



Long-Term Services and Supports Rebalancing Toolkit



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Intent of the Long-Term Services and Supports Rebalancing Toolkit

The Centers for Medicare & Medicaid Services (CMS) recognizes that states are working hard to ensure that individuals eligible for long-term services and supports (LTSS) receive high quality and cost-effective person-centered care that is consistent with the individual's needs and wishes and that promotes access to services in home and community-based settings. As the primary funder of LTSS nationally, Medicaid can play an important role in supporting states' efforts with LTSS rebalancing, which is commonly defined as achieving a more equitable balance between the share of spending and use of services and supports delivered in home and community-based settings relative to institutional care.

About this toolkit

Purpose: Provide background information, resources, and promising practices that support state efforts to rebalance Medicaid long-term services and supports (LTSS) in favor of home- and community-based services (HCBS)

Audience: State Medicaid agency staff

Contents:

- Module I: Background
- Module II: Advancing state HCBS rebalancing strategies
- Module III: Current flexibility under Medicaid to support state rebalancing strategies
- Module IV: State strategies to rebalance LTSS systems

CMS remains steadfast in its commitment to ensuring that states have the necessary tools to design, implement, and advance LTSS system reform. This LTSS Rebalancing Toolkit is intended to support states in their efforts to expand and enhance home and community-based services (HCBS) and to rebalance, or recalibrate, LTSS systems from institutional to community-based care. The toolkit identifies examples of innovative state models and best practices for strengthening state infrastructure to increase transitions from institutional settings to community-based settings, divert institutionalization, facilitate interaction of long-term care provider markets and states' Medicaid policies, and improve community living for individuals eligible for Medicaid HCBS.

The toolkit contains four modules that can each serve as an independent document. The toolkit provides:

- State strategies to increase the share of LTSS provided in community-based settings;
- Tools designed to assist states with policy and programmatic strategies;
- Case studies of innovative programs and creative ways states are leveraging available federal authorities to transform LTSS systems; and
- Links to relevant resources.

Additionally, the toolkit provides examples of state LTSS reform strategies that may be replicable, in whole or in part, and highlights opportunities for cross-system and community-wide collaboration that states can pursue to advance LTSS reform. Please note that references and links to external documents and resources are provided for informational purposes only and do not constitute CMS endorsement of the information included in the documents and resources. CMS is not responsible for the accuracy of the information included in external documents and resources.

This toolkit is intended to help states regardless of where they are in the evolution of rebalancing their LTSS systems. States with high-achieving rebalancing programs and strong HCBS systems may have new considerations in light of the COVID-19 public health emergency that call for more novel approaches for restructuring long-term care facilities and systems. States taking more incremental steps towards rebalancing their LTSS systems may look for ways to accelerate reform and more rapidly modernize the delivery of HCBS. States continue to be at the forefront of innovation in designing new models for the delivery and financing of LTSS. This toolkit is designed to support states to advance those efforts.

As part of the state-federal partnership in administering the Medicaid and CHIP programs, CMS issues guidance in the form of letters to State Medicaid Directors, Informational Bulletins, and Frequently Asked Questions to communicate with states and other stakeholders. Readers of this toolkit are encouraged to frequently visit Medicaid.gov <https://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html> to keep updated on federal legislation, regulations, and policies and to obtain more comprehensive information on many of the HCBS system concepts and provisions identified in this toolkit.

Module I: Background

Long-term services and supports (LTSS) enable millions of Americans, including children, individuals with disabilities, and older adults, to have their care needs met in a variety of settings. Medicaid is the single largest payer of LTSS and can cover a continuum of LTSS, ranging from institutional care, such as in nursing facilities, to home and community-based services (HCBS). The Centers for Medicare & Medicaid Services (CMS) is committed to supporting states with strengthening and enhancing their LTSS systems and helping to ensure that Medicaid beneficiaries receive high quality, cost-effective, person-centered services in the setting of their choice.

Contents of Module I:

- Description of HCBS and institutional services
 - Timeline of selected LTSS rebalancing legislative and program actions
 - Overview of LTSS rebalancing trends
 - Demographic trends for LTSS users
 - Nursing facility trends
 - Helpful resources on these topics
-

From the beginning of the Medicaid program in 1965, states were required to provide medically necessary nursing facility care for most eligible individuals, but coverage for HCBS was generally not included.¹ However, over the past several decades, states have used several federal authorities,² as well as federally funded grant programs,³ to develop a broad range of HCBS to provide alternatives to institutionalization for eligible Medicaid beneficiaries. Consistent with many beneficiaries' preferences of where they would like to receive their care, HCBS have become a critical component of the Medicaid program and are part of a larger framework of progress toward community integration of older adults and individuals with disabilities that spans efforts across the federal government.

Medicaid LTSS assist eligible individuals in improving or maintaining an optimal level of functioning and quality of life and can include help from other people and special equipment or assistive devices. LTSS, whether provided through HCBS in the community or in institutional settings, are essential to the health and well-being of Medicaid beneficiaries with limitations in performing daily activities. Figure I.1 compares HCBS to institutional services.

While rebalancing LTSS systems has been a long-standing priority in Medicaid, the COVID-19 public health emergency (PHE) has accelerated state interest and efforts in promoting the use of HCBS over institutional services. States are engaged in strengthening their HCBS programs, improving access to coverage and care, and safeguarding financial stability for HCBS providers to maintain access to services during the PHE.⁴

Figure I.1. Key features of HCBS and institutional services

	 Institutional services	 Home and community-based services
Do all states cover the service?	Yes (Mandatory benefit)	No (Optional services)
Where are services provided?*	<ul style="list-style-type: none"> • NFs • Hospitals • ICFs/IID • Other medical institutions 	<ul style="list-style-type: none"> • Home • Other integrated community-based settings that exclude coverage of room and board*
What services are provided?	<ul style="list-style-type: none"> • Hospital services • NF services • ICFs/IID • Inpatient psychiatric services for people age <21 or 65+ in an IMD 	<ul style="list-style-type: none"> • Case management services • Homemaker services • Home health aide services • Personal care services • Adult day health services • Habilitation services • Respite care services • Day treatment or other partial hospitalization services, psychosocial rehabilitation services and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness • Other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization**

*Exceptions to the exclusion of Federal Financial Participation (FFP) for room and board are found at section 1915(c)(1) of the Social Security Act and 42 C.F.R. section 441.310(a)(2). HCBS settings must comply with the 2014 HCBS Settings Rule. More information is available at: <https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html>

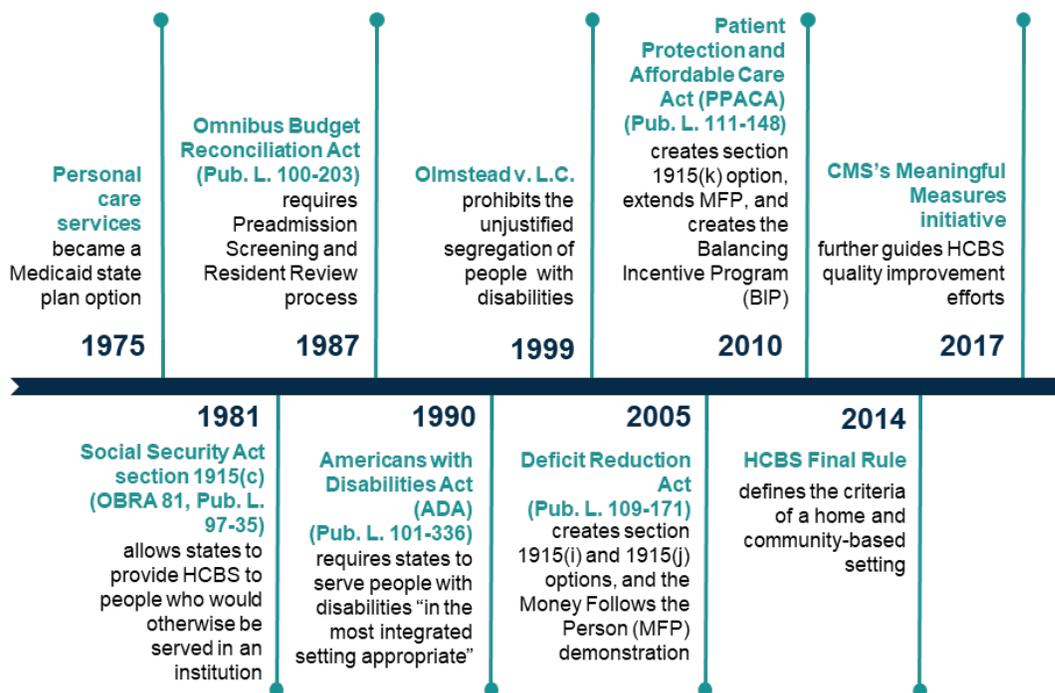
**42 C.F.R. section 440.180(b)(9)

Acronyms: ICFs/IID = intermediate care facilities for individuals with intellectual disabilities; IMD = institution for mental diseases; LTC = long-term care; NF = nursing facility

Timeline of Selected LTSS Rebalancing Legislative and Program Actions

Over the course of the last several decades, numerous federal incentives, legislative amendments, and new Medicaid coverage authorities have been enacted and implemented to support states with rebalancing LTSS systems. States have leveraged these opportunities to pursue both incremental and, for some states, comprehensive strategies to rebalance their LTSS systems. Over the past 40 years, a number of legislative and policy changes have worked to significantly increase the use and quality of HCBS (Figure I.2).

Figure I.2: Timeline of Selected LTSS Rebalancing Legislative and Program Actions



Major changes to HCBS include the following:

- When Medicaid first offered the option of providing personal care services (PCS) in 1975, services were limited in scope and had a medical orientation. Over the course of the last 40 years, regulatory changes broadened the scope of PCS to allow for services to be rendered in an individual's home and community. Spending on PCS, like spending on HCBS services generally, is an increasing portion of Medicaid spending.



See Module II for more on:

- HCBS quality measurement



See Module III for more on:

- Medicaid coverage of HCBS
- Section 1915(c) waiver programs
- The MFP demonstration
- Section 1915(i), 1915(j), and 1915(k) state plan benefits

- In 1981, the [Social Security Act \(the Act\)](#) was amended to provide authority under [section 1915\(c\) of the Act](#) for the Secretary to waive certain provisions of the Medicaid statute to allow states to provide HCBS to eligible individuals who would otherwise require institutional services, including adults with physical disabilities, individuals with HIV/AIDS, children experiencing a variety of disabling conditions, and individuals with serious mental illness, among others.
- The [Omnibus Budget Reconciliation Act of 1987](#) required state Medicaid programs to implement a [Pre-Admission Screening and Resident Review \(PASRR\)](#) process, which required all applicants to and residents of Medicaid-certified nursing facilities (NFs) to be screened for mental illness (MI) and intellectual disability (ID) and, if necessary, be provided specialized services while in the NF.
- The [Americans with Disabilities Act \(ADA\)](#) clarified that the “Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals.”
- In [Olmstead v. L.C., 527 U.S. 581](#), the Supreme Court held that Title II of the ADA prohibits the unjustified segregation of individuals with disabilities, and public entities are required to provide community-based services to persons with disabilities when (1) such services are appropriate; (2) the affected persons do not oppose community-based treatment; and (3) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services from the entity.
- The Deficit Reduction Act (DRA) of 2005 offered new opportunities for states to advance rebalancing strategies with the creation of two state plan options under sections 1915(i) and (j) of the Act, as well as the [Money Follows the Person Rebalancing Demonstration \(MFP\)](#).
 - [Section 1915\(i\) of the Act](#) provides states the ability to furnish HCBS to individuals who require less than an institutional level of care (LOC) but who meet specified needs-based criteria and who would otherwise not be eligible for HCBS under section 1915(c) waivers.
 - [Section 1915\(j\) of the Act](#) built upon the successes of the [Cash & Counseling Demonstration and Evaluation](#) that began in the late 1990s, allowing states to offer participants the ability to self-direct either state plan personal care services or state selected section 1915(c) waiver services without needing the authority of a section 1115 demonstration project.
 - With the history and strength of the [Real Choice Systems Change grants](#) as a foundation, which provided states with resources for administrative, program, financial, and regulatory infrastructure to increase community service provision, MFP assisted states in their efforts to reduce reliance on institutional care while developing community-based long-term care opportunities for individuals transitioning from institutional settings to homes in the community.

- With the passage of the [Patient Protection and Affordable Care Act \(PPACA\) of 2010](#), [section 1915\(k\) of the Act \(Community First Choice\)](#) was added, offering increased federal matching funds for the provision of statewide home and community-based attendant services and transition supports. The PPACA also extended [MFP](#), enhanced the [section 1915\(i\) state plan benefit](#), and established the [Balancing Incentive Program](#), which provided financial incentives in the form of enhanced federal reimbursement to states to increase access to non-institutional LTSS.
- CMS issued [final regulations](#) for section 1915(c), as well as section 1915(i) HCBS and section 1915(k) Community First Choice state plan authorities, in 2014, to ensure that services provided under these HCBS authorities are truly home and community-based. The regulations outline the criteria for residential and non-residential home and community-based settings. The principle of community integration, and the requirement that coverage of HCBS is based on person-centered service plans that outline how individuals wish to exercise choices, are at the heart of the home and community-based settings criteria.
- CMS’s comprehensive quality initiative “[Meaningful Measures](#)” was launched in 2017 and identifies high priority areas for quality measurement and improvement. Its purpose is to improve outcomes for individuals, their families, and providers while also reducing burden on clinicians and providers.

Helpful Resources

States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal guidelines. Federal law requires states to provide certain [mandatory benefits and allows states the choice of covering other optional benefits](#). CMS is working in partnership with states, consumers and advocates, providers, and other stakeholders to create a sustainable, person-driven [LTSS system](#) in which people with disabilities and chronic conditions have choice, control, and access to a full array of quality services that assure optimal outcomes, such as independence, health, and quality of life. This system includes both [institutional long-term care](#) and [HCBS](#).

For background information on LTSS and HCBS, see:

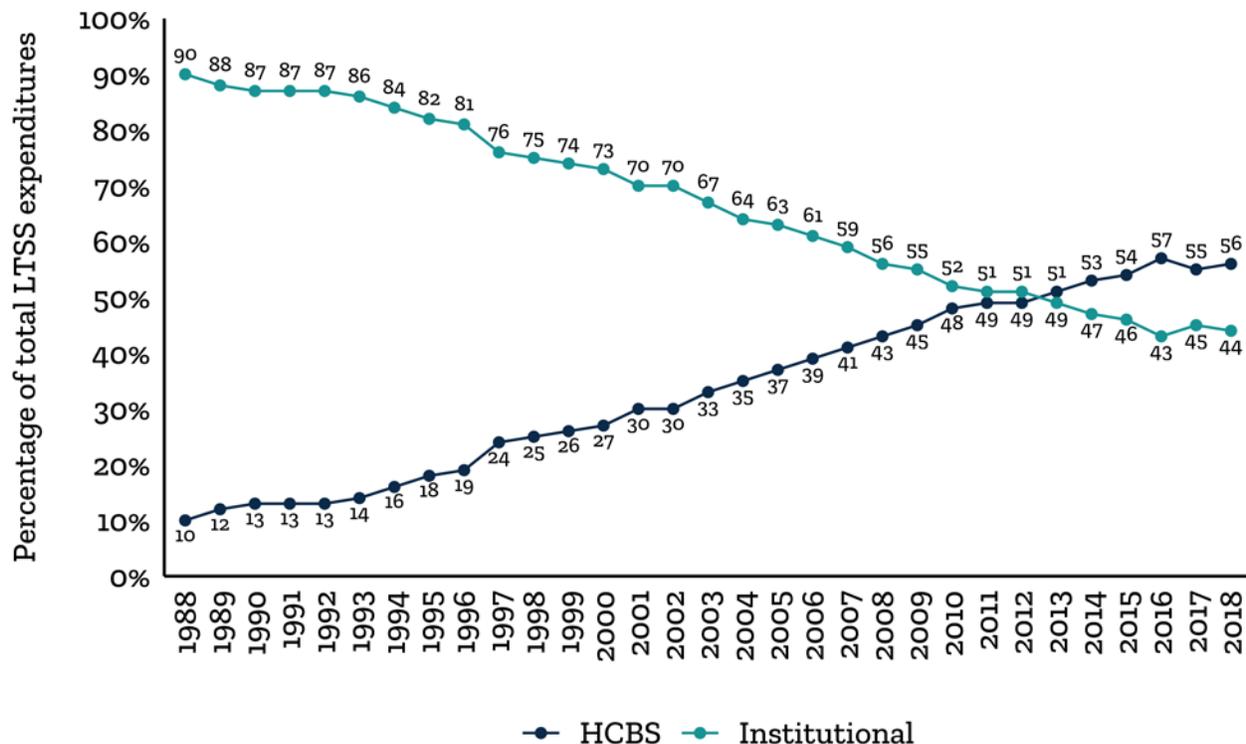
- Office of the Assistant Secretary for Planning and Evaluation (ASPE): An overview of Long Term Services and Supports and Medicaid (May, 2018) <https://aspe.hhs.gov/basic-report/overview-long-term-services-and-supports-and-medicaid-final-report>.
- Medicaid and CHIP Payment and Access Commission (MACPAC): Home and Community Based Services <https://www.macpac.gov/subtopic/home-and-community-based-services/> and
- MACPAC Long Term Services and Supports <https://www.macpac.gov/topics/long-term-services-and-supports>.

Medicaid LTSS Rebalancing Trends

Historically, Medicaid reimbursement for LTSS was primarily spent on institutional care, with very little spending for HCBS. The percentage of HCBS expenditures of total Medicaid LTSS expenditures has steadily increased over the last three decades, but it has slowed in recent years.

The U.S. total surpassed the long-standing benchmark of 50 percent of LTSS expenditures in FY 2013 and has remained higher than 50 percent since then, reaching 55.4 percent in FY 2017 and 56.1 percent in FY 2018. HCBS represented a majority of LTSS expenditures in 29 states, including the District of Columbia, and over 75 percent of expenditures in five states in FY 2018.⁵

Figure I.3. Medicaid HCBS and institutional LTSS expenditures as a percentage of total Medicaid LTSS expenditures, FY 1988 to 2018



Source: Forthcoming report on LTSS expenditures.

Data do not include LTSS within a large California managed care program for FY 2014 to 2016, expenditures through managed care plans before FY 2008, or for certain states and program authorities starting in FY 2008. California, Illinois, New York, North Carolina, and Virginia were excluded from FY 2017 and 2018 calculations because of missing data.

Variation in HCBS spending exists by population. In FY 2018, HCBS spending reflected that:

- 79 percent of total LTSS spending for individuals with intellectual and developmental disabilities (I/DD) was dedicated to HCBS;
- 33 percent was spent on HCBS for older adults and individuals with physical disabilities; and
- 49 percent of Medicaid LTSS spending for individuals with mental health and substance use disorders was for HCBS.⁶

Furthermore, rebalancing LTSS from institutional care toward HCBS reflects beneficiary preferences to receive LTSS in home and community-based settings. According to the AARP

2018 Home and Community Preferences: A National Survey of Adults Ages 18-Plus, 76 percent of Americans age 50 and older say they prefer to remain in their current residences and 77 percent would like to live in their communities as long as possible. Moreover, nearly 90 percent of adults 65 and older would prefer to “age in place,” or to receive care at home and in their communities as they age.⁷

Helpful Resources on LTSS Expenditures

- [Long-term Services and Supports: Reports and Evaluations](#) include Medicaid expenditures for all LTSS, including institutional services and HCBS, by service category and state.
- [Improving the Balance: The Evolution of Long Term Services and Supports, FY 1981-2014](#) uses state Medicaid expenditure data from federal fiscal years 1981 through 2014 to document changes to Medicaid LTSS delivery. A review of the program data by service type, for population subgroups, and for states with the highest percentage of LTSS expenditures for HCBS revealed that three factors were critical to Medicaid’s trend towards HCBS: sustained growth in section 1915(c) waiver programs and new HCBS programs, improved HCBS data reporting, and the stabilization of nursing facility spending since fiscal year 2002.
- [Medicaid Expenditures for Long-Term Services and Supports in FY 2016](#) is part of a series of annual reports on Medicaid LTSS expenditures. The series documents trends such as the increasing role of HCBS and the continued, significant variation in Medicaid LTSS spending across states. This report presents data for FY 2016, as well as updates for FY 2013 through 2015 that incorporate adjustments reported by states for those years.
- [Long-Term Services and Supports Expenditures on Home & Community-Based Services](#) shows expenditures on HCBS as a percent of total LTSS spending by state.
- [Medicaid Home- and Community-Based Services: Characteristics and Spending of High-Cost Users](#) examines high cost HCBS users in 44 states in 2012.

LTSS Demographic Trends

Although people of all ages may need LTSS, the risk of needing these services increases with age. Recent research indicates:

- Seventy percent of adults who survive to age 65 develop severe LTSS needs before they die.
- Fifty-four percent of people who survive to age 85 receive some paid LTSS and 34 percent will receive long-term nursing home care.⁸

The number of adults age 65 and older is expected to more than double in size between 2014 and 2060, with the largest increase expected from 2020 to 2030. By 2030, one in five U.S. residents will be age 65 or older.⁹ The number of adults age 85 or older will grow the fastest over the next few decades, constituting 4 percent of the population by 2050, or 10 times its share in 1950.¹⁰ The number of older adults in the United States with significant



Future trends

The group of people needing LTSS is:

- Growing in size
- Advancing in age
- Often rural
- Increasingly diverse

physical or cognitive disabilities is projected to increase from 6.3 million in 2015 to 15.7 million in 2065.¹¹

Approximately 60 million people live in rural areas across the United States, including millions of Medicare and Medicaid beneficiaries.¹² Nineteen percent of the rural population is 65 years or older, compared with 15 percent in urban areas. Rural counties make up nearly 85 percent of the 1,104 “older-age counties”—those with more than 20 percent of their population age 65 or older.¹³

Furthermore, the older adult population is growing more racially and ethnically diverse. From 2015 to 2050, non-White older populations—Hispanic, Black, and other non-Hispanic (including Asian, Pacific Islander, Native American, and other races)—are projected to increase much more rapidly than the White older population.¹⁴

The population of individuals with I/DD is also expected to grow. Life expectancy among individuals with I/DD is increasing. Adults with mild or moderate I/DD may live into their seventies and individuals with more severe I/DD are expected to live into their mid-50s.¹⁵

Between 2013 and 2018, Medicaid expansion increased Medicaid enrollment by about 32.6 percent, largely attributed to the adult group authorized in the Patient Protection and Affordable Care Act (PPACA).¹⁶ As of August 2020, 38 states and the District of Columbia have chosen to adopt the adult group¹⁷ including many individuals with complex medical and social conditions who may benefit from HCBS:

- Individuals experiencing or at risk of experiencing homelessness;
- Individuals with mental health and/or substance use disorders;
- Youth transitioning out of foster care; and
- Individuals transitioning from incarceration to their communities.

As states plan, design, and implement rebalancing strategies, projected increases in both the aging population and diversity of LTSS populations will become especially relevant. States are encouraged to consider:

- Ensuring effective cultural competency and accessibility practices for outreach, assessment, care planning, and service delivery;
- Proactive approaches to projecting aging and racial/ethnic demographic trends and access to HCBS;
- Attentiveness to demographic trends and access to HCBS in rural areas; and
- Designing benefit programs that support individuals with complex social and medical conditions to help individuals to remain in the community and avoid unnecessary institutionalization.

Helpful Resources on Demographic Trends

- [Explore Census Data](#) provides a set of high-level statistics by state, county, or place regarding people and population, race and ethnicity, families and living arrangements, health, education, business and economy, employment, housing, and income and poverty.
- [Disability & Health U.S. State Profile Data: Adults 18+ years of age](#) fact sheets provide an overview of disability in each state compared to national estimates. This information can be used to learn more about the percentages and characteristics of adults with disabilities in each state.
- [2016 Older Americans Key Indicators of Well-Being](#) is a report of the Federal Interagency Forum on Aging-Related Statistics, a forum founded in 1986 to foster collaboration among federal agencies that produce or use statistical data on older adults. The report provides a comprehensive, easy-to-understand picture of older adults by offering a compendium of indicators categorized into six broad groups: population, economics, health status, health risks and behaviors, health care, and environment.
- [United States Department of Agriculture, Economic Research Service](#) (ERS) tracks demographic change in non-metro areas and conducts research to help explain the relationship between population change and the socioeconomic well-being of rural and small-town residents. ERS also provides annual statistics in its [County-level Datasets: Population](#), and state-level (rural/urban) summaries in its [State Fact Sheets](#). A summary of rural population topics (among other rural issues) is found in the *Rural America at a Glance* series, updated in the fall each year. See the latest report in the series, [Rural America at a Glance, 2019 Edition](#).
- [Profile of Older Americans](#) is published annually by the [Administration on Community Living](#), an operating division of the U.S. Department of Health and Human Services. The report incorporates the latest data available on individuals over age 65. Principal sources of data for the Profile are the U.S. Census Bureau, the National Center for Health Statistics, and the Bureau of Labor Statistics.

Nursing Facility Trends

Recent research and data indicate several new trends in the long-term care facility industry that may impact state rebalancing strategies. As of 2016 in the United States, there were an estimated 15,600 nursing facilities with a total of 1,660,400 Medicare and Medicaid certified beds.¹⁸ Approximately 61.8 percent of nursing facility residents used Medicaid as a payer source.¹⁹ Recent trends indicate that nursing facility occupancy rates are declining, and nursing facility closures are increasing. According to a 2020 *Leading Age*²⁰ study:

- More than 550 nursing homes have closed since June 2015;
- Occupancy has decreased by almost two percentage points over four years; and
- In several states, nursing home closures are concentrated in rural areas.²¹

Helpful Resources on Nursing Facility Trends

- [Across the States: Profiles of Long-term Services and Supports](#) provides comparable state data, rankings, and national averages on age demographics and projections, living arrangements, income and poverty, disability rates, costs of care, private long-term insurance, Medicaid LTSS, family caregivers, HCBS, and nursing facilities.
- [Toolkit on State Actions to Mitigate COVID-19 Prevalence in Nursing Homes](#) is a compilation of actions employed by organizations, including state governments, in the United States and territories to assist nursing homes in meeting the needs of nursing home residents since the onset of the COVID-19 pandemic.

Key Considerations for States

- Rebalancing can be a long process, and often involves incremental steps to develop the infrastructure and sustainable financing to shift LTSS expenditures from institutional spending to HCBS.
- Leveraging federal funding opportunities designed to advance LTSS system reform can facilitate new opportunities to accelerate reform and to recalibrate existing systems.
- Changing demographics are likely to affect the demand for LTSS in the future, and subsequently Medicaid utilization and expenditures.
- Facilitating innovative long-term care facility restructuring to address challenging industry trends can support new opportunities and more creative ways to provide high quality, person-centered care.

Endnotes

- ¹ Wenzlow, Audra, Steve Eiken and Kate Sredl. 2016. Improving the Balance: The Evolution of Medicaid Expenditures for Long-Term Services and Supports (LTSS), FY 1981-2014. Retrieved from <https://www.medicaid.gov/sites/default/files/2019-12/evolution-ltss-expenditures.pdf>.
- ² These authorities include Medicaid state plan personal care services under section 1905(a) of the Social Security Act (the Act) and section 1915(c) waivers, section 1915(i) state plan HCBS, section 1915(j) self-directed personal assistant services, and section 1915(k) Community First Choice. See <https://www.medicaid.gov/medicaid/home-community-based-services/index.html> for more information on these authorities. Some states also use demonstration authority under section 1115(a) of the Act to test home and community-based service strategies. See <https://www.medicaid.gov/medicaid/section-1115-demonstrations/index.html> for more information.
- ³ Federally funded grant programs, such as the Money Follows the Person demonstration, which was initially authorized by the Deficit Reduction Act of 2005 and continues to operate in 43 states, and the Balancing Incentive Program, which provided financial incentives for four years (FY 2011-2015) to 13 states to increase access to HCBS, were designed to shift Medicaid's long-term care spending from institutional care to HCBS.
- ⁴ Additional flexibilities are available to states during PHEs and in response to natural and manmade disasters. See <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html> for guidance, resources, and other information available to states during the COVID-19 PHE, including in the provision of HCBS. See <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/index.html> and <https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/EPRO-Home> for guidance, information, and other resources related to PHEs, natural disasters, and manmade disasters, generally.
- ⁵ Forthcoming report on LTSS expenditures
- ⁶ Ibid.
- ⁷ 2018 Home and Community Preferences: A National Survey of Adults Ages 18-Plus, AARP. [https://www.aarp.org/research/topics/community/info-2018/2018-home-community-preference.html#:~:text=The%20AARP%20survey%20finds%20many,aging%20in%20place%20\(56%25\).](https://www.aarp.org/research/topics/community/info-2018/2018-home-community-preference.html#:~:text=The%20AARP%20survey%20finds%20many,aging%20in%20place%20(56%25).)
- ⁸ What is the Lifetime Risk of Needing and Receiving Long-Term Services and Supports? ASPE. April 2019. <https://aspe.hhs.gov/pdf-report/what-lifetime-risk-needing-and-receiving-long-term-services-and-supports>
- ⁹ Colby, Sandra L. and Jennifer M. Ortman, Projections of the Size and Composition of the U.S. Population: 2014 to 2060, Current Population Reports, P25-1143, U.S. Census Bureau, Washington, DC, 2014
- ¹⁰ <https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44363-ltc.pdf>
- ¹¹ Favreault M, Dey J. Long-term services and supports for older Americans: Risks and financing. ASPE Research Brief. 2016. Available from: <https://aspe.hhs.gov/system/files/pdf/106211/ElderLTCrb-rev.pdf>
- ¹² CMS Rural Health Strategy. <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf>
- ¹³ Rural America at a Glance <https://www.ers.usda.gov/webdocs/publications/90556/eib-200.pdf?v=8777.1>
- ¹⁴ <https://www.aarp.org/content/dam/aarp/ppi/2018/08/across-the-states-profiles-of-long-term-services-and-supports-full-report.pdf>
- ¹⁵ Lauer, E., McCallion, P, Mortality of People with Intellectual and Developmental Disabilities from Select US State Disability Service Systems and Medical Claims Data, September 2015. Journal of Applied Research in Intellectual Disabilities. Accessed at: <https://onlinelibrary.wiley.com/doi/10.1111/jar.12191>
- ¹⁶ <https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/>
- ¹⁷ <https://www.macpac.gov/subtopic/medicaid-expansion/>
- ¹⁸ Medicare and Medicaid do not actually "certify" beds. This term means counted beds in the certified provider or supplier facility or in the certified component.
- ¹⁹ Long-term Care Providers and Services Users in the United States, 2015–2016, Centers for Disease Control and Prevention, National Center for Health Statistics. https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf
- ²⁰ [Leading Age](https://www.leadingage.org/) is a national non-profit association dedicated to empowering people to live fully as they age.
- ²¹ Nursing Home Closures and Trends, 2015-2019. Leading Age <https://leadingage.org/sites/default/files/Nursing%20Home%20Closures%20and%20Trends%202020.pdf>

Module II: Advancing State Home and Community Based Services Rebalancing Strategies

States are in a unique position to accelerate the expansion of home and community-based services (HCBS). States implementing an array of HCBS strategies and approaches that promote community living over institutionalization offer older adults and individuals with disabilities choice, control, and access to services that help them achieve independence, optimal health, and quality of life. This module describes key HCBS elements that underpin systems that are economically sustainable, equitable across the broad range of people with LTSS needs, and continuously improving in terms of the quality of and access to HCBS. In addition, Module II discusses data-based decision-making in HCBS, stakeholder engagement, quality improvement, and financing approaches.

Contents of Module II:

- Discussion of key elements of an effective HCBS system
 - Examples of key elements in states
 - Helpful resources on these topics
-

Key Elements, Explained

As shown in Figure II.1, several interrelated key elements of an effective system to advance HCBS are: (1) person-centered planning and services; (2) No Wrong Door systems; (3) community transition support; (4) direct service workforce and caregivers; (5) housing to support community-based living options; (6) employment support; and (7) convenient and accessible transportation options.

Figure II.1. Key Elements



Person-Centered Planning and Services

Person-centered planning is a process for selecting and organizing the services and supports that an older adult or person with a disability may need to live in the community. Most importantly, it is a process that is directed by the person who receives the support. States play a critical role in supporting older adults and individuals with disabilities to have choice, control, and access to a full array of quality services that optimize independence, positive health, and quality of life outcomes. Developing meaningful systems to support person-centered thinking, planning, and



State Spotlight: Indiana
 Indiana’s [Person-Centered Individualized Support Plan \(PCISP\) Guide](#) utilizes tools with common and understandable language to assist in creating an ongoing person-centered plan that reflects individual needs and preferences to shape the delivery of services and supports. The PCISP Guide emphasizes HCBS settings and provides individuals with disabilities self-determination and choice.

practices can help individuals to achieve independent living goals and assist states with providing effective coordination of services across providers and state and local agencies. Person-centered planning is the foundation of Medicaid-funded HCBS provision and is central to turning the principles of choice and control into realities. Individualized care planning is also critical to quality service provision in institutional settings, although the ability of individuals to exercise meaningful control over those services is often less robust.

Several person-centered system elements and characteristics can support expanding and enhancing HCBS systems and advance rebalancing:

- Person-centered service planning and monitoring;
- Person-centered training for case managers, health plans, and health providers;
- Establishing strong person-centered contract requirements and policy guidance for managed care plans; and
- Developing and strengthening community-based partnerships and networks.

Helpful Links: Person-Centered Planning

- The [National Center on Advancing Person-Centered Practices and Systems \(NCAPPS\)](#) is an initiative from the Administration for Community Living and the Centers for Medicare & Medicaid Services that helps states, tribes, and territories implement person-centered thinking, planning, and practice in line with U.S. Department of Health and Human Services policy.
- Home and Community-Based Services [Fact Sheets](#) Regarding Final Regulation CMS-2249-F/CMS-2296-F

No Wrong Door Systems

No Wrong Door (NWD) systems streamline access to HCBS services through collaborative partnerships and a coordinated governance structure between state and local aging and disability programs. NWD systems build on the strength of existing entities, such as Aging and Disability Resource Centers (ADRC), Area Agencies on Aging (AAA), and Centers for Independent Living (CILs), by providing a single, coordinated system of information and access to services for all persons seeking HCBS. NWD ensures that older adults and individuals with disabilities can communicate with the HCBS system according to their method of preference (at an agency or community organization, by phone, paper, in person, or through an automated process) and provides them with access to HCBS services for which they qualify that best meet needs and preferences regardless of age, disability, or where they live.



State Spotlight: Virginia

Virginia [Options Counseling standards](#) are developed for Centers for Independent Living (CILs) and Area Agencies on Aging (AAAs) to engage in a process of collaboration around a common goal and to facilitate relationships that strengthen the NWD system. State reimbursement for each options counseling encounter provides funding for CILs and AAAs.

Building effective NWD systems can strengthen state LTSS systems and expand HCBS by:

- Providing a better vehicle for person-centered LTSS;
- Streamlining eligibility processes for LTSS;
- Fostering community-based partnerships; and
- Supporting data mechanisms for states to better understand HCBS system trends and utilization of public resources.

Helpful Links: No Wrong Door Systems

- CMS's [No Wrong Door System for Medicaid Administrative Claiming Guidance](#) informs states about methods for claiming federal matching funds, known as Federal Financial Participation (FFP), for Medicaid administrative activities performed through NWD systems and for ensuring non-duplication for any such claims.
- The [No Wrong Door](#) system model is a collaboration between the Administration for Community Living, the Centers for Medicare & Medicaid Services, and the Veterans Health Administration that supports states working to streamline access to HCBS for older adults, people with disabilities, and their families.
- [No Wrong Door: Person- and Family-Centered Practices in Long-Term Services and Supports](#) provides examples of how states promote person- and family-centered practice in their NWD systems.

Community Transition Support

Effectively developing and integrating transition opportunities into state HCBS programs can accelerate rebalancing away from institutional settings toward community living. States can design and implement care transition supports and programs to assist individuals residing in institutional settings to return to the community, to prevent or delay nursing facility admission, and to reduce hospital readmissions.

States have broad flexibility to develop programs and to utilize tools to increase the probability of community transition and prevent institutional admission for individuals eligible for LTSS. Effective use of the MDS

Section Q tool (see Module III) can identify an individual's preference for returning to the community. An adequate array of transition services and case management (also discussed in Module III) can support this preference. Effectively coordinating and communicating this



State Spotlight: Alabama

Alabama's Integrated Care Network (ICN) administered through a Primary Care Case Management Model focuses on care coordination for individuals in nursing homes and individuals enrolled through Alabama's section 1915(b)/1915(c) Elderly and Disabled and Alabama Community Transition waiver programs. The ICN Program focuses on providing education and outreach about the options for Medicaid recipients to receive LTSS, identifying individuals who could benefit from community options and alternatives to institutional stays, and providing case management that integrates medical and social services.

preference through NWD systems, especially during the early days of institutional admission, including hospital inpatient stays, can increase the likelihood of a successful return to the community and prevent a long-term institutional placement.

States can pursue innovative approaches to improve care transitions for Medicaid beneficiaries leaving medical institutions or who are frequent users of hospital emergency departments. For example, states can develop and adopt information sharing models to support care transitions based on real-time admission notifications, such as by:

- Establishing information-sharing requirements in managed care contracts related to hospital and skilled nursing facility (SNF) admissions;
- Utilizing event notification systems that share hospital and SNF admission data; and
- Partnering with Medicaid managed care plans and providers to develop processes and data elements to support routine information exchange about the notification of hospital and SNF admissions as beneficiaries move between acute, post-acute, and community or other long-term care settings.

Data sharing between Medicaid health systems, providers, and case management entities can support strategies that ensure that beneficiaries at high risk for institutionalization are identified early and receive assistance with discharge planning and returning to community settings.

Helpful Links: Transition Supports among Services and Settings

- [Improving Care Transitions](#) technical assistance and resources for states include promising practices of high quality, high impact, and effective care transition models and processes.

Direct Service Workforce and Caregivers

States have developed creative and effective HCBS programs to shift their long-term care service delivery systems toward HCBS and away from institutional care. As demand for HCBS increases, addressing the workforce stability of direct service workers and caregivers to deliver services is critical to sustaining the growth of HCBS and ensuring older adults and individuals with disabilities have access to needed services.

The availability of direct service workers can be impacted by several factors, including the ability to attract a sufficient mix of providers in urban and rural areas of a state and the adequacy of



State Spotlight: Georgia

Georgia includes “structured family caregiving” personal support services by a family caregiver in its section 1915(c) elderly and disabled waiver program, with activities provided to support family caregivers who live with and assist older adults and individuals with disabilities who require significant assistance with activities of daily living. The “structured family caregiving” support provides ongoing telephonic or electronic support to the family caregiver by a health coach and review of daily notes submitted by the caregiver reporting changes or concerns about the individual’s condition.

reimbursement, which affect provider willingness to accept Medicaid beneficiaries.

The impact of HCBS workforce issues, such as workforce shortages and staff turnover, on the quality of service is direct and immediate. Workforce issues also increase costs for HCBS providers. State Medicaid agencies play a key role in influencing the stability of the workforce by determining thresholds of quality assurance and oversight, worker and supervisor education, wages and benefits, and provider reimbursement.

Under the Medicaid program, states can pursue approaches aimed at the existing direct care workforce, along with strategies to increase the capacity of direct service workers, including caregivers, within the state who serve HCBS participants. For example, these strategies can include increasing wages for direct service workers, conducting competency and training to support DSW credentialing, implementing innovative recruitment strategies, investing in data and information technology, and developing community integrated approaches to LTSS that are inclusive of rural areas, such as [worker-owned cooperatives](#) that are owned and operated by direct service workers themselves. CMS created the [National Direct Service Workforce \(DSW\) Resource Center](#) in 2005 (updates to be published in 2021) to respond to the shortage of workers who provide direct care and personal assistance to individuals who need LTSS. The DSW Resource Center created a number of important resources designed to assist states in developing direct service workforce capacity and improving recruitment and retention efforts.



State Spotlight: Pennsylvania

Pennsylvania's managed care plans are required to implement a

home care workforce innovation component within their programs, utilizing person-centered planning principles, to improve the recruitment, retention, and skills of direct care workers. These may include but are not limited to direct or enhanced payment and other incentives to providers, participant-directed employers, and direct care workers for education, training, and other person-centered planning initiatives.

Helpful Links: Direct Service Workforce and Caregivers

- The Direct Service Worker Resource Center's [synthesis of direct service workforce demographics and challenges](#) describes state workforce practices and challenges related to intellectual/developmental disabilities, aging, physical disabilities, and behavioral health.

Housing to Support Community Living Options

Accessible and affordable housing can enable community living, maximize independence, and promote better health outcomes for individuals eligible for HCBS. Federal Financial Participation (FFP) is not available to state Medicaid programs for room and board (except in certain medical institutions). However, FFP is available under certain federal authorities for housing-related supports and activities that promote health and community integration for Medicaid beneficiaries, including one-time community transition costs, pre-tenancy and tenancy supports, home accessibility modifications, and state-level housing-related collaborative activities. States can pursue several approaches to increase access to affordable and accessible housing for Medicaid beneficiaries eligible for HCBS and to help individuals stay in their homes. For example:

- State Medicaid programs can play an integral role in developing, building, and strengthening cross-agency housing and health partnerships. These partnerships can involve developing models for coordinating and integrating housing-related supports, sharing information between housing and health care partners, and creating sustainable partnership models that increase housing opportunities for individuals eligible for HCBS;
- States can take advantage of the flexibility under certain Medicaid authorities to provide services and supports to help individuals maintain their health, to stay in their homes, and to avoid unnecessary institutionalization. States can choose to cover such services as personal care services, case management, behavioral health services, and housing-related supports such as: conducting an individualized screening and housing assessment that identifies the individual's preferences and barriers for community residence; education or training on the role, rights, and responsibilities of the tenant and landlord; and skill acquisition to help individuals maintain community-based housing;
- States can institute incentives and payment reform approaches to facilitate the delivery of high quality and effective services that support successful community living; and
- State Medicaid programs can help to coordinate cross-sector health and housing system networks that may include hospitals, managed care plans, community health centers, and supportive housing providers.



State Spotlight: Louisiana

Louisiana's Section 811 Project Rental Assistance program is a component of Louisiana's state-operated Permanent Supportive Housing (PSH) Program. Louisiana PSH is a cross-agency partnership between the Louisiana Department of Health (LDH) as the single state Medicaid agency and the state housing finance agency which operates the Louisiana Housing Authority and coordinates federal rental assistance programs. Louisiana PSH offers rental assistance and supportive services for individuals with significant, long-term disabilities of any age (though the 811 component serves those aged 18-61) prioritizing those who are at risk of being homeless or institutionalized. Louisiana Medicaid provides reimbursement for services furnished to individuals with disabilities residing in PSH under the section 1915(c) HCBS program and as a component of Medicaid Mental Health Rehabilitation services.

See Module III for a discussion of the Medicaid coverage authorities and how they may be used to provide housing supports and services for Medicaid beneficiaries.

Helpful Links: Housing to Support Community-based Living Options

- Medicaid Innovation Accelerator Program (IAP) [State Medicaid-Housing Partnership Toolkit](#)
- [Joint HHS, HUD, USDA Informational Bulletin: Living at Home in Rural America: Improving Accessibility for Older Adults and People with a Disability](#)

Employment Support

Employment is a fundamental part of comprehensive HCBS systems and important to people with and without disabilities. Employment provides a sense of purpose, is one of the key ways that people contribute to their communities, and is associated with positive physical and mental health benefits.

CMS's [HCBS Final Rule](#) requires that individuals receiving Medicaid HCBS have full access to the greater community, including opportunities to seek employment and work in competitive integrated settings. The [Employment First](#) initiative promotes making community employment the first and preferred outcome considered for people with disabilities who receive state services. Through the Administration for Community Living, the [Workforce Innovation and Opportunity Act \(WIOA\)](#) supports the implementation of programs and systems that introduce young adults with disabilities to different competitive work experiences.

Medicaid services enable workers with disabilities to gain and maintain employment. States can choose to implement several different types of employment models and services under Medicaid, such as:

- Supported employment services, which are ongoing supports to individuals who, because of their disabilities, need on-going support to obtain and maintain a job in competitive or customized employment, or self-employment, in an integrated work setting;
- Peer support providers for the delivery of counseling and other support services to Medicaid eligible individuals with mental health and substance use disorders. Additional information concerning peer support services is contained in the August 15, 2007, [State Medicaid Director Letter #07-011](#);



State Spotlight: Delaware

Delaware's "Pathways to Employment" program, implemented through section

1915(i) state plan HCBS, is designed to support low-income teens and young adults with disabilities to prepare for work, find jobs, and succeed in the workplace. Pathways to Employment participants receive supported employment-related services to meet their individual needs, including employment navigator, career exploration and assessment, benefits counseling, financial coaching, non-medical transportation, personal care (including a self-directed component), and orientation, mobility, and assistive technology.

- Self-directed service delivery models to provide employment supports. In a self-directed model, individuals may hire their own job coaches and employment support staff, rather than relying exclusively on agency based staffing models; and
- The [Medicaid Buy-In program](#), which is an optional state Medicaid benefit group for workers with disabilities who have earnings in excess of traditional Medicaid rules. Individuals who would be ineligible for Medicaid because of earnings can work and access the services and supports they need.

See Module III for specific Medicaid authorities under which these models may be implemented.

States can also engage in the development, design, and expansion of services and supports that enable individuals with disabilities to work in the community and promote community inclusion by:

- Establishing relationships with state programs and agencies that provide employment supports to expand and enhance linkages with a wide-range of funding and programming to support individuals with disabilities to secure and retain employment;
- Developing evidence-based supported employment models that identify the supports and services that individuals with disabilities seeking employment need to be successful. States may adopt approaches that meet state-specific policy and priority goals that support opportunities for competitive, integrated employment, including models that help to connect beneficiaries to work, employment supports, or other social services that support their ability to work;
- Building the capacity of existing providers to provide employment engagement activities through the provision of incentives, payment model reforms, and other strategies;
- Using the flexibility under Medicaid to provide comprehensive employment supports, which may include both state plan and HCBS waiver program services. States may choose to provide supportive employment programs that offer services such as skills assessment, job coaching, and training to help individuals with disabilities to achieve employment goals and to remain employed;
- Developing quality and data metrics to support continuous improvement. For example, states can choose to adopt the CAHPS Home and Community-Based Services (HCBS CAHPS®) Survey, consisting of 69 core items that ask beneficiaries to report on their community-living experience. States can include a set of supplemental items in the HCBS CAHPS® Survey that ask about experience with employment services; and
- Establishing Memorandums of Understanding with State Vocational Rehabilitation and the State Department of Education to ensure close coordination of services with entities.

Helpful Links: Employment Support

- The [Medicaid Employment Initiatives](#) resource webpage provides helpful information on federal employment initiatives.

Convenient and Accessible Transportation Options

Safe, reliable, and affordable transportation is an important HCBS element that can support states to expand and enhance HCBS systems. Transportation can help individuals to achieve community living goals, to access preventive health care, to increase functional independence, and to improve health and well-being.

Non-medical transportation can enable individuals receiving HCBS to gain access to community-based activities and resources consistent with their service plan. Examples include transportation to grocery stores and places of employment.

Transportation to and from medical care is a mandatory assurance in the Medicaid program when the beneficiary has no other available means to access medical services. Federal Medicaid regulations require states to detail the methods to be used to meet this requirement in the state's approved state plan. Each state is responsible for determining how to structure and administer the required transportation assurance under broad federal requirements.

States have flexibility in designing and implementing non-emergency medical transportation (NEMT) services. States are encouraged to adopt innovative approaches to delivery systems and payment models to provide convenient, accessible, and effective NEMT, such as:

- Using managed care contracting to strengthen NEMT services and to provide oversight of NEMT providers;
- Investing in state NEMT information technology infrastructure to improve efficiency and quality of NEMT services; and
- Working with NEMT brokers, vendors, and/or managed care plans to promote the use of technologies to improve beneficiary experience that could include scheduling, route development, automated ride reminders, on-time ride-request functionality, and real-time information on vehicle location and wait time.



State Spotlight: Idaho

Idaho's non-medical transportation services for Medicaid beneficiaries eligible for Idaho's section 1915(c) Aged and Disabled waiver and section 1915(c) Developmental Disabilities waiver programs are offered through a statewide network of transportation providers as part of a broad mobility benefit. This benefit includes coordination and assistance aimed at enhancing movement within the individual's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, and/or movement within the community.

Helpful Links: Convenient and Accessible Transportation Options

- [CMS Non-Emergency Medical Transportation](#) fact sheet explains Medicaid coverage of non-emergency medical transportation for Medicaid eligible individuals.

Aspects of an Effective HCBS System Foundation

States are encouraged to proactively build strong foundations for pursuing rebalancing strategies. A robust HCBS system includes focus on data-based decision-making, stakeholder engagement programs, financing approaches, and quality improvement.

Data-Based Decision-Making

State rebalancing goals can be advanced by using data to drive decision-making to inform HCBS policy, to better understand access to and quality of HCBS, and to achieve high quality coordinated care, improved health outcomes, and reduced costs. Using a data based decision-making process can help to guide state efforts to:

- Identify and understand a state's Medicaid population data sources (e.g., enrollment, utilization rates, costs by beneficiary type or subpopulations) and how they can be best utilized;
- Improve statistical programming and data modeling skills and efficiencies in data management; and
- Integrate Medicaid data with Medicare, and other data sets (such as housing records or public health data). Shared data systems enable state agencies to share data easily, obtain a more comprehensive view of costs and other metrics, and conduct Medicaid program integrity and quality analyses.



State Spotlight: Connecticut

Connecticut's Strategic Rebalancing Plan uses census and demographic

data to develop "supply and demand" projections for long-term care needs on a town-by-town basis. The projections help the state to target services that support quality of life and cost effectiveness in specific areas of the state while providing technical assistance to the nursing home industry in diversifying and focusing its business model to meet future trends in Connecticut's aging population.

Interoperable health information technology systems support quality reporting and improvement, improve care coordination, and promote person-centered planning for individuals receiving HCBS. Interoperable systems can also enable HCBS participants to have access to and control of their own service plans and direct service workforce providers and case managers to access consistent and accurate information.

The [CMS Interoperability and Patient Access final rule](#) focuses on advancing interoperability and patient access to health information using the regulatory authority available to CMS, putting individuals at the center of their health care and ensuring they have access to their health information.

Section 12006(a) of the 21st Century Cures Act mandates that states implement [electronic visit verification \(EVV\)](#) for all Medicaid personal care services (PCS) and home health care services (HHCS) that require an in-home visit by a provider. States must require EVV use for all Medicaid-funded PCS by January 1, 2021 and HHCS by January 1, 2023. This applies to PCS provided under sections 1905(a)(24), 1915(c), 1915(i), 1915(j), 1915(k), and section 1115 of the Social Security Act; and HHCS provided under 1905(a)(7) and section 1115. The EVV system must be able to electronically verify, with respect to visits conducted as part of personal care services or home health care services, the following:

1. The type of service performed;
2. The individual receiving the service;
3. The date of the service;
4. The location of service delivery;
5. The individual providing the service; and
6. The time the service begins and ends.

States are also required to provide for a stakeholder process to allow input into the state’s implementation of the EVV requirement from providers of PCS and home health services, beneficiaries, family caregivers, and other stakeholders.

States can leverage EVV systems to use data to improve HCBS service delivery, identify service gaps, and offset disruptions in services to HCBS beneficiaries. EVV systems are designed to ensure that personal care and home health services authorized for individuals are actually delivered, giving increased certainty to claims for services and future budget projections.

Helpful Links: Data-Based Decision-Making

- CMCS Informational Bulletin [Health and Welfare of Home and Community Based Services \(HCBS\) Waiver Recipients](#)
- CMCS Informational Bulletin [Electronic Visit Verification \(EVV\)](#) assists states with information in implementing EVV systems for Medicaid personal care services and home health care services.
- CMS [EVV resource webpage](#)
- Medicaid Innovator Accelerator Program (IAP) [Data Analytics resource](#) webpage

Stakeholder Engagement

Engaging the community of stakeholders – Medicaid and agency leadership, participants in HCBS programs, residents in long-term care facilities, family members and other caregivers, HCBS providers, the aging and disability network, health plans, and the direct support workforce – can provide feedback critical to inform the state’s approach to enhance efforts to rebalance the HCBS delivery system. Ensuring the transparency of information associated with HCBS quality oversight is a critical step in fully utilizing the perspectives of such a wide array of stakeholders. States are encouraged to establish regular and clear communications with stakeholders, including

individuals receiving or on a waiting list for HCBS. Public notice processes can also ensure that stakeholders have the opportunity to provide input on substantive actions proposed for implementation in the state.

Stakeholder engagement is a requirement of the rate setting process outlined in the section 1915(c) waiver program application. Stakeholder engagement processes should take into account person-centered planning consistent with requirements for section 1915(c) waivers and section 1915(i) and 1915(k) state plan options for HCBS. In addition, states are required to engage with stakeholders in the development and implementation of their Statewide Transition Plans, which outline each state's action steps and timelines for achieving compliance with the federal criteria of a home and community-based setting.

When conducted effectively, these stakeholder engagement processes can provide states with a better understanding of varied perspectives on the current HCBS service delivery system, creates opportunity to communicate directly with stakeholders, and encourages effective communication avenues as states enhance efforts to rebalance HCBS programs.

Section 1902(a)(73) of the Social Security Act requires a state in which one or more Indian Health Programs or Urban Indian Organizations furnishes health care services to establish a process for the state Medicaid agency to seek advice on a regular, ongoing basis from designees of such Indian health programs and Urban Indian Organizations. Section 2107(e)(F) of the Act applies these requirements to the Children's Health Insurance Program (CHIP). Under these statutory provisions, consultation is required on Medicaid and CHIP matters that are likely to have a direct effect on Indian health programs and Urban Indian Organizations. The tribal consultation process that a state establishes under these provisions must also include solicitation of advice prior to submission of any state plan amendments, waiver requests, and proposals for demonstration projects likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations.



State Spotlight: Massachusetts

Under **Massachusetts'** Financial Alignment Initiative (FAI) "One Care: MassHealth Plus Medicare" (One Care), serving dual eligible adults with disabilities who are 21 through 64 years of age at enrollment, the One Care Implementation Council was established to engage consumer and advocate stakeholders to inform strategic elements, implementation, and improvements of One Care. The Implementation Council is intended to represent diverse stakeholder perspectives, with the majority of participants being One Care members with disabilities or their family members and guardians. Massachusetts sought participation in the Implementation Council from MassHealth members with disabilities and their family members or guardians, representatives of community-based organizations, representatives of consumer advocacy organizations, union representatives, and providers, representing the diverse communities affected by One Care. Selection of members to the Council aims to represent diverse perspectives, including from adult populations with physical disabilities, intellectual/developmental disabilities, serious mental illness, substance use disorders, multiple chronic illnesses, or functional cognitive limitations, and individuals with disabilities who are experiencing homelessness.

Helpful Links: Stakeholder Engagement

- [Engaging Stakeholders in the Rate Setting Process](#) web presentation
- [Balancing Long Term Services & Supports](#) webpage
- [Indian Health & Medicaid](#) resource webpage
- CMS [Tribal Consultation Policy](#)

Financing Approaches

States have flexibility to develop innovative payment models and set payment rates for services provided within the Medicaid program to promote efficiency, access, and quality of care for HCBS. States may implement innovative payment models as part of fee-for-service and managed care delivery systems under Medicaid authorities (see Module III), such as state plan authority under section 1902 of the Act, managed care authorities under section 1915(b), primary care case management authority under section 1932(a), and section 1115(a) demonstration authority.

Through partnerships with states, CMS has approved innovative fee-for-service payment methodologies that reward providers for improvements in care coordination, clinical care quality, and service cost reduction. Medicaid statute, regulations, and policies provide states with flexibility to design innovative value based payment methodologies for HCBS. A state may pay providers for authorized Medicaid services and recognize the varied costs of providing care based on the setting(s) in which the services are provided or the severity of need. For instance, states may pay higher rates for services provided to individuals with significant care needs or in geographic areas where access to care may be of concern. Further, states may pay for individually covered services or, if determined as a more efficient payment method, may develop bundled rates to pay for services. States may also offer providers financial incentives to improve beneficiary outcomes based on meeting certain quality benchmarks, which may include treatment outcomes or recognized standards of care.

Further, in April 2019, CMS released a State Medicaid Directors Letter, [Three New Opportunities to Test Innovative Models of Integrated Care for Individuals Dually Eligible for Medicaid and Medicare](#), inviting states to partner with CMS to test innovative approaches for serving individuals who are dually eligible for Medicaid and Medicare. These opportunities



State Spotlight: Vermont

State leaders in **Vermont** leveraged the Medicaid section 1115 demonstration to increase access to HCBS for adults at risk for nursing home admission who may not be eligible for Medicaid and do not meet nursing facility level of care criteria. This approach was intended to delay or prevent the need for more costly LTSS and increase the opportunity for people to receive services in their homes and communities. The Department of Disabilities, Aging and Independent Living worked closely with state leadership on the program and influenced the decision to allow savings to be reinvested into HCBS if it exceeded 1 percent of state spending on the demonstration.

include the [Financial Alignment Initiative \(FAI\)](#) that tests integrated care and financing models to improve care and reduce program costs for dually eligible individuals, as well as improve coordination between the Medicaid and Medicare programs. Under FAI, CMS made two financial alignment models available to states: (1) a capitated model in which health plans coordinate the full range of health care services, and (2) a managed fee-for-service (MFFS) model in which states are eligible to benefit financially from savings resulting from initiatives that improve quality and reduce costs.

There are a variety of approaches that state Medicaid programs can pursue related to value-based payment, including adopting options available through the state plan and managed care authorities and testing innovative approaches through section 1115 demonstrations. For example, CMS released two letters to state Medicaid directors in 2012, providing guidance regarding Medicaid integrated care models, including accountable care organizations (ACOs) and ACO-like models for payment and service delivery reform. CMS also released guidance in a Center for Medicaid and CHIP Services Informational Bulletin in 2013, [Targeting Medicaid Super-Utilizers to Decrease Costs and Improve Quality](#), clarifying how care delivery models such as integrated care

models can help states and Medicaid providers to meet the complex needs of the highest utilizers of acute care in Medicaid populations. Through the [Medicaid IAP website](#), states can access various tools, resources, and webinar slides related to Medicaid payment and services delivery models. CMS released a State Medicaid Directors Letter, [Value-Based Care Opportunities in Medicaid](#), to provide information on how states can advance value-based care (VBC) across their health care systems. CMS is available to work with states interested in pursuing value-based payment methods and to address opportunities and challenges to VBC.



State Spotlight: Washington

The **Washington** Health Homes managed fee for service demonstration leverages Medicaid health homes to integrate care for full-benefit Medicare-Medicaid beneficiaries by targeting high-cost, high-risk dual eligible enrollees. Washington has designated Medicaid health homes to be the lead local entities to organize enhanced integration of primary, acute, LTSS, and behavioral health services for demonstration enrollees. Preliminary evaluation results through the fourth year of the demonstration estimate that the demonstration has reduced Medicare costs by a total \$166.8 million, with savings shared between the Medicare program and the state, dependent on state performance on quality measures.

Helpful Links: Financing Approaches

- [State Medicaid Director Letter # 20-004](#) on Value-Based Care Opportunities in Medicaid
- [Bundled Rate Payment Methodology](#) guidance assists states that develop bundled rates as a Medicaid fee-for-service (FFS) payment methodology.
- [State Medicaid Director Letter #19-002](#) on Opportunities to Test Innovative Models of Integrated Care for Individuals Dually Eligible for Medicaid and Medicare

Quality Improvement

CMS works with states to assure and improve quality across the Medicaid authorities that support LTSS, including the Medicaid [section 1915\(c\) HCBS waiver programs](#). Current approaches to quality have expanded to include managed care delivery systems, section 1115 demonstrations, and state plan services. Through cross-cutting initiatives, these programs and services seek to maximize the quality of life, functional independence, health, and well-being of individuals served by the HCBS programs.

Medicaid HCBS quality assurance requirements for section 1915(c) HCBS waiver programs focus on structural and process measures. Federal regulations (42 C.F.R. §441.301 and §441.302) require each state that operates a section 1915(c) HCBS waiver program to develop and implement systems to measure and improve its performance in meeting six major system components needed to assure quality. The assurances include:

- **Administrative authority**, which places ultimate responsibility for assuring and improving quality with the state Medicaid agency, even if section 1915(c) HCBS waiver programs are administered by other state agencies or non-state (i.e., contracted) agencies;
- **Level of care determination**, which requires a formal assessment of all waiver applicants' and participants' need for assistance to ensure that they meet the state's institutional level of care criteria;
- **Qualified providers**, which verifies that HCBS providers delivering section 1915(c) waiver services meet state licensure or certification standards and adhere to training requirements;
- **Service plan**, which details the processes used to ensure that each participant's service plan addresses their health and functional assistance needs, meets their personal goals and preferences, and gives them a choice of waiver services and providers;
- **Health and welfare**, which includes: procedures to identify, address, and prevent abuse, neglect, exploitation and unexplained deaths; an incident management system to resolve critical incidents; policies and procedures for the use or prohibition of restraints and seclusion; and systems to ensure minimum health care standards are met; and
- **Financial accountability**, which cover systems to ensure that services are reimbursed using the rates and methods approved during each waiver program cycle.

Over the past several years, CMS has also made investments in new tools, resources, and measures to promote quality in HCBS. These activities support the [Meaningful Measures initiative](#), which identifies CMS's highest priorities for quality measurement and improvement, focused on providing high-quality care and improving individual outcomes for beneficiaries.

CMS maintains eight standardized [quality measures for managed long-term services and supports \(LTSS\) programs](#):

- LTSS Comprehensive Assessment and Update;
- LTSS Comprehensive Care Plan and Update;

- LTSS Shared Care Plan with Primary Care Practitioner;
- LTSS Re-Assessment/Care Plan Update After Inpatient Discharge;
- Screening, Risk Assessment, and Plan of Care to Prevent Future Falls;
- LTSS Admission to an Institution from the Community;
- LTSS Minimizing Institutional Length of Stay; and
- LTSS Successful Transition After Long-Term Institutional Stay.

The National Committee for Quality Assurance (NCQA) Healthcare Effectiveness and Data Information Set (HEDIS®) measure set includes the first four measures in its standardized quality measures for managed care plans that cover LTSS populations and benefits. One of the MLTSS measures – minimizing institutional length of stay – received endorsement by the National Quality Forum ([NQF # 3457](#)), while LTSS Admission to an Institution from the Community has also been adapted for use in fee-for-service programs.

The [CAHPS Home and Community-Based Services Survey \(HCBS CAHPS\)](#) is the first cross-disability survey of HCBS beneficiaries' experience receiving LTSS. It is designed to facilitate comparisons across the hundreds of state Medicaid HCBS programs throughout the country that target adults with disabilities, including older adults and individuals with physical disabilities, developmental or intellectual disabilities, acquired brain injury, and severe mental illness. The HCBS CAHPS Survey is available for voluntary use in HCBS programs as part of quality assurance and improvement activities and public reporting. The HCBS CAHPS Survey received NQF endorsement for 19 person-reported experience-of-care outcome measures ([NQF # 2967](#)). States that administer the HCBS CAHPS Survey to beneficiaries with physical, intellectual, cognitive, and developmental disabilities can use the experience-of-care measures to compare quality outcomes across Medicaid HCBS program populations and over time. In collaboration with Agency for Healthcare Research and Quality, CMS has also recently developed an [HCBS CAHPS Survey database](#) to promote public reporting and enable comparisons of experience of care within and across states.

CMS developed, tested, and integrated the [Functional Assessment Standardized Items \(FASI\)](#) within the [CMS Data Elements Library \(DEL\)](#). FASI covers three types of functional abilities and goals found in most state Medicaid HCBS assessment tools: (1) self-care (for example, ADLs related to eating, dressing, and bathing); (2) mobility, including ambulation and manual or motorized wheelchair use; and (3) instrumental ADLs, such as preparing meals and grocery shopping. It also includes questions about the use of assistive devices and caregiver assistance. The FASI is an interoperable assessment which is available for use by states. Two measures derived from FASI questions assess and compare state performance related to the quality of person-centered planning: (1) the percentage of HCBS participants needing help who identified at least three personal priorities, and (2) the percentage of HCBS participants with functional needs who have a comprehensive person-centered service plan that addresses their functional needs.

[Personal Health Records \(PHRs\)](#) for HCBS participants incorporate non-medical, HCBS information into a person-centered health information technology (IT) system. HCBS PHRs enhance state workflow, improve beneficiary communications, and support HCBS visit verification. States can use PHRs to improve communication and information exchange among HCBS beneficiaries and providers.

The [Electronic Long Term Services and Support \(eLTSS\) Standard](#) initiative is a partnership between the Office of the National Coordinator (ONC) and CMS focusing on the identification and harmonization of electronic standards that can enable the creation, exchange, and re-use of interoperable service plans by health care and community-based LTSS providers, payers, and the individuals they serve. The eLTSS standard supports [information exchange](#) that states can use to improve the coordination of health and social services for HCBS beneficiaries.

CMS is working on a set of recommended measures for Medicaid-funded HCBS. The HCBS recommended measure set is intended as a resource for voluntary use by states, MLTSS plans, providers, and other entities to support more consistent use of HCBS quality measures, including to meet the [section 1915\(c\) assurances and sub-assurances](#) or other CMS requirements. The recommended measure set can also create opportunities to have comparative quality data on HCBS programs and services, including for the purposes of value-based purchasing and alternative payment models. It is further intended to reduce some of the burden that states and others may experience in identifying and using HCBS quality measures. By providing states and other entities with a set of standard measures to assess HCBS quality and outcomes and by facilitating access to information on those measures, CMS may be able to reduce the time and resources expended on identifying, assessing, and implementing measures for use in HCBS programs. CMS released a [request for information on the draft recommended measure set](#) in September 2020 and plans to release a final version of the initial recommended measure set in the near future.

Helpful Links: Quality Improvement

- [Assessment and Care Planning Measures](#) issue brief describes person-centered assessment and care planning quality measures for Medicaid HCBS beneficiaries.
- [Person-Reported Outcome Measures for Home and Community-Based Services](#) issue brief describes person-reported outcome measures for Medicaid HCBS beneficiaries.
- [Technical Assistance Guide for Administration of the CAHPS® HCBS Survey](#) supports the survey administration and data collection process for HCBS-CAHPS survey sponsors. The survey questionnaire can be found in English [here](#); a Spanish version is available [here](#).
- [Measures of State Long-Term Services and Supports System Rebalancing](#) issue brief describes measures available to monitor and evaluate progress toward LTSS rebalancing.

Module III: Current Flexibility under Medicaid to Support State Rebalancing Strategies

Medicaid provides numerous opportunities and pathways to support states with shifting from a reliance on institutional services to community-based care for Medicaid beneficiaries eligible for long-term services and supports (LTSS) or at risk of needing LTSS. Under Medicaid, states can develop system capacity to: ensure greater access to home and community-based services (HCBS); offer programs and services to support Medicaid beneficiaries to transition from medical institutions to the community; provide a diversity of services and supports to help individuals achieve community living goals; and test, pilot, and target HCBS programs and services to foster efficiency, reduce and contain costs, and improve health outcomes for Medicaid beneficiaries. States can also use several institutional tools to advance rebalancing strategies.

Contents of Module III:

- Overview of Medicaid authorities covering HCBS
 - Brief synopsis on how Medicaid authorities and programs can support rebalancing strategies
 - Examples of how states use the Medicaid program to expand and enhance HCBS
 - Examples of strategies states can consider to advance and accelerate rebalancing
 - Institutional tools that states can use to advance rebalancing strategies
 - Helpful resources on these topics
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Overview of Medicaid Authorities Covering HCBS

HCBS include services and supports, such as (but not limited to) case management, homemaker, home health aide, personal care, adult day health services, habilitation²² (both day and residential), and respite care. HCBS programs serve a variety of targeted populations groups—such as older adults, people with intellectual or developmental disabilities, physical disabilities, or mental health and substance use disorders (MH/SUD)— and provide opportunities for Medicaid beneficiaries to receive services in their own homes and communities rather than in institutions. The HCBS taxonomy for section 1915(c) waiver programs provides definitions for HCBS categories and subcategories in the [Medicaid Home and Community-Based Services \(HCBS\) Taxonomy Category and Subcategory Definitions](#) document. A comparison of Medicaid authorities covering HCBS and CMS requirements can be found on CMS’s [HCBS Technical Assistance web site](#). Figure III.1 below provides a snapshot of the Medicaid benefits and programs described in this Module that can be used to advance the availability of community-based services.

Figure III.1. Medicaid Benefits and Programs that Can Advance the Availability of Community-based Services

State plan benefits that include HCBS	HCBS authorities	Research and demonstration programs	Integrated care programs	Managed long term services and supports (MLTSS)	Medicaid administrative activities
<ul style="list-style-type: none"> • Home health • Personal care services • Case management and targeted case management • Section 1945 Health Home 	<ul style="list-style-type: none"> • Section 1915(c) • Section 1915(i) • Section 1915(j) self-directed personal care services • Section 1915(k) Community First Choice 	<ul style="list-style-type: none"> • Section 1115 demonstrations • Money Follows the Person (MFP) demonstration 	<ul style="list-style-type: none"> • Programs for All-Inclusive Care for the Elderly (PACE) • Accountable care organizations (ACOs) • Integrated care for people dually eligible for Medicare and Medicaid 	<ul style="list-style-type: none"> • Including those authorized under Section 1915(a) or 1915(b) waivers 	<ul style="list-style-type: none"> • Partnership development • Data and information technology

Federal Medicaid law requires states to provide certain mandatory Medicaid state plan benefits under sections 1902(a)(10) and 1905(a) of the Social Security Act (the Act) and 42 C.F.R. §440.210 and §440.220. Additionally, pursuant to section 1905(a)(4)(B) and (r)(5) of the Act, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit requires that states provide all medically necessary section 1905(a) services coverable under the Medicaid program to eligible children under age 21.

States can also choose to provide other optional benefits under state plan authority, as well as through waiver authority under section 1915 of the Act, or they can offer additional non-mandatory benefits under demonstration project authority under section 1115 of the Act. States have a certain degree of flexibility in determining which non-mandatory benefits to provide under these authorities. In most cases, state flexibility is limited by section 1902(a)(1) of the Act and 42 C.F.R. §431.50 (statewideness), section 1902(a)(17) of the Act and 42 C.F.R. §440.230 (requirements regarding the amount, duration, and scope of covered services), and section 1902(a)(10)(B) of the Act and 42 C.F.R. §440.240 (comparability of services within and among eligibility groups), among other provisions. These requirements apply unless the statute makes them non-applicable to the specific benefit or CMS waives the requirement.

HCBS are a critical component of successful rebalancing strategies. States may employ a diversity of approaches under Medicaid to implement rebalancing strategies that enhance and expand HCBS. For example, states can choose to combine or limit various Medicaid authorities to target HCBS benefits to certain populations, offer a robust array of HCBS, or offer HCBS benefits in specific geographic areas, among other approaches. These flexibilities under the Medicaid program allow states to pursue rebalancing strategies that may incorporate broad system changes or targeted reform efforts. State decision-making on which Medicaid authority or combination of authorities to implement will depend on the benefits and constraints of each authority and the unique needs and priorities of a state. CMS is available to provide technical assistance to states in planning and designing benefits and programs to enhance and expand HCBS and to reduce the reliance on institutional services in their LTSS systems.

State Plan Benefits That May Include the Provision of HCBS

Through the Medicaid state plan, Federal Financial Participation (FFP) is available for a number of services to enable individuals to remain at home, prevent institutionalization, or help individuals to transition safely from institutions to the community.

Home Health Services

Brief Description: Home health services are mandatory services authorized at section 1905(a)(7) of the Act, and defined in regulations at 42 C.F.R. §440.70. Home health services include nursing services, home health aide services, medical supplies, equipment, and appliances, and may include therapy services (physical therapy, occupational therapy, speech pathology and audiology).

How the Benefit Can Support Rebalancing Strategies: Home health services can support strategies aimed at reducing unnecessary institutionalization and avoiding costlier medical interventions. For instance, the services available under the home health benefit can divert the individual from a skilled nursing facility admission following a hospitalization. Ensuring that the home health benefit is optimally used according to federal requirements can be a key strategy in avoiding unnecessary institutional stays. Services may be furnished in a person's home and in any setting in which normal life activities take place, enabling home health services to foster community integration and inclusion. As indicated above, home health services include: home health aide services to provide hands-on assistance with activities of daily living (ADLs); nursing services to manage wound care; and medical equipment and supplies to support individuals' safe and independent living in their own homes. States may also choose to provide therapies to improve individuals' recovery at home following a hospital stay.

Personal Care Services

Brief Description: Personal care services (PCS) are optional services authorized at section 1905(a)(24) and defined in regulations at 42 C.F.R. §440.167. Personal care services can include a range of human assistance provided to persons who need assistance with daily activities. Depending on how broadly the state covers the benefit, PCS can include: a) assistance with ADLs such as bathing, eating, dressing, mobility, and using the bathroom; and b) instrumental activities of daily living (IADLs) such as financial management, taking medications, and shopping for groceries. These services are provided to individuals who are not an inpatient or resident of a hospital, nursing facility (NF), intermediate care facility for individuals with intellectual disabilities (ICF/IID), or institution for mental diseases (IMD), and may be provided in the individual's home and, at state option, in other locations.

How the Benefit Can Support Rebalancing Strategies: Personal care services can help individuals to avoid institutional care, live independently in the community, and avoid or delay the need for institutional placement. In addition to assistance with ADLs and IADLs, personal care services can include cueing an individual to pay rent on time, scheduling transportation, or assisting an individual with meal preparation. This service plays a pivotal role in ensuring a

strong HCBS infrastructure, as many individuals enter institutions because of need for support with ADLs.

Case Management and Targeted Case Management

Brief Description: States can choose to furnish case management services under sections 1905(a)(19) and 1915(g) of the Act and 42 C.F.R. §440.169 to assist Medicaid-eligible individuals in gaining access to needed services. If a state elects to cover case management under the Medicaid state plan, the state can also opt to provide this benefit without regard to the statewideness and comparability requirements at section 1902(a)(1) and (a)(10)(B) of the Act, in which case the benefit is referred to as targeted case management (TCM). This means that states can target the benefit to specific populations, as described in section 1915(g)(1) of the Act. Case management services, as defined in section 1915(g)(2) of the Act and 42 C.F.R. §440.169, mean services that assist eligible individuals to gain access to needed medical, social, educational, and other services. Case management services must include all of the following: comprehensive assessment and periodic reassessment of an eligible individual’s needs; development and periodic revision of a person-centered care plan; referral to services and related activities to help the eligible individual obtain needed services; and monitoring activities.

How the Benefit Can Support Rebalancing Strategies: Case management and TCM can support strategies to provide services and supports to help individuals achieve community living goals, divert individuals from unnecessary institutionalization, and transition from medical institutions to the community. States may reimburse for services based on case or task complexity to reflect the need to draw on additional resources to develop and implement comprehensive assessments, person-centered care plans, referrals, and monitoring. While case management does not pay for the non-Medicaid services to which an individual is referred, it does provide an important linkage to those services as part of a holistic approach to addressing beneficiary needs and can avoid or delay the need for institutionalization, among other goals.



State Spotlight: Colorado
Colorado added TCM services as a state plan benefit (SPA 18-0021) to provide case management to individuals who want to transition to a community setting from a nursing facility or an intermediate care facility for individuals with intellectual and developmental disabilities (ICFs/IID). The TCM services support individuals to successfully integrate into community living by facilitating linkages to needed assistance.

Section 1945 Health Homes

Brief Description: The health homes state plan benefit authorized under section 1945 of the Act includes various services that help to ensure the coordination of all primary care services, acute care services, behavioral health (including mental health and substance use) services, and LTSS for individuals with chronic conditions and thus helps to ensure treatment of the “whole person.” Section 1945 defines health home services as: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate

follow-up, from inpatient to other settings; individual and family support; referral to community and social supports, if relevant; and use of health information technology to link services, as feasible and appropriate.

How the Benefit Can Support Rebalancing Strategies: The section 1945 health homes benefit can be used to support state strategies to provide services and supports that might help individuals achieve community living goals, divert individuals from unnecessary institutionalization, and transition individuals to integrated community settings. It can also be used to help coordinate primary, behavioral, and social support care. Health home services must also include comprehensive transitional care, including appropriate follow-up, from inpatient to other settings, and thus can support individuals as they transition between settings. States can provide comprehensive care management services that could include an assessment to identify the need for HCBS and referrals to community supports that might help with integration into the community. CMS expects that health outcomes for Medicaid beneficiaries enrolled in health homes will improve and that health homes will result in lower rates of emergency department use, reduction in hospital admissions and readmissions, reduction in health care costs and reliance on long-term care facilities, and improved experience of care for Medicaid beneficiaries with chronic conditions.

Examples of Rebalancing Strategies Using State Plan Benefits

- Develop person-centered **care management strategies** that support beneficiaries to live independently in the community. Strategies can include broadening the state coverage of certain state plan benefits to support individuals to achieve community living goals and avoid unnecessary institutionalization or combining state plan benefits with other HCBS programs to provide a more robust array of HCBS for a targeted population group.
 - Use **reimbursement methodologies based on case or task complexity** for beneficiaries with more complex needs who are eligible for state plan HCBS benefits.
 - Increase access to state plan benefits by **covering services provided by diverse caregiver provider types**, including agency providers, independent providers, and, within program requirements, family members, other relatives, or other individuals who support the beneficiary.
 - Use **census and demographic data to develop projections for HCBS needs on a state and local basis** to determine the extent to which additional state plan services might be needed to divert individuals from unnecessary institutionalization and to live independently in the community.
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Table III.1. Eligibility, limits and flexibilities, and targeting of state plan benefits

State Plan Benefits	Eligibility	Limits and Flexibilities	Population Targeting (comparability)	Geographic Targeting (statewideness)
Home Health Benefit	Mandatory for categorically needy eligibility groups and for individuals entitled to skilled nursing services in the medically needy eligibility groups.	States cannot limit the number of eligible individuals served. States may limit amount, duration, and scope of the benefit as approved by CMS and described in the state's Medicaid state plan. States may require prior authorization.	States cannot target benefit to a particular population.	Services must be offered statewide.
Personal Care Services	Individuals who meet the state's medical necessity criteria, if any. Service is mandatory for individuals under age 21 who are eligible for the EPSDT benefit, when medically necessary.	States cannot limit the number of eligible individuals served. States may limit amount, duration, and scope of the benefit as approved by CMS and described in the state's Medicaid state plan. States may require prior authorization.	States cannot target benefit to a particular population.	Services must be offered statewide.
Targeted Case Management (TCM)	Individuals who meet the state's medical necessity criteria, in any, and are in the state's defined target group. Service is mandatory for individuals under age 21 who are eligible for the EPSDT benefit, when medically necessary.	States may limit amount, duration, and scope of the benefit as approved by CMS and described in the state's Medicaid state plan. States may require prior authorization.	Under TCM, states may target benefit to specific populations.	Under TCM, states can target services less than statewide.
Health Homes	Individuals who have: (1) two or more chronic conditions; (2) have one chronic condition and are at risk for a second; or (3) have one serious and persistent mental health condition. Chronic conditions include mental health conditions, substance use disorder, asthma, diabetes, heart disease, and being overweight (body mass index over 25). States may propose including other conditions, e.g., opioid use disorder.	Enhanced federal matching funds for health home services for an initial period (90 percent federal match for health home services during the first 8 fiscal year quarters that the approved health home SPA is in effect). States can request an additional two quarters of enhanced federal match under SUD-focused health home SPAs approved on or after October 1, 2018. After the period of enhanced federal match ends, services are matched at the state's usual service rate.	Benefit is limited to individuals with chronic conditions.	States can target services less than statewide.

Helpful Resources

- [Compliance with Medicaid Home Health Final Regulation](#)
- [Targeted Case Management Services \(TCM\) Preprint](#)
- [Health Home Information Resource Center](#)
- [Health Home MACPro Portal](#)

HCBS Authorities

States can choose to provide other optional benefits under state plan authority specific to the provision of HCBS. Within broad federal guidelines, states can develop HCBS programs to meet the needs of people who prefer to receive LTSS in their home or community, rather than in an institutional setting.

Self-Direction

In [self-directed](#) service models, participants, or their representatives if applicable, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. The self-directed service delivery model is an alternative to traditionally delivered and managed services, such as an agency delivery model. Self-direction of services allows participants to have the responsibility for managing all aspects of service delivery in a person-centered planning process.

Self-direction promotes personal choice and control over the delivery of HCBS under a waiver or the state plan, including who provides the services and how services are provided. For example, participants are afforded the decision-making authority to recruit, hire, train and supervise the individuals who furnish their services. CMS calls this "employer authority." Participants may also have decision-making authority over how the Medicaid funds in a budget are spent. CMS refers to this as "budget authority."

States can choose to offer self-directed HCBS under a section 1915(c) HCBS waiver program, section 1915(i) HCBS State Plan benefit, section 1915(j) Self-Directed Personal Assistance State Plan benefit, and section 1915(k) Community First Choice State Plan benefit. However, these authorities vary in terms of the model of self-direction that is permitted under each.

Section 1915(c) Waiver Programs

Brief Description: Section 1915(c) of the Act gives states the option to offer LTSS in home and community-based settings to individuals who would otherwise require institutional care. States have broad latitude to determine the services to offer under waiver programs. However, those waiver services must not cost more than what would have been incurred to care for waiver participants in an institution. Section 1915(c) allows states to waive certain Medicaid requirements (i.e., statewideness, comparability, and income and resource rules applicable in the

community). Medicaid coverage does not extend to supporting room and board costs or other benefits that are not directly related to the provision of HCBS.

How the section 1915(c) Waiver Option Can Support Rebalancing Strategies: Section 1915(c) waiver programs can include institutional diversion services to maintain individuals in the community and transition services to actively move individuals from institutional settings to community settings. States have flexibility to offer a broad array of services and supports to help individuals achieve community living goals, improve quality of life, and achieve positive health outcomes. Under section 1915(c)(4)(B), states can also propose “other” types of services that may assist in diverting individuals from institutional placement and supporting community living for eligible individuals.



State Spotlight: Louisiana

Louisiana utilizes a tiered system to facilitate placement in the most appropriate HCBS waiver for individuals with intellectual and developmental disabilities. HCBS waiver enrollment is based on the individual's prioritized need for support identified using a standardized screening tool. Individuals with the most emergent and urgent needs for support have priority for waiver opportunities. This needs-based allocation replaced a first-come, first-served process that was previously in place.

Section 1915(i)

Brief Description: Section 1915(i) State Plan Amendments (SPA) allow states to provide HCBS to individuals who meet state-defined needs-based criteria that are less stringent than institutional criteria and, if chosen by the state, target group criteria. Section 1915(i) permits a state to furnish HCBS without regard to whether Medicaid-eligible individuals require a state-defined institutional level of care (LOC). States have the option to cover any services permissible under section 1915(c) HCBS waiver programs, which include services to support an individual in the community.

How the Benefit Can Support Rebalancing Strategies: Targeting individuals eligible for section 1915(i) services and providing them HCBS benefits before they need institutional care may help prevent the need for institutional care from ever materializing. Section 1915(i) state plan HCBS offers states the option to target the benefit to a specific population based on age, disability, diagnosis, and/or Medicaid eligibility group. Needs-based criteria may include state-defined risk factors that apply to specific groups of individuals in need of HCBS, such as homelessness, risk of food insecurity, and risk of social isolation. However, eligibility for the section 1915(i) state plan benefit must include criteria on level



State Spotlight: Arkansas

Arkansas utilizes a section 1915(i) ([SPA # 18-0016](#)) targeted to individuals with a behavioral health diagnosis who have high service needs, as indicated on a functional assessment to authorize the provision of services to support participants with functioning in home and community-based settings and moving towards recovery. Services provided through this section 1915(i) include: partial hospitalization; adult rehabilitative day treatment; supported employment; supportive housing; adult life skills development; and peer support.

of functionality and may not be determined using only risk factors. Section 1915(i) supports strategies to provide services and supports to help individuals achieve community living goals and to divert individuals from unnecessary institutionalization.

Section 1915(k) Community First Choice Optional State Plan Benefit

Brief Description: The section 1915(k) Community First Choice (CFC) state plan benefit provides certain individuals, who meet an institutional level of care, the opportunity to receive necessary personal attendant services and supports in a home and community-based setting. States receive an extra six percentage points of federal match for CFC state plan service expenditures.

How the Benefit Can Support Rebalancing Strategies: CFC can support strategies to provide services and supports to help individuals achieve community living goals, divert individuals from unnecessary institutionalization, and transition individuals to integrated community settings. Services authorized under the section 1915(k) state plan benefit facilitate beneficiary autonomy and support individuals to participate in their communities. CFC includes an option for states to pay family caregivers for personal attendant services through a self-directed model. Family caregivers could also provide services through the agency model,²³ if they meet the state's provider qualifications. CFC requires person-centered care by giving enrollees greater choice of personal care providers and offering beneficiaries more control, flexibility, responsibility, and choice in how they use the service. CFC is the only Medicaid authority that allows for reimbursement of first month's rent as an optional transition service. Coverage of transition costs can be a key service to support an individual transitioning from an institutional setting to an HCBS setting.

Section 1915(j) Optional Self-Directed Personal Assistance Services

Brief Description of Benefit: Section 1915(j) self-directed personal assistance services (PAS) means personal care and related services or HCBS otherwise available under the state plan or a section 1915(c) waiver program that are self-directed by an individual who has been determined eligible for the PAS option. Self-directed PAS also includes, at the state's option, items that increase the individual's independence or substitute for human assistance (such as a microwave oven or an accessibility ramp) to the extent that expenditures would otherwise be made for the human assistance. This inclusion also applies to CFC as described earlier.

How the Benefit Can Support Rebalancing Strategies: Section 1915(j) self-directed personal assistance services can support strategies to provide services and supports to help individuals achieve community living goals, divert individuals from unnecessary institutionalization, and transition individuals to integrated community settings. States can use this benefit to provide all eligible individuals the opportunity to use their budgets to purchase goods and services, supports, or supplies related to a need or goal identified in their state-approved person-centered service plans.

Examples of Rebalancing Strategies using HCBS Authorities

- Develop cohesive approaches to **standardizing state plan personal care services and payment rates**. States can use the CFC state plan benefit to consolidate personal care services across HCBS programs into a single state plan benefit. Approaches can include using an acuity-based service budget to contain costs and to facilitate person-centered service planning appropriate to an individual's level of need.
 - Design innovative strategies that **promote section 1915(c) waiver coverage** for a greater number of individuals while also **providing more predictable and sustainable budget outlays**. The strategies can include using a tiered system that enrolls individuals based on the severity of their needs, instead of based on the date they applied for services, or other approaches to eliminating waiver program wait lists.
 - Exercise the flexibility under **section 1915(i) authority to create highly targeted programs** that serve individuals with specific needs, including high-cost or hard-to-serve populations.
 - Use flexible approaches based on **person-centered principles** rather than a one-size-fits all approach to expand and enhance self-directed programs.
 - **Expand the continuum of HCBS** to provide a broader array of service options and caregiver supports.
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Helpful Resources

- [Section 1915\(c\) webpage](#)
- [Application for a §1915\(c\) Home and Community-Based Waiver: Instructions, Technical Guide and Review Criteria](#)
- [Section 1915\(i\) webpage](#)
- [Section 1915\(i\) Pre-Print](#)
- [Section 1915\(k\) Community First Choice](#)
- [Community First Choice Preprint](#)
- [Section 1915\(j\) webpage](#)
- [Section 1915\(j\) Pre-Print](#)
- [Home and Community-based Services During Public Health Emergencies](#)

Table III.2. Eligibility, Limits and Flexibilities, and Targeting of HCBS Authorities

HCBS Authorities	Eligibility	Limits and Flexibilities	Population Targeting (Comparability)	Geographic Targeting (Statewideness)	Self-Direction
Section 1915(c)	Individuals who meet the state's institutional level of care (meaning individuals could be admitted to a nursing facility, hospital, ICF/IID); the need for services must be based on an assessed need and identified in a state-approved service plan.	States may cap enrollment. In the aggregate, program services must not cost more than what would have been incurred to care for participants in an institution, referred to as "cost neutrality."	States may target based on age or diagnosis, including children, adults with physical disabilities, individuals with intellectual or developmental disabilities, individuals with traumatic brain injuries, individuals with MH/SUD, and older adults, among others.	States may limit a program geographically.	States can choose to offer self-directed HCBS under this benefit.
Section 1915(i)	Individuals who are eligible for medical assistance under the state plan, meet state-defined needs-based criteria, and reside in the community.	No cost neutrality requirement. States may not cap enrollment or maintain waiting lists. States may limit participation through needs-based eligibility criteria.	Option to target the benefit to a specific population based on age, disability, diagnosis, and/or Medicaid eligibility group. The lower threshold of needs-based criteria must be "less stringent" than institutional and HCBS waiver program level of care.	Benefit must be offered statewide.	States can choose to offer self-directed HCBS under this benefit.
Section 1915(k) Community First Choice Optional State Plan Benefit	Individuals who meet the state's institutional level of care (meaning the individual could be admitted to a nursing facility, hospital, ICF/IID, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the state plan) can qualify for services under section 1915(k).	States cannot limit the number of eligible individuals served.	States cannot target the benefit to a particular population.	Benefit must be offered statewide.	States can choose to offer self-directed HCBS under this benefit.
Section 1915(j) Optional Self-Directed Personal Assistance Services (PAS)	Individuals must be eligible for state plan personal care services or a section 1915(c) waiver program to qualify for services under section 1915(j).	States may limit the number of people who will self-direct their PAS.	States can target people already getting section 1915(c) waiver services.	PAS may be offered in certain areas of the state or statewide.	PAS is self-directed.

Managed Long Term Services and Supports (MLTSS)

Managed Long Term Services and Supports (MLTSS)

Brief Description: Managed long term services and supports (MLTSS) refers to the delivery of LTSS through capitated Medicaid managed care programs. States can implement MLTSS using an array of managed care authorities, including a section 1915(a) voluntary program, a section 1932(a) state plan amendment, a section 1915(b) waiver, or a section 1115 demonstration. Any of those managed care authorities can be “paired” with state plan HCBS benefits offered under section 1905(a), 1915(i), 1915(j), or 1915(k) or an HCBS waiver program under section 1915(c).

Additionally, section 1115 demonstrations can be used to authorize both the managed care delivery system and the HCBS benefits offered through that delivery system, when these reforms are part of a larger demonstration project (see discussion below). In MLTSS programs, states contract with managed care plans to deliver LTSS either as a stand-alone benefit (i.e., institutional care and HCBS) or as part of a comprehensive package of physical and behavioral health and LTSS.

How the MLTSS Program Can Support Rebalancing Strategies:

Medicaid MLTSS programs can support strategies to improve quality and cost-effectiveness of LTSS. MLTSS has the potential to: (1) increase the share of LTSS spending on HCBS relative to



State Spotlight: Wisconsin

Family Care program is a program of services for older adults and adults with developmental or physical disabilities. The program integrates HCBS, as well as a subset of state plan Medicaid services, including nursing home services, which are intended to support members living in home or community based settings. Nursing home services may be authorized to provide skilled nursing or rehabilitation services aimed at helping the member regain the ability to live more independently in his or her own home. The managed care capitation payment blends costs for both long term services and supports (LTSS) and HCBS to establish a capitation rate through value-based contracting, leading to process improvements and training opportunities.



State Spotlight: Minnesota

Minnesota requires MLTSS plans serving older adults and individuals with disabilities to enter into value-based contracts with primary/acute care, behavioral health, and LTSS providers through the Integrated Care System Partnership (ICSP) initiative. ICSP has resulted in: (1) new payment arrangements connecting provider payment to performance-defined measures; (2) investments in delivery system changes such as funding community health workers and investments in system-wide care coordination processes; and (3) strengthening of relationships between health plans and providers through value-based contracting, leading to process improvements and training opportunities.



State Spotlight: Florida

Florida's MLTSS program adjusts payments to managed care plans to incentivize the provision of HCBS. When the managed care plans achieve a designated mix of enrollees receiving HCBS and services in an institutional setting, the plans receive an incentive adjustment in capitation rates in order to increase the number of enrollees receiving services in the community instead of in institutions.

institutional care; (2) improve the quality of LTSS; and (3) establish budget predictability and growth control. MLTSS programs can support HCBS strategies that aim to promote community integration, prevent unnecessary institutionalization, and provide HCBS services to assist individuals transitioning from institutional settings. Additionally, MLTSS programs can include the coordination of primary, behavioral, and social support care for beneficiaries, depending on the scope of services the state contracts with health plans to provide.

Examples of Rebalancing Strategies using MLTSS Programs

- Use **financial incentives** for MLTSS plans to **offer HCBS** instead of institutional care.
- Use **contract incentives and risk-adjustment methods** under MLTSS programs to promote the delivery of services in HCBS settings.
- Promote **value-based payment (VBP) arrangements** with providers in MLTSS programs to increase the value and quality of HCBS services. VBP models could be delivered through shared savings/shared risk arrangements, episode-based payments, or other alternative payment models.²⁴
- Expand the scope of MLTSS programs to include **enrolling individuals with intellectual or developmental disabilities**.

Table III.3. Eligibility, limits and flexibilities, and targeting of MLTSS Programs

MLTSS Programs	Eligibility	Limits and Flexibilities	Population Targeting	Geographic Targeting
Managed long term services and supports (MLTSS)	Medicaid beneficiaries who receive services under Medicaid managed care contracts who meet the state's defined medical necessity criteria, if any, for the services defined under the contract.	States can use financial incentives and risk adjustment to promote the delivery of services in HCBS settings. States can contract with managed care plans to deliver LTSS either as a stand-alone benefit, as part of a limited set of non-inpatient services, or as part of a comprehensive package of services.	States may choose to include LTSS beneficiaries and HCBS services and supports in managed care delivery systems or choose to carve out certain populations from receiving HCBS under managed care and instead retain a fee for service arrangement. Under section 1915(b) authority, states may require dually eligible, American Indians/Alaska Natives, and children with special health care needs to enroll in a managed care delivery system.	Under waiver or demonstration authority or using a section 1932 state plan amendment, states may limit a MLTSS program geographically.

Helpful Resources

- [Managed Long-term Services and Supports \(MLTSS\) webpage](#)
- [Managed Long-Term Services and Supports FAQs](#)

Research and Demonstration Programs

Research and demonstration programs provide opportunities for states to test and demonstrate services and activities that may improve access, promote service quality, drive better health outcomes and quality of life improvements, and institute reforms that focus on evidence-based interventions.

Section 1115 Demonstration Authority

Brief Description: States can utilize section 1115 demonstration authority to test new strategies to promote the objectives of the Medicaid program that are not available under other authorities. Section 1115(a)(1) of the Act allows the Secretary to waive compliance with the Medicaid requirements of section 1902 of the Act,

including but not limited to statewideness and comparability, to the extent and for the period necessary to carry out the demonstration project. In addition, section 1115(a)(2) of the Act allows the Secretary to provide FFP for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.

How Demonstration Projects Can Support

Rebalancing Strategies: Section 1115 demonstration authority can support strategies to test and provide services and supports to help individuals achieve community living goals, to divert individuals from unnecessary institutionalization, transition to integrated community settings, and coordinate primary, behavioral, and social support care. States can use section 1115 demonstration authority to expand eligibility for HCBS

and to expand the amount and type of services offered. States may test innovative approaches for providing HCBS for a specific target population or a new eligibility group or in a limited geographic area. States can test services and supports that could enhance HCBS and that would not typically be eligible for FFP under a state Medicaid program. Some states use section 1115 demonstration authority to authorize both managed care and HCBS.



State Spotlight: Rhode Island

Rhode Island's section 1115 demonstration allows new applicants who are functionally eligible for LTSS to self-attest to financial eligibility and receive a limited benefit package of HCBS while their eligibility determination is pending. This strategy can help to divert individuals from unnecessary institutionalization in addition to helping individuals retain their community housing by expediting transitions from institutions to the community.



State Spotlight: New Jersey

New Jersey's section 1115 demonstration requires participating managed care organizations to have a nursing facility diversion plan for beneficiaries who receive HCBS.

Consistent with all section 1115 demonstrations, states interested in using demonstration authority to address HCBS are required to conduct independent and robust interim and summative evaluations that draw on data collected for monitoring, as well as other data and information needed to support an evaluation that will describe the effectiveness and impact of the demonstration using quantitative and qualitative analytical methods. States with section 1115 demonstrations are also required to conduct quarterly and annual monitoring, which will lean on measures identified to monitor LTSS and HCBS programs more generally.



State Spotlight: Hawaii

Hawaii's section 1115 demonstration provides HCBS services to Medicaid eligible individuals who meet an institutional level of care and an expanded subset of HCBS services for individuals who do not meet an institutional level of care but are assessed to be at risk of deteriorating to institutional care in order to prevent a decline in health status and maintain individuals safely in their homes and communities. In 2019, Hawaii included a rebalancing quality measure for managed care organizations in its managed care pay for performance program. Hawaii also has efforts underway to enhance competency among HCBS providers in the community to serve LTSS beneficiaries with complex behavioral health needs.

Money Follows the Person Demonstration

Brief Description: The Money Follows the Person (MFP) demonstration is a grant-funded initiative designed to shift Medicaid's long-term care spending from institutional care to HCBS. Program goals include: increasing the use of HCBS and reducing the use of institutionally-based services; eliminating barriers in state law, state Medicaid plans, and state budgets that restrict the use of Medicaid funds to let people receive long-term care in the settings of their choice; strengthening the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions; and putting procedures in place to provide quality assurance and improvement of HCBS.

How the MFP Demonstration Program Can Support Rebalancing Strategies: The MFP demonstration has supported strategies to test and provide services and supports to help individuals to transition from medical institutions to integrated community settings, to achieve community living goals, and to divert individuals from unnecessary institutionalization. MFP provides critical tools to address gaps in the availability of transition services and community services for Medicaid eligible individuals with disabilities and older adults.

Examples of Rebalancing Strategies Using Research and Demonstration Programs

- **Pilot and test new HCBS services or new eligibility groups under section 1115 demonstration authority** to expand and enhance HCBS. For example, states can test the effectiveness of providing early use of HCBS to individuals who may not meet the financial eligibility for Medicaid.
- **Test financial eligibility incentives** to encourage use of HCBS over institutional care.
- **Exercise the flexibility under Medicaid to combine authorities** to implement programs aimed at maintaining individuals in the community and diverting individuals from unnecessary institutionalization. For instance, states can pursue a strategy to overlay a section 1115 demonstration authority over a section 1915(i) authority to provide HCBS to a section 1915(i) eligible population group in a specific geographic area.
- For MFP participating states, leverage the demonstration to **expand and enhance HCBS systems**. For instance, MFP grantees can use grant funding to assess and implement changes to reimbursement rates and payment methodologies to expand HCBS provider capacity, build Medicaid-housing partnerships, provide caregiver training and education, and promote pre-admission diversion strategies, among others.

Table III.4. Eligibility, limits and flexibilities, and targeting of research and demonstration programs

Research and Demonstration Programs	Eligibility	Limits and Flexibilities	Population Targeting	Geographic Targeting	Self-Direction
Section 1115 Demonstration Authority	States may waive certain statutory provisions such as “comparability” to define target populations for demonstration services/activities, which should be available based on individual assessments of need as defined by the state.	Demonstrations must be budget neutral, meaning that the federal costs associated with the proposed demonstrations cannot exceed the federal Medicaid costs absent the demonstration.	States can target section 1115 demonstration services to particular populations meeting defined characteristics.	States can waive “statewideness” to target demonstration services at particular geographic areas.	States can choose to offer self-directed HCBS under this authority.
Money Follows the Person Demonstration	Participants must be Medicaid beneficiaries residing in an institution for 90 days or more, not counting short-term rehabilitation days. In addition, participants must move to a qualified residence in the community.	States project annual transition benchmarks to determine enrollment based on an annual grant-funded budget.	States can target demonstration services to particular populations meeting a state’s institutional level of care and MFP eligibility criteria.	States can target MFP demonstration services at particular geographic areas.	States can choose to offer self-directed HCBS under this project.

Helpful Resources

- [Section 1115 Demonstrations](#) webpage
- CMCS Informational Bulletin on [Section 1115 Demonstration Process Improvements](#)
- [Money Follows the Person Demonstration](#) webpage

Integrated Care to Enhance and Expand HCBS

Accountable Care Organizations and Patient-Centered Medical Homes

Brief Description: Patient-centered medical homes (PCMHs) and accountable care organizations (ACOs) are integrated care models that emphasize person-centered, continuous, coordinated, and comprehensive care. These models typically include partnerships with community-based organizations, social service agencies, counties, and public health resources.

How the Program Can Support Rebalancing Strategies: Medicaid ACO models generally fall into three types: provider-based; MCO-based; or regional/community partnership based. These models can support strategies to coordinate comprehensive care that may include the integration of LTSS. ACO models can

support a variety of innovative approaches to address the needs of individuals eligible for LTSS, such as interdisciplinary care teams and comprehensive care coordination services, while providing flexibility for states to develop payment mechanisms that support intensive care interventions such as tiered rate

methodologies and shared savings models. In some models, ACOs can also receive a per member per month payment to provide services and accept full financial risk for the health of their assigned or attributed population.²⁵ CMS allows states considerable flexibility in structuring payment mechanisms for PCMH, ACO, and ACO-like models and encourages states to move from volume-based FFS reimbursement to integrated care models with financial incentives to improve beneficiary health outcomes.



State Spotlight: Massachusetts

Massachusetts requires Medicaid ACOs and MCOs to contract with community-based LTSS and behavioral health entities to help participants navigate the LTSS and behavioral health systems and to provide cross-continuum coordination with the goal of improving participant experience and quality of care and to leverage the expertise of existing community-based organizations serving these populations.

Integrated Care for Dually Eligible Individuals

Brief Description: Dually eligible individuals must typically navigate between two separate programs: (1) Medicare for the coverage of most preventive, primary, and acute health care services and prescription drugs, and (2) Medicaid for the coverage of LTSS, certain behavioral health services, and Medicare premiums and cost-sharing. Medicare’s Dual Eligible Special Needs Plans (D-SNPs) must have contracts with the applicable state Medicaid program that describe how the plan will coordinate Medicare and Medicaid services. Medicare-Medicaid integrated care refers to delivery system and financing approaches that maximize care coordination and mitigate cost-shifting incentives, including total-cost-of care accountability across Medicare and Medicaid. Some states also partner with CMS on demonstrations to promote integrated care under the Financial Alignment Initiative.



State Spotlight: Arizona

Arizona’s Medicaid agency uses several strategies to enroll dually eligible individuals in aligned D-SNP and Medicaid plans, including: requiring that Medicaid contractors operate a D-SNP in the same service areas as their Medicaid plans; permitting D-SNPs to tailor their marketing efforts to their own Medicaid MLTSS members; investing in educational outreach to promote aligned enrollment; and coordinating with state Aging and Disability Resource Center State Health Insurance Assistance Program (SHIP) information and referral specialists to educate individuals about the benefits of D-SNPs.

How the Program Can Support

Rebalancing Strategies: Integrated care programs for dually eligible beneficiaries can support state strategies to better coordinate care, provide high quality HCBS, and improve administrative processes between the Medicare and Medicaid programs. Aligning Medicare and Medicaid’s financing and delivery of services can support dually eligible individuals to avoid unnecessary institutionalization and to achieve community living goals.²⁶ Integrated care programs for dually eligible beneficiaries can expand HCBS provider networks and streamline access to services. States can promote integrated care and LTSS policy objectives through contracts with D-SNPs, as described in the [December 19, 2018 State Medicaid Director letter](#). States can also pursue integrated care through opportunities described in the [April 24, 2019 State Medicaid Director letter](#).

Programs of All-Inclusive Care for the Elderly (PACE)

Brief Description: PACE provides comprehensive medical and social services to certain frail, elderly individuals, most of whom are dually eligible for Medicare and Medicaid. An interdisciplinary team of health professionals provides PACE participants with coordinated care.

How the Program Can Support Rebalancing Strategies: PACE provides a range of integrated preventive, acute care, and long-term care services to manage the often complex medical, functional, and social needs of individuals over age 55. PACE provides participants, families, caregivers, and health care providers the flexibility to meet a person’s health care needs while continuing to live safely in the community as long as is feasible. The PACE benefit package consists of all Medicare and Medicaid covered services, along with other services the interdisciplinary team determines are necessary to improve and maintain the participant’s overall health status.



State Spotlight: California

In response to COVID-19, WelbeHealth, a **California** PACE program provider, has shifted to a remote home-based model to provide care while enabling participants to stay physically distanced. PACE program participants are provided with tablets to enable video communications to manage medical and social needs. If in-person care is needed, it is conducted by a single caregiver in the home whenever possible.

Examples of Rebalancing Strategies Using Integrated Care to Enhance and Expand HCBS

- Develop programs that align MLTSS with Medicare managed care for individuals who are dually eligible for Medicare and Medicaid.
 - Use a variety of levers when developing Medicaid ACO programs to expand HCBS services. For example, states can include HCBS measures in its required ACO measurement, incorporate socioeconomic factors into ACO rate setting, and require ACOs to partner with providers that offer HCBS and social services.
 - Promote the value of integrated care for dually eligible individuals to both providers and beneficiaries. For example, states could coordinate with D-SNPs to develop education and outreach activities to help beneficiaries understand the value of integrated programs.
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Table III.5. Eligibility, limits and flexibilities, and targeting of integrated care to enhance and expand HCBS

Integrated Care to Enhance and Expand HCBS	Eligibility	Limits and Flexibilities	Population Targeting	Geographic Targeting
Accountable Care Organizations (ACO)	States have broad flexibility in the design of ACO models.	States typically use a per member per month payment model, with or without quality or cost incentives, in PCMH models. States use shared savings and/or shared risk models, with quality requirements and/or incentives, to create a financial incentive for providers to deliver value over volume in ACO models.	ACOs and PCMHs can target specific populations.	ACOs and PCMHs can target specific geographic areas.
Programs of All-Inclusive Care for the Elderly (PACE)	Individuals can generally join PACE if they meet certain conditions: age 55 or older; live in the service area of a PACE organization; require a nursing facility level of care; and be able to live safely in the community.	Financing for the program is capitated; providers deliver all services participants need rather than only those reimbursable under Medicare and Medicaid fee-for-service.	Individual must meet PACE eligibility criteria and live in the PACE organization's service area.	Each PACE organization has a defined service area.
Integrated Care for Dually Eligible Individuals	Must meet federal requirements for Medicare eligibility and state-specific qualifications for Medicaid eligibility. An individual may be eligible for Medicare if he/she is 65 or older, younger than 65 with disabilities, or has end-stage renal disease.	Varies by type of integrated care approach. Most states use capitated managed care approaches that are subject to Medicaid actuarial soundness requirements.	Integrated care programs may target specific subsets of dually eligible beneficiaries.	Integrated care programs may target specific geographic areas.

Helpful Resources

- Agency for Healthcare Research and Quality [Patient-Centered Medical Home Resource Center](#)
- [Programs of All-Inclusive Care for the Elderly \(PACE\)](#) webpage
- [Medicare-Medicaid Coordination Office: Opportunities for State](#) webpage
- [People Dually Eligible for Medicare and Medicaid](#) fact sheet
- [State Medicaid Director Letter # 20-004](#) on Value-Based Care Opportunities in Medicaid

Administrative Activities under Medicaid to Enhance and Expand HCBS

Federal matching funds under Medicaid are available for costs incurred by the state for administrative activities that directly support efforts to identify and enroll eligible individuals into Medicaid and that directly support the provision of medical services covered under the state Medicaid plan to Medicaid eligible individuals. The administrative activities must be performed either directly by the state Medicaid agency or through contract or interagency agreement with another entity.

Partnership Development

State Medicaid agencies employing individuals to perform certain partnership building and collaboration activities may claim the 50 percent federal administrative claiming rate for these activities if the costs can be recognized as allowable Medicaid administrative costs. These costs may be claimed only to the extent that the state has documented that the costs directly benefit the Medicaid program and are claimed consistent with federal cost allocation principles.

How Partnership Development Can Support Rebalancing Strategies: Medicaid can support collaboration with other community-based programs including state and local housing agencies, Area Agencies on Aging (AAAs), centers for independent living (CILs), Aging and Disability Resource Centers (ADRCs), social service agencies, advocacy agencies, faith-based organizations, and other community-based entities that support an individual's ability to live and receive needed care in their chosen community setting. These partnerships can support state strategies aimed at increasing access to HCBS and enhancing and expanding HCBS system capacity.

State Medicaid agencies with detailed questions regarding the availability of Medicaid administrative funding should contact CMS for further information and technical support.



State Spotlight: Oregon

As a state participant in the Medicaid Innovation Accelerator Program (IAP) Community Integration through Long-Term Services and Supports (CLTSS) housing partnership track, **Oregon** formed an IAP Core Team with active participation by the Oregon Health Authority (OHA), the Department of Human Services, Aging and People with Disabilities (DHS-APD), and the Oregon Housing and Community Services (OHCS). The partnership identified cross-system strategies for increasing community-integrated housing opportunities, resulting in substantial increases of supportive housing for Medicaid beneficiaries eligible for LTSS.



State Spotlight: Washington

Washington State uses a high level of data aggregation and sharing across Medicaid claims, criminal justice, behavioral health, and social service systems. The state has two data integration activities: AIM (Analytics, Interoperability, and Measurement), which is funded through a State Innovation Models (SIM) grant, and PRISM (Predictive Risk Intelligence System), which is a sustainable and ongoing activity of Washington State's Department of Social and Health Services. In addition, using the state's integrated data platform facilitates understanding of the needs of Medicaid beneficiaries across all domains of service interaction, providing critical information to identify outcomes of rebalancing efforts.

Helpful Resources

- [Medicaid Administrative Claiming](#) webpage
- [Medicaid Innovation Accelerator Program, Community Integration through Long-term Services and Supports](#) webpage

Data and Information Technology

Integrated information systems and data sharing capabilities at the state level are critical to supporting the role of states in assuring appropriate, accessible, and cost-effective care for individuals with LTSS needs. Medicaid offers a variety of pathways to support the design and development of statewide data and analytic infrastructure for expanding and enhancing HCBS.

How Data and Information Technology Can Support Rebalancing Strategies: Leveraging Medicaid resources to support data integration and data sharing can assist state health systems to identify individuals who want to transition to a less restrictive setting and to link individuals to community-based resources and social support services. States can also promote data sharing and integration across various agencies, such as human services programs, housing programs, employment agencies, transportation agencies, Area Agencies on Aging (which coordinate and offer services that can help older adults remain in their homes), and Aging and Disability Resource Centers (which provide objective information, advice, counseling, and assistance to help older adults, people with disabilities, and their family members, regardless of income, with accessing LTSS).

Examples of Rebalancing Strategies using Administrative Activities under Medicaid to Enhance and Expand HCBS

- Develop formal and informal agreements and working relationships with state and local housing and community development agencies to facilitate access to existing and new housing resources for Medicaid beneficiaries transitioning from institutional settings to the community.
 - Build data sharing and interoperability systems that allow HCBS care coordinators to identify community partners to expand access to community-based resources and make direct referrals.
 - Employ staff with expertise in housing, employment, and transportation to build relationships with community-based organizations and programs to increase access to community integration opportunities for Medicaid beneficiaries eligible for HCBS.
 - Streamline and simplify HCBS eligibility processes to shorten the amount of time that it takes to determine eligibility and begin services, as well as to reduce administrative barriers to eligibility and enrollment.
 - Consider changes to institutional eligibility criteria and processes, particularly for low acuity beneficiaries who can be better served in the community.
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Helpful Resources

- [State Medicaid Director Letter #16-003](#) on Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers
- [State Medicaid Director Letter # 16-004](#) on Mechanized Claims Processing and Information Retrieval Systems-Enhanced Funding
- [State Medicaid Director Letter # 13-004](#) on Transformed Medicaid Statistical Information System (T-MSIS) Data

Institutional Tools That Can Support Rebalancing Strategies

As described in table III.6, under the Medicaid program, the institutional benefit has several requirements that prevent inappropriate admissions or facilitate nursing facility residents’ safe return to their communities.

Table III.6. Institutional Tools that May Support Rebalancing Strategies

Tool	Description
Discharge requirements and guidance for Nursing facility Mandatory Benefit	<p>In October 2016, CMS published a final rule that revised the requirements for long-term care facilities that participate in the Medicare and Medicaid programs (81 FR 68688-68872). In November 2017, CMS issued revised interpretive guidance in the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities. The guidance discussed requirements related to discharge planning in nursing homes found at 42 C.F.R. §483.21(c)(1). The requirements include:</p> <ul style="list-style-type: none"> • Focusing on the resident’s discharge goals; • Making the resident an active partner in discharge planning; • Reducing factors which lead to preventable readmissions; • Considering caregiver availability, capacity, and capability to care for the resident after discharge; • Documenting that a resident has been asked about their interest in returning to the community; and • Using data to select another post-acute care provider for residents who are being transferred. <p>The updated interpretive guidance for discharge planning provides additional information and examples of non-compliance at different levels of severity to help federal and state surveyors, as well as nursing homes, evaluate whether a nursing home is compliant with the federal requirements.</p>
Preadmission Screening & Resident Review (PASRR)	<p>PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care and to ensure that people with intellectual and developmental disabilities and/or serious mental illness receive necessary services in nursing homes or in the community. PASRR is an important tool for states to use in rebalancing services away from institutions and towards supporting people in their homes. The process advances person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long-term care.</p>
Minimum Data Set (MDS)	<p>MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing facilities. Among other things, it is used by nursing facility staff to assess each resident’s functional capabilities and identify health problems. Section Q of the MDS is used by nursing facility staff to assess the resident’s expectations (directly or through family</p>

Tool	Description
	<p>members/representatives) of outcomes of care in the nursing home and expectations about returning to the community. The Section Q assessment:</p> <ul style="list-style-type: none">• Is resident-driven, not what the nursing home believes is the best option;• Engages residents in their discharge planning goals; and• Directly asks residents if they want information about options in the community. <p>MDS Section Q promotes information exchange and discharge planning collaboration between nursing homes, local contact agencies, and home and community-based care providers.</p> <p>Information on how states can access MDS data, as well as Medicare data on beneficiaries dually eligible for Medicare and Medicaid, for care coordination, quality improvement, and program integrity purposes is available here.</p>

Endnotes

²² Defined at section 1915(c)(5) of the Act, “habilitation services means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings.”

²³ The agency-provider model can include two different approaches. In a traditional agency model, the agency is the attendant’s employer yet the individual retains hiring and firing authority of their personal care attendants. In an agency-with-choice model, the individual and the agency are “co-employers” with the agency operating solely as a fiscal intermediary. Under the traditional model, the employment relationship between the provider and the agency does not change; however, under the “co-employment” model, the agency-provider definitions can be altered to better reflect various service provision arrangements. Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services. 2012. Medicaid Program: Community First Choice Benefit. Final Rule. 77 Fed. Reg. 26828-26903.

²⁴ Medicaid managed care regulations at 42 CFR 438.6(c) include requirements for how states may direct plan expenditures in connection with implementing delivery system and provider payment initiatives under Medicaid managed care contracts. These types of payment arrangements permit states to direct specific payments made by managed care plans to providers under certain circumstances, including payments to promote specific value-based payment (VBP) arrangements. Additional information on payment arrangements under 42 CFR 438.6(c) is available here: <https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/index.html>.

²⁵ As discussed in the Medicaid and CHIP Managed Care Final Rule (81 Fed. Reg. 88 (May 6, 2016): 27731-27732), states may operate PCCM programs - under the rubric of integrated care models, ACOs, or other similar arrangements - without triggering the standards of 42 C.F.R. Part 438 (which include additional contractual obligations) as long as enrollees’ freedom of choice is not constrained and any willing and qualified provider can participate - that is, where traditional FFS rules for provider participation remain in place. States operating ACOs, integrated care models, or PCMH programs are outside of the purview of Medicaid managed care and are not bound by 42 C.F.R. Part 438. However, the requirements of 42 C.F.R. Part 438 may apply if the ACOs function as managed care plans. Additional information is available at <https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-final-rule/index.html>.

²⁶ Assistant Secretary for Planning and Evaluation (ASPE). *Minnesota Managed Care Longitudinal Data Analysis*. Available at: <https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis>.

Module IV: State Strategies to Rebalance LTSS Systems

Many state Medicaid programs are implementing strategies to achieve a more equitable balance between the share of spending and use of services delivered in home and community-based services (HCBS) settings relative to institutional care. This section provides examples of innovative models of care and strategies that states are implementing to reform and recalibrate long-term services and supports (LTSS) systems and to expand and enhance HCBS.

Contents of Module IV:

- Case studies on state strategies to expand and enhance HCBS
- Transforming institutional models
- Helpful resources on these topics

State Strategies to Expand and Enhance HCBS and Promote Transitions to the Community

Testing new eligibility groups and benefit packages for individuals “at risk” of future Medicaid long-term services and supports. Some states are testing and evaluating the provision of a broad array of service options to enable older adults and individuals with disabilities to remain at home, delaying or avoiding the need for more intensive services.



Washington State’s Medicaid transformation project section 1115(a) demonstration is testing three services: (1) a new optional Medicaid Alternative Care (MAC) benefit package for individuals eligible for Medicaid LTSS but choosing to wrap services around their unpaid family caregiver rather than receiving services through traditional personal care services paid through Medicaid; (2) a new eligibility category and limited benefit package, Tailored Supports for Older Adults (TSOA), for individuals “at risk” of future Medicaid LTSS who do not currently meet Medicaid financial eligibility criteria; and (3) a Foundational Community Supports (FCS) Program to provide a set of HCBS to a population who meet risk and needs-based criteria. The MAC benefit package will provide another community option for clients and their families to choose from—and will provide support for unpaid family caregivers—avoiding or delaying the need for more intensive Medicaid-funded services. The services could include training, respite, and support groups, and the necessary services will be defined during the person-centered planning process. At any time, beneficiaries can opt out of MAC and receive the traditional Medicaid services for which they are eligible. The TSOA benefits are nearly identical to the MAC benefit package, but are furnished to individuals whose Medicaid eligibility could have been provided under 42 C.F.R. §435.236 and §435.217 but, instead, is authorized through the 1115 demonstration. Under the FCS program, the state is providing two categories of HCBS, consistent with services provided under a section 1915(c) waiver program or 1915(i) SPA, to eligible beneficiaries: community transition services for individuals moving from institutional settings to community settings, chronic homeless

populations, and those at imminent risk of institutional placement. Employment supports are targeted to individuals with significant behavioral health needs and/or individuals with chronic health or complex physical health challenges such as traumatic brain injury. Employment supports are also intended to support participants with achieving financial self-sufficiency and avoiding long-term dependence on public systems.

Increasing access to and use of HCBS over institutional services by targeting an at-risk population group. Some states are using the section 1915(i) state plan HCBS authority to target populations who would benefit from HCBS but do not meet an institutional level of care to qualify for section 1915(c) waiver programs. The section 1915(i) state plan benefit can be effective at targeting populations who may be at risk of unnecessary or inappropriate institutionalization.



Texas utilizes a section 1915(i) ([SPA # 20-0003](#)) to provide Medicaid state plan HCBS to individuals over the age of 18 with a serious mental illness who need assistance with behavioral health, ADLs and IADLs, or functional needs and strengths, and who meet certain risk factors. Texas provides the following services through this section 1915(i) benefit: transition assistance; HCBS psychosocial rehabilitation; adaptive aids; employment support; transportation; community psychiatric supports and treatment; peer support; host home/companion care; supervised living; assisted living; supported home living; respite care; home delivered meals; minor home modifications; nursing; substance use disorder services; and HCBS adult mental health recovery management.

Authorizing higher reimbursement rates for HCBS in rural areas. Older adults living in rural areas are less likely than those in urban areas to use HCBS and are more likely to use nursing facility services. Some states are implementing strategies to help Medicaid beneficiaries eligible for LTSS in rural areas to remain in their own homes and communities and, in turn, to contain Medicaid LTSS costs.



Utah implemented the Rural Home Health Travel Enhancement ([SPA 16-0011](#)) under a state plan home health benefit to authorize higher rates for providers delivering home health services in rural areas. The enhancement is available only in rural counties where round-trip travel distances from the caregiver's base of operations are in excess of 50 miles.

Enhancing a state's HCBS system by expanding coverage of HCBS, standardizing personal care services, and increasing direct service workforce capacity. Some states use the section 1915(k) Community First Choice state plan benefit to expand HCBS coverage while also containing costs. CFC can help states to standardize personal care across HCBS programs, reduce administrative burden, implement cost-containing utilization controls, and provide the state opportunities to invest the CFC enhanced match into HCBS system improvements.



Connecticut's Community First Choice (CFC) section 1915(k) state plan benefit aligns with the self-directed service budget model. Under Connecticut's CFC program, an individual has a service plan and an individual service budget based on a person-centered assessment of need. The individual has the opportunity to hire, supervise, and train their own staff as well as the opportunity to manage their own budget, either on their own or with support from someone of their choosing, exclusive of the individual's spouse or legally liable

family member. Individual service budgets are based on need grouping categories that reflect expected resource utilization based on functional needs and risks. In addition to the required CFC services, Connecticut also covers expenditures for transition costs of establishing a community residence for an individual moving into the community from an institution and expenditures for services substituting for human assistance, including home delivered meals, environmental assessments, and assistive technology.

Investing in technology improvements to increase efficiency and to strengthen capability to coordinate with community-based partners. Developing a partnership between the Preadmission Screening and Resident Review (PASRR) program and local Aging and Disability Resource Centers (ADRCs) can help to ensure that older adults with mental health and/or intellectual disability are in the most appropriate setting of their choice. Regulations governing PASRR are found in the Code of Federal Regulations, primarily at [42 C.F.R. § 483.100-138](#).



Utah's electronic PASRR system provides screening for evidence of mental illness and/or intellectual disabilities to evaluate and facilitate the most appropriate setting for applicants and to provide applicants the services they need in those settings. Utah's electronic PASRR system has improved tracking and reporting capability for the Medicaid agency by adopting a secured web-based electronic process to automate PASRR evaluations of individuals' health status and to automate billing systems. The turnaround time for Utah PASRR Level II evaluations has improved from nine business days under the paper process to two business days under the new electronic system. This efficiency reduces the delay in initiating services needed by the individual based on their evaluation. In addition to the improvements with PASRR, Utah is working toward bridging PASRR and the ARDCs as a part of the state's larger rebalancing effort. This will be done through collaboration and a secure web based system that sends an automated secure email to the nursing facilities and the ARDCs to help facilitate community integration.

Testing and evaluating value-based payment models to create more accountability for the quality and cost of LTSS. Some states are implementing and testing performance-based payment strategies that have the goal of linking financial incentives to providers' performance on a set of defined measures of quality and/or cost or resource use. Value-based payment models range from rewarding performance in fee-for-service to models that involve capitation.



Arizona's Long Term Care System (ALTCS) program contracts with managed care plans to provide LTSS coverage for older adults and individuals with physical or intellectual disabilities through a risk-based capitation model. The ALTCS program covers members enrolled in the Elderly and Physical Disabilities program (EPD) and members enrolled in the Developmental Disabilities program (DDD) under unique contracts. The EPD program provides acute care, behavioral health services, case management, and LTSS, including HCBS, for eligible older adults and individuals with physical disabilities, using fully integrated contracts where the LTSS are provided by the same managed care plan that provides the acute care, behavioral health, and case management services. Both EPD and DDD managed care plans are required to meet value based purchasing strategy thresholds/targets in contracting with their providers. Under the ALTCS-EPD contracts, the state has structured managed care plan contracts

to include value-based purchasing targets on several measures: emergency department utilization; hospital readmission within 30 days of discharge; hemoglobin A1c (HbA1c); testing; low-density lipoprotein cholesterol (LDL-C) screening; and flu shots for adults 18 years and older. Managed care plans are granted flexibility to implement value-based payment arrangements with providers that are appropriate for their populations and business models.



Minnesota requires managed care plans serving older adults and individuals with disabilities to enter into value-based contracts with primary care, long-term, and/or behavioral health providers, referred to as the Integrated Care System Partnership (ICSP) initiative. The ICSPs are designed to improve health care access, coordination, and outcomes by establishing partnerships between managed care plans and health care providers. Each ICSP must incorporate quality measures and monitor for progress. For example, under the ICSP initiative an ACO organization and a managed care plan entered into a shared savings agreement to improve care coordination for older adults. The two organizations sought cost savings from improved care coordination, care transitions, and management of chronic diseases, which contributed to a reduction in hospital admissions and emergency room visits. The amount of savings that the ACO is eligible to receive is determined by performance on two Healthcare Effectiveness Data and Information Set (HEDIS) measures: plan all-cause readmissions and use of high-risk medications in older adults. HEDIS is a comprehensive set of standardized performance measures related to public health issues, such as cancer, heart disease, smoking, asthma, and diabetes.



The **Kansas** Medicaid program implemented a pay for performance incentive for nursing facilities to improve quality and incorporated a withhold measure²⁷ with managed care plans to promote contracting with nursing facilities that improved quality. Under the Promoting Excellent Alternatives in Kansas Nursing Homes Program, known as PEAK, nursing facilities can be placed in one of five incentive levels to track how they are pursuing culture change that supports person-centered care based on resident choice, staff empowerment, physical environment, and meaningful life. A pay for performance incentive payment is attached to each level.

Leveraging state and other federal programs (for instance, programs funded by the [Older Americans Act](#)) that could help to delay or avoid Medicaid enrollment for older adults. Some individuals who have entered nursing facilities may exhaust their assets and resources to pay for their institutional care to the point of meeting income qualifications for Medicaid. States can leverage federal programs and tools in coordination with state-only funding resources to help individuals who are residing in nursing facilities or living in the community delay or avoid qualifying for Medicaid.



Minnesota's Return to Community Initiative (RTCI) is a statewide program that assists non-Medicaid individuals who are at risk of becoming long-stay nursing home residents with returning to the community. The RTCI program utilizes the Minimum Data Set (MDS) to identify individuals who: are not Medicaid eligible at nursing facility admission; have resided in a nursing facility for at least 45 days; indicated on section Q of the MDS a desire to return to the community; and have met certain health and functional criteria documented during

admission. The RCTI program is administered by the Minnesota Board on Aging in coordination with local Area Agencies on Aging who employ Community Living Specialists to facilitate transitions to the community for program participants. The return on investment objective for the state is to achieve cost savings indirectly by delaying or avoiding consumer spend down to Medicaid.

Transforming Institutional Models

In addition to expanding and enhancing HCBS capacity, some states are implementing LTSS rebalancing strategies that focus on decreasing the use of institutional care. Among more than 15,000 nursing homes that were operating in 2018, many have declining occupancy rates, indicating less demand for nursing facility care. Reductions in acute care hospitalizations that have lowered the demand for post-acute care in nursing facilities, as well as the increasing availability of HCBS, are just a few of the factors contributing to declining occupancy rates.^{28,29}

In addition to these “push” factors that reduce the need for nursing facility beds, a number of states have introduced policies or programs intended to proactively “pull” institutions to downsize, close, or shift their operations to the delivery of HCBS. States have a number of options to encourage this type of institutional transformation, including:

- Nursing home bed buyback programs;
- Repurposing long-term care facilities; and
- Supporting new business models for direct service workers (DSWs).

Many factors influence LTSS system rebalancing, and institutional transformations represent an important set of tools for states to use to support nursing homes and other institutions, as well as their staff, in the transition to delivering HCBS. In the remainder of this section, we profile a sample of state approaches to using these tools.

Nursing home bed buyback programs. Many states have tried to encourage nursing homes to downsize or close by compensating owners. This approach has had mixed success.



In **Minnesota**, the state legislature passed legislation in 2000 that allowed nursing facilities to lay-away up to 50 percent of their licensed and certified beds for up to five years. Such beds had the same status as voluntarily delicensed beds and were not subject to license fees, but could be put back into service at any time after at least one year of lay-away status. This was followed in 2001 by a Voluntary Planned Closure Program, which granted a rate increase to nursing facilities that voluntarily closed beds on a permanent basis, at a rate of \$2,080 per bed. As of January 2005, 4,900 bed closure applications had been approved, and 3,300 had closed. The program remains in effect and is referred to as the Planned Closure Rate Adjustment program.



North Dakota implemented a similar nursing home bed buyout program from June 2001 – June 2003, funded through intergovernmental transfer supplemental payments. The buyback fee varied by facility depending on the number of closed beds, ranging

from \$8,000 - \$15,000 per bed. The program resulted in 286 closed beds and two facility closures, at a cost of approximately \$3.4 million and was considered to have accomplished its goal of reducing the number of licensed, unoccupied beds.



More recently in 2013, **Oregon** instituted bed buy-back program to incentivize nursing facilities to reduce their licensed capacity. Oregon had the nation's lowest occupancy rates, averaging approximately 60 percent, compared to the national rate of 81 percent. The state aimed to decrease the number of beds by 1,500 by allowing nursing facilities to purchase other facilities' full bed capacity in exchange for a rate augmented by \$9.75 per resident day for up to four years. Only facilities that closed the other nursing facility's operations were eligible for the incentive. Oregon nearly achieved the 1,500 bed goal. However, only one nursing facility ended up closing as a result of this program. The remaining beds were reduced through voluntary reduction of licensed beds. Industry sources informed Oregon that more "buy and close" transactions did not take place because the \$9.75 incentive did not "pencil-out" from a fiscal perspective.

Repurposing of long-term care facilities. A number of states have introduced programs to help nursing homes transform their physical space to support a greater diversity of LTSS and were generally successful in increasing assisted living units and available HCBS.



To respond to high rates of nursing home occupancy stemming from lack of community residential options in rural areas, **Nebraska** established a grant program in 1998 to encourage nursing facilities to convert to assisted living facilities or provide adult day and respite care services. The program focused on low-density rural areas in order to encourage a single site to provide a continuum of care options. Nursing Home Conversion Funds could be used for construction, start-up, training, or first-year operating losses, and 40 percent of the new assisted living units were reserved for Medicaid eligible residents. Approximately \$53 million was dispersed through the program, resulting in 74 conversions creating 967 new assisted living units, 16 respite care units, and 27 adult day care programs. The state estimates that the program achieved \$5.5 million in annual Medicaid program savings due to the reduced per-person costs of assisted living services relative to nursing home occupancy.



Iowa introduced the Senior Living Trust Fund in 2001 to finance the total or partial conversion of nursing facilities to assisted living residences and provide new services such as adult day and respite care. Beginning in 2004, an additional fund was introduced to provide below market rate loans to purchase existing buildings and convert them to assisted living residences. Grants were limited to \$1 million per facility, with up to \$100,000 additional available if adult day and respite services were offered. As a result of these initiatives, a total of 294 nursing facility beds were delicensed, and 246 new assisted living beds were established, for a total cost of around \$13 million. Grants continue to be made as funds are available, as determined by the state legislature.



In 2014, **Connecticut** launched a "Right-Sizing Plan" intended to meet residents' future needs and preferences for LTSS and meet the goal of providing 75 percent of

LTSS in the community by 2025. As part of this initiative, grants were provided to nursing facilities to begin planning for repurposing their physical space to implement new business models. Funds could be used to obtain architectural and site development plans, with funding for construction awarded in future rounds.

It should be noted that simply converting beds in a nursing facility to another purpose, such as an assisted living bed, does not automatically achieve the true goals of rebalancing. While expenditures for services described as HCBS may quickly increase, the real systems change results from the increased autonomy and community integration opportunities experienced by individuals receiving these HCBS. The criteria of a home and community-based setting, as promulgated by CMS in the [2014 final rule on HCBS](#), are meant to ensure that such autonomy and integration become realities. Significant efforts underway by states, providers, health plans, advocates and beneficiaries to comply with those criteria must continue to achieve that reality.

Supporting new business models for direct service workers (DSWs). A few states have also targeted initiatives around ensuring the institutionally-based LTSS workforce can meet the growing preference for community-based care, but their impact has yet to be evaluated.

Part of **Connecticut's** "Right-Sizing Plan" also includes a number of workforce-focused incentives to help nursing facility staff transition to work in home and community based settings and increase the availability of caregivers to serve people living in those settings, including:

- Re-training nursing aides to provide services in the community;
- Providing workforce training that addresses physical and mental health needs across the lifespan, with a focus on informed choice, least restrictive and most enhancing setting, and community inclusion; and
- Developing and maintaining a well-trained and equitably reimbursed agency-based HCBS workforce for individuals.

These efforts are intended to meet the expected increased demand for personal care aides (25 percent) and home health aides (34 percent) by 2026.

Helpful Resources

- Connecticut Long-Term Care Planning Committee. "[Balancing the System: Working Toward Real Choice for Long-Term Services and Supports in Connecticut](#)." January 2019.
- 2019 Minnesota Statutes. Public Welfare and Related Activities. [Chapter 256R, Section 256R.40](#).
- 77th Oregon Legislative Assembly – 2013 Regular Session. [House Bill 2216](#).
- Iowa State Legislature. July 2, 2008. Human Services. Chapter 162. [Nursing Facility Conversion and Long-Term Care Services Development Grants](#).

Endnotes

²⁷ As discussed in [SMD # 20-004](#), states can implement a withhold arrangement with their managed care plans. For a withhold arrangement, a portion of a capitation payment is withheld from the plans, which can be earned back by the plan for meeting targets specified in the contract, such as meeting quality performance targets. For more information on withhold measures, see <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidance060614.pdf>.

²⁸ Edelman, T., and D. Valanejad. “What’s Causing Nursing Home Closures?” Center for Medicare Advocacy. April 2019. <https://medicareadvocacy.org/whats-causing-nursing-home-closures/>.

²⁹ Healy, Jack. “Nursing Homes Are Closing Across Rural America, Scattering Residents.” New York Times, 4 Mar. 2019. <https://www.nytimes.com/2019/03/04/us/rural-nursing-homes-closure.html>.