaries, and improve equity in access to services.

Key Provisions

Congress should establish a new consolidated SPA that would combine existing authority from Medicaid state plan options, including 1915(i), (j), and (k), and Medicaid waivers, including 1915(c) and Section 1115 (except in limited circumstances). Congress should phase out existing authorities and require states to deliver HCBS through the new SPA within five years of enactment. Existing enrollees served under current HCBS authorities should be grandfathered to prevent a disruption in services. Under this approach, the HHS secretary would develop a template for the consolidated SPA that states would use to address eligibility, benefits, and projected enrollment.

Eligibility: The new consolidated SPA would maintain current income eligibility rules and flexibilities. Similar to rules governing section 1915(i) SPAs, states could cover individuals with incomes up to 300% of SSI, or about 221% of the federal poverty level (FPL). States would provide an estimate of the number of eligible individuals based on state-established criteria, and could modify the needs-based criteria if enrollment exceeds projections. States could provide HCBS to beneficiaries before their conditions meet an institutional level of care standard, and that earlier access could delay or avoid more costly care.

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

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

comparability or amount, scope, and duration of services standards; however, states must continue to comply with federal nondiscrimination rules and the HHS secretary should establish and enforce protections against discrimination.

Maintenance of Effort: As discussed in more detail below, to receive an enhanced administrative match under the consolidated SPA, states must comply with a maintenance-of-effort requirement for HCBS eligibility and benefit standards.

Spousal Impoverishment Protections: When simplifying and streamlining HCBS authorities into a single SPA, Congress should permanently authorize the state option to extend protection against impoverishment for spouses of individuals receiving Medicaid HCBS.

Enhanced Match and Payment for Services

Enhanced Administrative Match: States that comply with a maintenance-of-effort requirement for HCBS eligibility and benefit standards would be eligible for an enhanced administrative match for activities related to streamlined eligibility and enrollment functions, such as those typically performed by states' "No Wrong Door" system, as well as for ombudsman activities and infrastructure development.

Additional Enhanced Administrative Match for HCBS Quality Reporting: Congress should direct the secretary of HHS to develop recommended core and supplemental sets to measure HCBS quality.[2] States that choose to measure and report on an approved set of HCBS quality measures would be eligible to receive an additional 1% Federal Medical Assistance Percentage (FMAP) increase beyond the enhanced administrative match.

Maintaining Existing Initiatives: The 6% enhanced FMAP for 1915(k) and the enhanced FMAP available for the Money Follows the Person (MFP) demonstration would extend to the consolidated SPA. The MFP demonstration would be permanently reauthorized. Under current law, states can also receive a 90% enhanced FMAP for integration and coordination of services for eight quarters through the Medicaid Health Homes model. This should continue under the consolidated SPA.

The Need for Bipartisan Action

The growing need for HCBS, coupled with the impact of COVID-19 on congregate settings and individuals' preferences to receive care in the home or community, has brought national attention to the need for HCBS reform. BPC's recommendation to simplify and streamline Medicaid HCBS waivers and SPAs offers a bipartisan pathway toward improving the availability of Medicaid HCBS. BPC believes streamlining HCBS into a single state plan option strikes a balance between simplifying administrative complexity and providing states with budget

[2] CMS is considering establishing a nationally available set of recommended Medicaid HCBS quality measures; in September 2020, CMS sought public feedback on a draft for a voluntary set of HCBS quality measures. Congressional action would ensure continued progress toward a nationally available set of quality measures for HCBS care delivery.

predictability, while helping to advance the goal of expanding access to services and improving the beneficiary experience.

Critical to the success of this effort will be ensuring that states receive comprehensive guidance and technical assistance from CMS to support transition to a consolidated SPA, and to ensure clarity around the flexibilities and characteristics of the new authority. This should be implemented in close coordination with states and other stakeholders.

Thank you once again to the Committee for convening this hearing. The enormously complex HCBS system remains a challenge to the availability of home and community-based services, but with your continued leadership and bipartisan collaboration, we can help more Americans access the critical services they need to live independently and to work. I look forward to your questions.

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[i] www.bipartisanpolicy.org.

[ii] MaryBeth Musumeci, Molly O'Malley Watts, and Priya Chidambaram, "Issue Brief: Key State Policy Choices About Medicaid Home and Community-Based Services," Kaiser Family Foundation, February 2020, 37. Available at: http://files.kff.org/attachment/Issue-Brief-Key-State-Policy-Choices-About-Medicaid-Home-and-Community-Based-Services.