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Long-Term Care
Home- and Community-Based Services

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I. INTRODUCTION

Home- and community-based services (HCBS) are a form of long-term care that provide a range of personal, support, and health services for individuals in their homes or communities. These services are designed to help people remain in their homes and live as independently as possible. [FN2]

Over 10 million people in the United States need long-term care services and supports to assist them in life's daily activities, and about 83 percent of them remain in the community, rather than in institutionalized settings. [FN3] HCBS include medical and non-medical care to the aged and to those with chronic illnesses or disabilities. [FN4] The primary types of HCBS include homemaker services, personal care assistance, home health services, companion services, meal programs, senior centers, adult day care, rehabilitative services, transportation and respite care. For several reasons, HCBS programs have become more popular in recent years.

II. COSTS AND FUNDING

Many patients prefer HCBS because they provide them with the freedom to remain in their homes or communities instead of institutions. In addition, many studies indicate that HCBS offer significant savings for insurers as compared to institutional settings. Federally-funded Medicaid support, in the form of Medicaid waivers and direct personal assistance services (PAS), provides another significant reason for the rising popularity of HCBS. Section 1915(c) of the Social Security Act [FN5] offers states a federally-supported alternative to providing long-term care services in institutional settings by allowing them the option to waive Medicaid provisions in order to offer individuals HCBS. PAS allow Medicaid beneficiaries receiving personal care or HCBS to supervise, manage, and personalize their care.

Between 2008 and 2013, the nursing care sector grew at an average annual rate of 1.6% while home care and assisted living grew at a rate of 7.2% and 5.6%, respectively, according to a report announced on May 13 by Research and Markets, an international market research firm, *McKnight's* reports. [FN6] The skilled care market is ‘increasingly suffering from state efforts to reimburse lower cost home care over higher priced nursing care,” according to a summary of the report. The study found that long-term care, as a whole, has been in a period of ‘solid expansion,” the market “encompassing assisted living, home care, nursing and hospice” grew from more than $224 billion in 2008 to nearly $277 billion last year.

The National Investment Center for the Seniors Housing & Care Industry (NIC) found that the occupancy rate for seniors in independent living and assisted living properties averaged 90.5% and 89.0%, respectively, during the second quarter of 2014, representing a 1% overall increase from a year earlier. By contrast, the nursing care occupancy rate was 88.2% in the second quarter of 2014, a decrease of 0.2 percentage points from the first quarter of 2013. [FN7]

A final rule released on January 10, 2014 by CMS will give states more flexibility on how they are able to use federal Medicaid funds to pay for HCBS, to better meet the needs of Medicaid enrollees, particularly the elderly and disabled. The final rule amends the Medicaid regulations to define and describe state plan section 1915(i) HCBS under the Social Security Act, as amended by the Affordable Care Act (ACA). Under the ACA, Medicaid programs will support HCBS settings that serve as an alternative to institutional care and that take into account the quality of individuals' experiences. According to CMS, the rule is meant to ensure that Medicaid's HCBS programs

provide full access to the benefits of community living, and offer services in the most integrated settings. The final rule will be published in the January 16 Federal Register, and takes effect on March 17,

The rule also provides for a five-year duration for certain demonstration projects or waivers, at the discretion of CMS, when they provide medical assistance for individuals dually eligible for Medicaid and Medicare benefits, and includes payment reassignment provisions because state Medicaid programs often operate as the primary or only payer for the class of practitioners that includes HCBS providers.

Thefinal rule also makes several important changes to the regulations implementing Medicaid 1915(c) HCBS waivers to add new person-centered planning requirements, allows states to combine multiple target populations in one waiver and streamlines waiver administration. [FN8]

Costs for HCBS remained relatively flat over 2013, a survey by long-term care insurer Genworth Financial finds. Nationally, the 2013 median hourly cost of homemaker services and home health aide services is $18 and $19 respectively, the Genworth 2013 Cost of Care Survey has found. Homemaker costs have risen just 1.4 percent since 2012 and 0.8 percent annually over the past five years, the report says. Home health aide services have risen 2.3 percent since 2012 and 1.0 percent annually over the past five years. The vast majority prefer care in their own homes: Genworth finds that 70% of Genworth's first-time long-term care claimants choose in-home care where the costs have remained more manageable. By contrast, the daily cost for a semi-private skilled nursing facility room grew 3.6% since 2011 to a national median rate of $200 per day, according to the survey. The rate for a private SNF room jumped 4.2% since 2011, up to a median daily rate of $222. [FN9]

As the popularity of assisted living facilities continues, concerns were raised in a report released in December 2012 by the HHS Office of Inspector General. The OIG is asking the Centers for Medicare & Medicaid Services (CMS) to issue additional guidance to state Medicaid programs, emphasizing the need to comply with federal requirements for covering HCBS under the 1915(c) waiver. Assisted living programs might not be giving enough information about access to HCBS funds, the agency said. In 2009, 35 state Medicaid programs reported that they covered HCBS at an annual cost of $1.7 billion, for more than 54,000 beneficiaries residing in approximately 12,000 ALFs, according to the report. Seven states with the highest numbers of beneficiaries that did not completely comply with the federal provider standards were selected. In the group, 77 percent of beneficiaries received HCBS in ALFs that were cited for noncompliance with at least one state licensure or certification requirement. Nine percent of beneficiaries' records did not include plans of care, and 42 percent did not include information on the frequency of HCBS furnished, the report found. CMS has concurred with the OIG recommendation to issue more guidance to state Medicaid programs and emphasize compliance with federal requirements. [FN10]

Rising Medicaid costs and continuing fiscal pressures have led a number of state governments to look for savings by enrolling more Medicaid beneficiaries into managed care plans. State Medicaid programs are increasingly considering risk-based contracting with managed care organizations (MCOs) to provide long-term supports and services (LTSS)—and often acute and primary care as well—to those enrollees. As many as 20 states are expanding or plan to introduce risk-based managed care programs for Medicaid beneficiaries needing LTSS. In risk-based managed care arrangements, state Medicaid agencies pay their contracted MCOs a predetermined monthly per-member rate and the MCOs bear financial risk for providing all covered services within the rate. These fixed payments make Medicaid costs more predictable for states, but they may create incentives for plans to restrict access to services for individuals who have costly health care needs. This potential risk highlights the importance of state oversight to ensure that MCOs comply with all contract requirements—including the provision of all LTSS required to provide optimal care to their enrollees.

To help keep seniors, disabled individuals and veterans in their homes and out of institutionalized long-term care facilities, additional government funding is being distributed. As authorized under the Affordable Care Act, nearly every state will receive a piece of the $25 million to establish Aging and Disability Resource Centers (ADRCs), meant to be a ‘one-stop shop” for elderly and disabled individuals who want to receive care in their homes and communities, rather than a long-term care facility. The funds will be made available over a one- to three-year period. The Veterans Health Administration will funnel an additional $27 million over three years to ADRC-funded states to help disabled veterans remain in their communities, as part of the initiative. Eight states will be selected for fast-track implementation of the program. The ADRCs will provide counseling services for those looking for access to services such as transportation to rehabilitation therapy, home health, and support with activities of daily living. The program is being administered through a partnership between the new Administration for Community Living, the Centers for Medicare & Medicaid Services (CMS) and the Department of Veterans Affairs' Veterans Health Administration. [FN11]

A recent study compared the probability of older dual eligible Medicaid HCBS users and nursing home residents experiencing potentially preventable hospitalizations. Three years of Medicaid and Medicare claims data (from 2003 to 2005) from seven states (**Arkansas**, **Florida**, **Minnesota**, **New Mexico**, **Texas**, **Vermont**, and **Washington**) were analyzed. A primary diagnosis of an ambulatory care sensitive condition on the inpatient hospital claim was used to identify potentially preventable hospitalizations. Researchers used inverse probability of treatment weighting to mitigate the potential selection of HCBS versus nursing home use.

Researchers found that the most frequent conditions accounting for hospitalizations were the same among the HCBS users and nursing home residents, and included congestive heart failure, pneumonia, chronic obstructive pulmonary disease, urinary tract infection, and dehydration. Compared to nursing home residents, however, elderly HCBS users had an increased probability of

experiencing hospitalizations. The researchers concluded that the increased probability for hospitalizations of HCBS users suggests a need for more proactive integration of medical and long-term care. [FN12]

PACE Program

The Program for All-Inclusive Care for the Elderly (PACE) should be expanded to include patients in accountable care organizations (ACOs) and other delivery system models, beyond fee-for-service, speakers urged at a briefing sponsored by the National PACE Association, *BNA* reports. [FN13] PACE uses Medicare and Medicaid funds to cover all of a beneficiary's medically necessary care and services for individuals 55 or older who are certified as needing nursing home levels of care. The program serves more than 30,000 participants in 31 states.

Anne Montgomery, a senior policy analyst at the Altarum Institute's Center for Elder Care and Advanced Illness, said that expanding the program would require waivers from Medicare requirements such as the three-day hospitalization requirement before admission to a nursing home. Joseph Antos, an economist at the American Enterprise Institute pointed out that while the waivers may be necessary, Congress is generally risk-averse and wouldn't want to end up writing a blank check. PACE needs more flexibility, but he said Congress needs to find a way to make sure it doesn't give the program too much flexibility and spend too much money.

A bipartisan group of senators, however, has urged expansion of the regulatory flexibility of PACE programs, in a letter sent to CMS on September 17. In the letter, lawmakers stated that ‘current regulatory and statutory barriers have inhibited PACE growth and innovation,” and call on CMS to allow PACE to operate in a variety of community settings—such as adult day health centers or senior centers—as well as to offer concurrent reviews at the federal and state level to speed up the provider application process. [FN14]

Conditions Of Participation For Home Health Agencies

On October 6, 2014, CMS released a proposed rule revising the current conditions of participation (CoPs) that home health agencies (HHAs) must meet to participate in the Medicare and Medicaid programs. In the rule, CMS proposes four new HHA CoPs and revises several others. The new CoPs proposed by CMS include:

• patient rights measures, which ‘would emphasize an HHA's responsibility to respect and promote the rights of each home health patient”;

• care planning, coordination of services and quality of care measures, which ‘would incorporate the interdisciplinary team approach”;

• quality assessment and performance improvement (QAPI) measures, which ‘would charge each HHA with responsibility for carrying out an ongoing quality assessment, incorporating data-driven goals, and an evidence-based performance improvement program of its own design to affect continuing improvement in the quality of care furnished to its patients”; and

• infection prevention and control measures, which ‘would require HHAs to follow accepted standards of practice to prevent and control the transmission of infectious diseases and to educate staff, patients, and family members or other caregivers on these accepted standards. The HHA would be required to incorporate an infection control component into its QAPI program.”

According to the rule, ‘The proposed requirements would focus on the care delivered to patients by home health agencies, reflect an interdisciplinary view of patient care, allow home health agencies greater flexibility in meeting quality care standards, and eliminate unnecessary procedural requirements. “ [FN15]

III. ‘MONEY FOLLOWS THE PERSON” GRANTS

The ‘Money Follows the Person” (MFP) grant program, a part of the Deficit Reduction Act of 2005, was an important component of the New Freedom Initiative, a nationwide effort to remove barriers to community living for people of all ages with disabilities or chronic illnesses. The MFP grant program is a five-year demonstration project with an incremental appropriation of $1.75 billion between fiscal year (FY) 2007 and fiscal year (FY) 2011. Participating states receive an enhanced federal match for key Medicaid services that facilitate and ensure the successful transition of individuals from institutions to community settings. States are then expected to reinvest the savings provided by the enhanced match into their long-term care system in order to expand the availability and quality of community-based long-term care services over time.

The objectives of the MFP program are as follows:

• Increase the use of home- and community-based, rather than institutional, long-term care services.

• Eliminate barriers or mechanisms, whether in the state law, the state Medicaid plan, the state budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice.

• Increase the ability of the state Medicaid program to assure continued provision of HCBS to eligible individuals who choose to transition from an institutional to a community setting.

• Ensure that procedures are in place (at least comparable to those required under the qualified HCBS program) to provide quality assurance for eligible individuals receiving Medicaid HCBS and to provide for continuous quality improvement in such services.

Phase I of the MFP grants were announced in January 2007, identifying 17 states that would receive the money. Thirteen more states and the District of Columbia were added in May 2007, for a current total of 31 jurisdictions.

The following table shows the distribution of the awards based on CMS data:

In order to continue participation in the program, the selected states are expected to demonstrate annual numeric benchmarks, such as an increase in state Medicaid support for HCBS and satisfaction of the specified number of eligible individuals assisted to transition. States are also expected to select additional benchmarks that will be used to measure the impact of the long-term care investments made by the MFP demonstration program which resulted in improvements to the ways that individuals access and receive community-based long-term care services.

On February 22, 2012, Sebelius announced that 13 states will receive a total of $621 million in grants through 2016 to help move Medicaid recipients out of nursing homes and into home- or community-based settings. The states will also receive $45 million to fund 'Money Follows the Person" demonstration programs. The Affordable Care Act extended the MFP demonstration program until 2016. The MFP program provides funding for people with intellectual, physical, or developmental disabilities who live in nursing homes or other institutions to live in residential settings.

In August 2012, the Kaiser Commission on Medicaid and the Uninsured surveyed states about the current status of their MFP demonstrations. Key findings include:

• Over 25,000 individuals have transitioned back to the community since 2008 and another 6,400 transitions were in progress. The pace of transitions has accelerated over the past couple years, averaging 8,000 since 2010.

• Comprehensive benefits are provided to participants to ensure successful transition back to the community. Demonstration-specific services were offered by 36 states; supplemental services (not necessarily long-term care in nature) were offered by 22 states.

• Average monthly cost savings per MFP participant in the community was $4,432 per person.

• Housing resources are seen as an issue in many states; housing specialists and statewide partnerships help bridge the gap between demand and availability of safe, affordable housing options. [FN16]

The budget proposed by President Obama would extend the demonstration period through FY 2020 to enable states to continue to rebalance their long-term care systems and transition individuals to home and community-based services within the existing appropriation. Individuals currently must enter institutions to qualify for covered home and community-based services in the Money Follows the Person Demonstration. To support individuals remaining in the community, this proposal would modify the demonstration to allow funds to be used to prevent individuals from entering an institution in the first place, as well as transition services. This proposal would also reduce the institutional requirement from 90 to 60 days and allow skilled nursing facility days to be counted towards the institutional requirement. Lastly, this proposal would allow individuals in certain mental health facilities to transition to home and community-based services under the demonstration. [FN17]

IV. MEDICAID WAIVERS, PERSONAL ASSISTANCE SERVICES AND OTHER MEDICAID-RELATED OPTIONS

HCBS provide opportunities for Medicaid beneficiaries to receive services in their own home or community. HCBS programs under Medicaid serve a variety of targeted population groups, such as people with mental illnesses, intellectual disabilities, and/or physical disabilities. HCBS first became available in 1983 when Congress added Section 1915(c) to the Social Security Act, giving states the option to receive a waiver of Medicaid rules governing institutional care. In 2005, HCBS became a formal Medicaid State plan option. Several states include HCBS services in their Medicaid State plans, with 47 States and DC operating at least one 1915(c) waiver. State Medicaid agencies have several HCBS options:

• ? 1915(c) Home and Community-Based Waivers

• ? 1915(i) State Plan Home and Community-Based Services

• ? 1915(j) Self-Directed Personal Assistance Services Under State Plan

• ? 1915(k) Community First Choice

CMS works in partnership with states, consumers and advocates, providers and other stakeholders to create a sustainable, person-driven long-term support 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. [FN18]

The programs and partnerships contained in this section of Medicaid are aimed at achieving a system that is:

• Person-driven: The system affords older people, people with disabilities and/or chronic illness the opportunity to decide where and with whom they live, to have control over the services they receive and who provides the services, to work and earn money, and to include friends and supports to help them participate in community life.

• Inclusive: The system encourages and supports people to live where they want to live with access to a full array of quality services and supports in the community.

• Effective and Accountable: The system offers high quality services that improve quality of life. Accountability and responsibility is shared between public and private partners and includes personal accountability and planning for long-term care needs, including greater use and awareness of private sources of funding.

• Sustainable and Efficient: The system achieves economy and efficiency by coordinating and managing a package of services paid that are appropriate for the beneficiary and paid for by the appropriate party.

• Coordinated and Transparent: The system coordinates services from various funding streams to provide a coordinated, seamless package of supports, and makes effective use of health information technology to provide transparent information to consumers, providers and payers.

• Culturally Competent: The system provides accessible information and services that take into account people's cultural and linguistic needs.

In 2012, HHS Secretary Sebelius announced the creation of a new agency, the Administration for Community Living (ACL), to help enable those with disabilities and seniors 'to live at home with the supports they need, participating in communities that value their contributions—rather than in nursing homes or other institutions." [FN19] The goal of the new agency is to promote community living and finding new mechanisms to help ensure that the supports people with disabilities and seniors need to live in the community are accessible, Secretary Sebelius said. The creation of ACL brings together the Administration on Aging, the Office on Disability and the Administration on Developmental Disabilities into a single agency 'that supports both cross-cutting initiatives and efforts focused on the unique needs of individual groups, such as children with developmental disabilities or seniors with dementia," according to Sebelius. The new agency will collaborate with CMS 'to develop, refine, and strengthen policies that promote independent living among all populations, especially those served by Medicaid," according to HHS. [FN20]

? 1915(c) Home and Community-Based Waivers

One way that states can provide Medicaid HCBS is through the optional Section 1915(c) HCBS waiver. Section 1915(c) of the Social Security Act [FN21] gives states authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. In 2009, nearly one million individuals were receiving services under HCBS waivers. Nearly all States and the District of Columbia offer services through HCBS waivers. States can operate as many HCBS Waivers as they want; currently, more than 300 HCBS Waiver programs are active nationwide. [FN22]

To qualify, state HCBS Waiver programs must: demonstrate that providing waiver services won't cost more than providing these services in an institution; ensure the protection of people's health and welfare; provide adequate and reasonable provider standards to meet the needs of the target population; and ensure that services follow an individualized and person-centered plan of care.

Specific Medicaid program requirements that can be waived include:

• 'Statewideness"—lets states target waivers to areas of the state where the need is greatest, or where certain types of providers are available. [FN23]

• 'Comparability of services"—lets states make waiver services available only to certain groups of people who are at risk of institutionalization. For example, states can use this authority to target services to the elderly, technology-dependent children, people with behavioral conditions, or people with intellectual disabilities, or they might target services on the basis of disease or condition, such as AIDS. [FN24]

• 'Income and resource rules applicable in the community"—lets states provide Medicaid to people who would otherwise be eligible only in an institutional setting, often due to the income and resources of a spouse or parent. States can also use spousal impoverishment rules to determine financial eligibility for waiver services. [FN25]

States can offer a variety of unlimited services under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose 'other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. [FN26]

? 1915(i) State Plan Home and Community-Based Services

States can offer a variety of services under a ? 1915(i) State Plan HCBS benefit, which was first authorized in 2005 and then enhanced by the Affordable Care Act permitting states to offer HCBS without the use of a waiver. People must meet state-defined criteria based on need and typically get a combination of acute-care medical services (like dental services, skilled nursing services) and long-term services (like respite, case management, supported employment, and environmental modifications).

Under the ? 1915(i) State Plan HCBS benefit, the state can: target the HCBS benefit to one or more specific populations; establish separate additional needs-based criteria for individual HCBS; establish a new Medicaid eligibility group for people who get state

plan HCBS; define the HCBS included in the benefit, including state- defined and CMS-approved ‘other services” applicable to the population; and allow any or all HCBS to be self-directed.

States can develop HCBS benefits to meet the specific needs of a population, within Federal guidelines. Requirements include: establishing a process to ensure that assessments and evaluations are independent and unbiased; availability of the benefit to all eligible individuals within the state; measures taken to protect the health and welfare of participants; adequate and reasonable provider standards to meet the needs of the target population; services provided in accordance with a plan of care; and a quality assurance, monitoring and improvement strategy for the benefit.

To be approved, the state Medicaid agency must submit a state plan amendment to CMS for review and approval to establish a 1915(i) HCBS benefit. State plan HCBS benefits don't have a time limit on approval except when states choose to target the benefit to a specific population. When a state targets the benefit, approval periods are for 5 years, with the option to renew with CMS approval for additional 5-year periods. [FN27]

In 2012, CMS proposed additional guidance to states regarding the option. Under 1915(i), states can receive federal reimbursement for services that were previously only eligible for federal funding through a waiver or demonstration. CMS first proposed a regulation to implement the 1915(i) benefit in April 2008. However, that proposed rule was not finalized and, with the enactment of ACA in 2010, CMS concluded that the proposed regulation would not comply with new requirements in ACA. As a result, it issued the new proposed rule which retains many of the policies contained in the April 2008 proposed rule, CMS said in a background summary, and also reflects comments received. The new proposed rule:

• provides a five-year approval or renewal period for certain Medicaid waivers in which a state provides services for ‘dual eligibles” (enrollees who are eligible to receive both Medicare and Medicaid).

• eliminates the ‘direct payment” requirement that mandates Medicaid payments be made only to certain individuals or entities and allows the state to claim as a provider payment amounts that are not directly paid to the provider, but are withheld and paid to a third party on behalf of the provider.

• defines a home and community-based setting that would be used for services offered through the CFC option and the 1915(i) state plan option.

Additional information is available in a fact sheet provided by CMS. [FN28]

? 1915(j) Self-Directed Personal Assistance Services Under State Plan

Self-directed personal assistance services (PAS) are personal care and related services provided under the Medicaid state plan and/ or section 1915(c) waivers that the state already has in place. Participation in self-directed PAS is voluntary. Participants set their own provider qualifications and train their PAS providers, and determine how much they pay for a service, support, or item.

Under this plan, states can target people already getting section 1915(c) waiver services, limit the number of people who will self-direct their PAS, and limit the self-direction option to certain areas of the state, or offer it Statewide.

Enrollees can hire legally liable relatives (such as parents or spouses); manage a cash disbursement; purchase goods, supports, services or supplies that increase their independence or substitute for human help (to the extent they'd otherwise have to pay for human help); and use a discretionary amount of their budget to purchase items not otherwise listed in the budget or reserved for permissible purchases.

The 1915(j) service plan is based on an assessment of need for PAS. The service plan and budget plan are developed using a person-centered and directed process in which participants can engage in and direct the process. They can choose family, friends, and professionals to be involved as needed/wanted. The participant's preferences, choices, and abilities and strategies to address these preferences must be identified in the service plan.

In addition, the plan must include an assessment of contingencies that pose a risk of harm to participants and an ‘individualized backup plan” to address those contingencies, as well as a ‘risk management plan” that outlines risks participants are willing to assume. [FN29]

Alabama was the first state to receive federal approval to allow self-directed PAS as a feature of its Medicaid plan. A number of states have expressed interest in following Alabama's lead in taking advantage of the DRA provision. [FN30]

? 1915(k) Community First Choice

The ‘Community First Choice (CFC) Option” lets states provide home and community-based attendant services to Medicaid enrollees with disabilities under their State Plan. This option became available on October 1, 2011 and provides a 6% increase in federal matching payments to states for expenditures related to this option. Community First Choice was established under the Affordable Care Act of 2010.

In 2012, CMS released the final rule implementing the CFC option that provides an incentive for states to expand their Medicaid coverage for person-centered home- and community-based attendant services and supports. According to a fact sheet provided by CMS, [FN31] states that elect the CFC option are eligible for a 6 percent increase in their federal medical assistance percentage.

Individuals who require an institutional level of care are eligible for the services, which will be offered in community-based settings. States electing the CFC option will make available HCBS to assist beneficiaries in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks. States may also choose to provide coverage for transition costs to assist Medicaid beneficiaries who are leaving institutions and for services that increase independence or substitute for human assistance, such as non-medical transportation services.

In order to qualify for the enhanced match, States must agree to develop their CFC benefit with the input of a stakeholder council that includes members with disabilities, elderly individuals, and their representatives; establish a comprehensive quality assurance system; collect and report information for federal oversight and program evaluation; and for the first 12 months, maintain or exceed the level of expenditures for HCBS provided under the state plan, waivers or demonstrations for the preceding 12 month period. The ACA directs that the CFC benefit may only be available in a 'home or community" setting, and this rule does not finalize the definition for such settings. CMS estimated that the final rule would have an economic impact of $1.3 billion in fiscal year 2012, with federal and state shares reflecting $820 million and $480 million, respectively.

In a proposed rule also released on April 26, 2013, CMS issued revised standards for HCBS settings. While the setting requirements are proposed, the CFC option is in full effect, and CMS will rely upon these proposed provisions as it reviews new state plan amendments to implement the CFC option. To the extent there are changes when the settings standard is finalized, CMS will offer states a reasonable transition period (of not less than one year) to make any needed changes to come into compliance with the final rule.

ACA requires CMS to conduct an evaluation by December 31, 2015, in order to determine the effectiveness of the CFC option in allowing individuals to lead an independent life, the impact on the physical and emotional health of individuals receiving these services, and a comparative analysis of the costs of services provided under CFC and those provided in an institution. An interim report of this evaluation is due to Congress by December 31, 2013.

California is the first state to get regulatory approval for CFC. By approving the First Choice program, CMS will now give the state a 6% increase in its federal medical assistance percentage for funds spent on personal attendant services. California will immediately get the increased federal funding, with the state slated to get an additional $573 million in government funds in the first two years. [FN32]

News Highlights

Biden Jobs Plan Includes $400 Billion for HCBS

The second installment of the Biden administration's $2.3 trillion recovery plan, called the American Jobs Plan, contains $400 billion to revamp and reinvest in Medicaid home and community-based services over the next 8 years. [FN33]

Biden's strategy is to provide more solutions to help the overburdened healthcare systems serve the country's aging and other special needs populations through increased funding. Across 41 states, nearly 820,000 people are currently on HCBS waiting lists with an average wait of 39 months. Expanding access will also help alleviate the 53 million family members providing care to vulnerable seniors and people with disabilities.

Aside from more funding, the plan aims to bolster the 'care infrastructure" (i.e. low-wage workers providing care, who are often women, immigrants and people of color). Increasing pay and benefits for workers seeks to help recruit more caregivers as demand for HCBS increases.

Thus far, the plan lacks specific provisions in the bill, which, as a whole, will likely face a lengthy political battle due its hefty price tag. However, the plan has been met with industry praise, including the American Association of Family Physicians, the National Association for Home Care & Hospice and others, which could aid in the plan's passage.

American Rescue Plan Funds Trickling Down to HCBS Programs

Earlier this month, the Biden administration released over $350 billion in funding as part of the American Rescue Plan (ARP) to help state and local governments respond to COVID-19. [FN34] These added resources are leading to some states to ramp up their Medicaid funding allotments, including those for home and community-based services (HCBS).

Nevada has rolled back previously approved Medicaid rate cuts while also approving a rate increase to acute hospitals. In California, Governor Gavin Newsom (D) has released a May budget plan that includes more funding for doula benefits and expanded Medicaid coverage for undocumented immigrants.

The Biden administration has made supporting HCBS providers a main focus. The ARP also includes a 10% increase for the Federal Medical Assistance Percentages (FMAP) for Medicaid HCBS, active from April 1 through March 31, 2022.

It is estimated that over 800,000 seniors in need of HCBS care are currently on waiting lists.

CMS Issues Guidance on How States Can Use Enhanced HCBS Funding

CMS recently released guidance that states can only use enhanced Medicaid funds from the recently passed $1.9 trillion economic stimulus package to strengthen their home- and community-based services. A major parts of the package that President Biden signed in March is a 10% boost in the Federal Medicaid Assistance Percentage (FMAP) for state expenditures on HCBS.

Additional federal funds must be used to ‘supplement, not supplant” existing state funds. Also, state funds must be used to supplement Medicaid HCBS, not pay for HCBS that is currently available. The funds must ‘enhance, expand, or strengthen HCBS beyond what is available under the Medicaid program as of April 1, 2021,” according to the guidance.

States can implement various activities, including HCBS service enhancements, and infrastructure and reimbursement methodologies, to improve existing HCBS programs. Participating states will be required to submit both initial and quarterly HCBS spending plans related to the use of the increase FMAP funds, according to the guidance.

Biden Continues Push for Largest-Ever HCBS Boost

President Joe Biden is pushing ahead with plans to make the biggest investment in Medicaid home and community-based services in 40 years as part of an ambitious package of social safety net reforms. [FN35] The $1.75 trillion reconciliation bill includes $150 billion for Medicaid home and community-based services to help get people with disabilities off of waiting lists and address issues plaguing the nation's workforce of direct support professionals.

The figure is less than half of the $400 billion Biden originally wanted for the program. However, it still represents ‘the most transformative investment in access to home care in 40 years, when these services were first authorized for Medicaid,” the White House said. Biden called the framework ‘historic” and said it will ‘fundamentally change the lives of millions of people for the better,” but he acknowledged it doesn't include everything on his wish list.

The President also said everything in the framework would be fully paid for through a variety of mechanisms including increased taxes on the wealthy and a corporate minimum tax.

Indiana Officials Seek to Make HCBS More Accessible

Indiana officials, including Governor Eric Holcomb (R) are seeking to overhaul the state's Medicaid rules to allow more elderly residents to access home and community-based services so they can age at home, rather than at nursing homes. [FN36] With revamped rules, the Family and Social Services Administration (FSSA) plans to let HCBS applicants know within 72 hours of inquiring whether they are eligible for services.

The proposed changes come as Indiana continues to face a COVID-19 pandemic that has ravaged nursing homes. Currently, many residents who wish to age at home are receiving care in nursing home settings due to a fragmented long-term care system that is difficult to navigate. This is why officials are pursuing a managed care system allowing residents to access information about available types of care, including home care.

Indiana would join 25 other states administering long-term care services through a managed care system. Recent surveys indicate that 75% of elderly residents would prefer long-term care at home, although only 45% now qualify for Medicaid funding for home care. Officials hope the rules changes will allow up to 60% of the state's elderly to qualify for long-term home care.

The overhaul faces significant challenges. It will require an expanded workforce to conduct home health visits and community health programs. The state also has a managed care ban in place, which is set to expire at the end of 2021, barring an extension by the state assembly. A pilot program is currently in place to allow expedited approvals in several counties.

Highlights of Recent Activity

Federal

On December 3, 2020, 2019 CONG US S 4957 was introduced. If adopted, it will provide for an emergency increase in Federal funding to State Medicaid programs for expenditures on home and community-based services.

• On December 4, 2020, 2019 CONG US HR 8871 was introduced. If adopted, it will provide for an emergency increase in Federal funding to State Medicaid programs for expenditures on home and community-based services.

• On December 10, 2020, 2019 CONG US HR 8934 was introduced. If adopted, it will ensure that Medicaid beneficiaries have the opportunity to receive care in a home and community-based setting.

On January 28 and February 2, 2021, 2021 CONG US HR 525 and 2021 CONG US S 151 were introduced. If adopted, they will provide for an emergency increase in Federal funding to State Medicaid programs for expenditures on home and community-based services.

• On March 9 and April 13, 2021, 2021 CONG US HR 1717 and 2021 CONG US S 1099 was introduced. They would amend title XIX of the Social Security Act to make permanent the protections under Medicaid for recipients of home and community-based services against spousal impoverishment.

On June 24, 2021, 2021 CONG US S 2210 was introduced. If adopted, it will amend title XIX of the Social Security Act to expand access to home and community-based services (HCBS) under Medicaid, and for other purposes.

On June 24, 2021, 2021 CONG US HR 4131 was introduced. It would amend title XIX of the Social Security Act to expand access to home and community-based services (HCBS) under Medicaid, and for other purposes.

Arkansas

Effective January 1, 2021, 2021 AR REG TEXT 569828 (NS) updates provider manuals to clarify the distinction between an assessment, annual re-evaluation, and a reassessment of functional eligibility for a Home and Community Based Services waiver beneficiary.

On April 15, 2021, 2021 AR REG TEXT 581691 (NS) was proposed. If adopted, it will renew the Living Choices Assisted Living (LCAL) waiver as required by s. 1915(c) of the Social Security Act. The current waiver expired 01/31/21 and operates under a temporary extension until the renewal is approved.

California

On January 29, 2021, 2021 CA REG TEXT 575956 (NS) provided notice that the Department of Developmental Services (DDS) is seeking renewal for the 1915(c) HCBS Self-Determination Program Waiver from the Federal Centers for Medicare and Medicaid Services. DDS intends to renew the Waiver for a five-year period from July 2021 to June 2026.

On May 7, 2021, 2021 CA REG TEXT 583128 (NS) provided notice that the California Department Health Care Services (DHCS) in collaboration with the California Department of Public Health (CDPH) intends to submit the 1915(c) Home and Community - Based Services, Medi - Cal Waiver Program (MCWP), HIV/AIDS Waiver Renewal Application to the federal Centers for Medicare and Medicaid Services (CMS).

• On August 13, 2021, 2021 CA REG TEXT 590814 (NS) provided notice that the Department of Health Care Services (DHCS) is posting a draft of the 2022 HCBA Waiver Renewal Application for a 30-day Public Comment Period in August 2021, prior to submitting the final version to the Centers for Medicare and Medicaid Services (CMS) for reauthorization.

• On August 13, 2021, 2021 CA REG TEXT 590815 (NS) provided notice that the California Department of Health Care Services in collaboration with the California Department of Public Health intends to submit the 1915(c) Home and Community-Based Services, Medi-Cal Waiver Program, HIV/AIDS Waiver Renewal Application to the federal Centers for Medicare and Medicaid Services.

Colorado

On November 25, 2020, 2020 CO REG TEXT 571028 (NS) provided notice that the Department intends to submit waiver amendments for certain Home and Community-Based Services (HCBS) waivers.

On February 25, 2021, 2021 CO REG TEXT 578010 (NS) provided notice that the Department intends to submit amendments for the following Home and Community-Based Services (HCBS) waivers.

• On June 10, 2021, 2021 CO REG TEXT 585535 (NS) provided notice that the Department has made determinations relating to settings subject to heightened scrutiny under the federal Home and Community-Based Services (HCBS) Settings Final Rule.

• On June 25, 2021, 2021 CO REG TEXT 586448 (NS) provided notice that the Department has made determinations relating to settings subject to heightened scrutiny under the federal Home and Community-Based Services (HCBS) Settings Final Rule.

On June 30, 2021, 2021 CO S.B. 286 (NS) was adopted. It concerns the distribution of money received under the federal American Rescue Plan Act of 2021 for HCBS.

On August 10, 2021, 2021 CO REG TEXT 590451 (NS) provided notice that the Department intends to submit amendments for the following Home and Community-Based Services (HCBS) waivers.

On August 25, 2021, 2021 CO REG TEXT 591741 (NS) provided notice of various HCBS waiver amendments.

District of Columbia

Effective December 23, 2020, 2021 DC REG TEXT 574188 (NS) provides notice of the adoption of, on an emergency basis, and the intent to adopt, on a permanent basis, a new Chapter 90 (Home and Community-Based Services Waiver for Individual and Family Support), of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

Illinois

• On July 16, 2021, 2021 IL REG TEXT 588494 (NS) updates the language to be consistent with new federal Home and Community-Based Services waiver regulations which add flexibility to help increase integration into community-based day programs.

• On July 16, 2021, 2021 IL REG TEXT 588511 (NS); 2021 IL REG TEXT 588516 (NS); 2021 IL REG TEXT 588512 (NS) and 2021 IL REG TEXT 588517 (NS) update and/or add new language regarding Home and Community-Based Services.

• On July 16, 2021, 2021 IL REG TEXT 588493 (NS) updates language to be consistent with new federal Home and Community-Based Services waiver regulations which add flexibility to help increase integration into community-based day programs. Additionally, amendments will be made to address the name of the program and to include community integration as a separate billable service.

• On July 16, 2021, 2021 IL REG TEXT 588513 (NS); 2021 IL REG TEXT 588514 (NS) and 2021 IL REG TEXT 588515 (NS) update language to ensure the rule is consistent with current Program standards and practices that relate to federal Home and Community-Based Services regulations.

Indiana

On February 24, 2021, 2021 IN REG TEXT 577724 (NS) provided a public notice regarding home and community-based settings that require heightened scrutiny.

Effective July 11, 2021, 2021 IN REG TEXT 539956 (NS) amends 405 IN ADC 2-1.1-7 (Post-eligibility treatment of income) to update definitions and terms and include procedures for determining income for members receiving home and community-based service waivers.

On July 28, 2021, 2021 IN REG TEXT 589321 (NS) provides a public notice regarding amendments to the Community Integration and Habilitation Waiver and the Family Supports Waiver.

Kansas

On February 4, 2021, 2021 KS H.B. 2249 (NS) was introduced. If adopted, it will set the protected income level for persons receiving home and community-based services at 150% of federal supplemental security income.

Kentucky

Effective June 16, 2021, 2021 KY REG TEXT 578507 (NS) amends 907 KAR 7:020 (1915(c) Home and community-based services waiting list and waiting list placement appeal processes).

Louisiana

Effective December 20, 2020, 2020 LA REG TEXT 565650 (NS) amends various sections regarding the New Opportunities Home and Community-Based Services Waiver.

Effective January 20, 2021, 2021 LA REG TEXT 568158 (NS) adopts a rule regarding licensing standards for home and community-based service providers.

• Effective July 20, 2021, 2021 LA REG TEXT 581770 (NS) makes changes regarding HCBS waivers—support coordination standards for participation.

• Effective July 20, 2021, 2021 LA REG TEXT 581769 (NS) makes changes regarding HCBS waivers—community choices waiver.

Effective August 23, 2021, 2021 LA REG TEXT 550005 (NS) amends the provisions governing the ADHC Waiver, the CCW, and LT-PCS throughout the COVID-19 public health emergency declaration, and clarify that the HCBS waiver provisions which correspond to Louisiana's section 1915(c) Appendix K waiver will remain in effect for the duration of the Emergency Rules published in the April 20, 2020 Louisiana Register or until the Appendix K waiver termination date of January 26, 2021, whichever is later, in order to continue the provisions of the Emergency Rule adopted on August 25, 2020.

• Effective October 1, 2021, 2021 LA REG TEXT 594252 (NS) amends LA ADC 50:XXI.14301 (Unit of Reimbursement) regarding Home and Community-Based Services Waivers - New Opportunities Waiver - Direct Support Worker Wages.

• Effective October 1, 2021, 2021 LA REG TEXT 594253 (NS) amends LA ADC 50:XXI.16903 (Direct Support Professional Wages) regarding Home and Community-Based Services Waivers - Residential Options Waiver - Direct Support Worker Wages.

• Effective October 1, 2021, 2021 LA REG TEXT 594254 (NS) amends LA ADC 50:XXI.6101 (Unit of Reimbursement) regarding Home and Community-Based Services Waivers - Supports Waiver - Direct Support Worker Wages.

• Effective October 20, 2021, 2021 LA REG TEXT 588925 (NS) makes changes regarding HCBS waivers—residential option waiver.

Maine

• Effective May 2, 2021, 2021 ME REG TEXT 572678 (NS) aligns and complies with 42 CFR 441.301(c), the federal Home and Community Based Settings (HCBS) rule (the ‘Settings Rule’).

On September 8, 2021, 2021 ME REG TEXT 591308 (NS) was proposed. It would implement the federal requirements for Maine's Section 1915(c) home and community-based waiver programs as set forth in 42 CFR s.441.301(c) and includes requirements for person-centered service planning and for settings in which home and community-based waiver services are provided, including requirements for provider-owned or controlled residential settings.

Maryland

• On January 29, 2021, 2021 MD REG TEXT 576000 (NS) provided notice that the Maryland Department of Health (MDH) will submit a 1915(c) home and community-based services waiver application for the Medical Day Care Services Waiver to the Centers for Medicare and Medicaid Services (CMS) to renew the waiver for 5 additional years effective July 1, 2021.

• On January 29, 2021, 2021 MD REG TEXT 576001 (NS) provided notice that the Maryland Department of Health (MDH) will submit a 1915(c) home and community-based services waiver application for the Home and Community Based Options Waiver to the Centers for Medicare and Medicaid Services (CMS) to renew the waiver for 5 additional years effective July 1, 2021.

• On January 29, 2021, 2021 MD REG TEXT 576003 (NS) provided notice that the Maryland Department of Health (MDH) will submit a 1915(c) home and community-based services waiver application for the Medical Day Care Services Waiver to the Centers for Medicare and Medicaid Services (CMS) to renew the waiver for 5 additional years effective July 1, 2021.

• On January 29, 2021, 2021 MD REG TEXT 576004 (NS) provided notice that the Maryland Department of Health (MDH) will submit a 1915(c) home and community-based services waiver application for the Home and Community Based Options Waiver to the Centers for Medicare and Medicaid Services (CMS) to renew the waiver for 5 additional years effective July 1, 2021.

On May 7, 2021, 2021 MD REG TEXT 583410 (NS) provided notice that the Maryland Department of Health (MDH) will submit a 1915(b)(4) waiver application for its 1915(c) Home and Community-Based Options Waiver to the Centers for Medicare and Medicaid Services (CMS) to renew the waiver for 5 additional years.

On May 21, 2021, 2021 MD REG TEXT 584291 (NS) provided notice that the Maryland Department of Health (MDH) will submit a 1915(b)(4) waiver application for its 1915(c) Home and Community-Based Options Waiver to the Centers for Medicare and Medicaid Services (CMS) to renew the waiver for 5 additional years.

Massachusetts

• Effective January 29, 2021, 2021 MA REG TEXT 577579 (NS) makes amendments providing a rate add-on of $2.60 per hour for home and community-based services for home health aide, homemaker and personal care homemaker services provided on or after January 1, 2021, through June 30, 2021.

• On February 19, 2021, 2021 MA REG TEXT 577582 (NS) was proposed. If adopted, it will make an emergency adoption of 101 CMR 359.00: Rates for Home and Community Based Services Waivers.

Effective July 19, 2021, 2021 MA REG TEXT 590470 (NS) revises rates for certain HCBS related to the American Rescue Plan Act.

Effective October 1, 2021, 2021 MA REG TEXT 590475 (NS) finalizes 101 CMR 447.00, a new chapter that was originally filed as an emergency on 7/19/21, with changes after a public hearing. The changes involve rates for certain Home- and Community-Based Services related to Section 9817 of the American Rescue Plan Act.

On October 15, 2021, 2021 MA REG TEXT 596706 (NS) and 2021 MA REG TEXT 596695 (NS) proposed emergency adoption of rules regarding rates for certain home and community-based services for workforce development.

Michigan

On March 4, 2021, 2021 MI H.B. 4432 (NS) and 2021 MI S.B. 203 (NS) were introduced. If adopted, they will provide eligibility criteria for a program of all-inclusive care for the elderly (PACE).

Minnesota

On February 1, 2021, 2021 MN S.F. 492 (NS) was introduced. If adopted, it will extend remote home and community-based service waivers.

• On February 10, 2021, 2021 MN H.F. 976 (NS) was introduced. If adopted, it will extend remote provisions regarding home and community-based service waivers.

• On February 18, 2021, 2021 MN H.F. 1175 (NS) was introduced. If adopted, it will establish and appropriate money for home and community-based service providers.

• On March 8, 2021, 2021 MN H.F. 1996 (NS) was introduced. If adopted, it will expand medical assistance coverage to community-based service coordination in jails.

• On March 11, 2021, 2021 MN S.F. 1075 (NS) was engrossed. If adopted, it will modify home and community-based waiver assessment requirements for people temporarily entering health care facilities.

Mississippi

On January 18, 2021, 2021 MS H.B. 1085 (NS) was introduced. If adopted, it will provided Medicaid coverage for community-based home-visitation, pregnancy and postpartum support to services to eligible mothers and children under one year of age. [FN37]

Montana

• On March 26, 2021, 2021 MT H.B. 38 (NS) was adopted. It establishes legislative intent for home and community-based services waivers.

• On April 20, 2021, 2021 MT S.B. 33 (NS) was adopted. It requires a 30-day notice before termination of participation in the HCBS waiver program.

• On April 20, 2021, 2021 MT S.B. 43 (NS) was adopted. It requires administrative rulemaking for substantive changes to HCBS programs.

Nebraska

Effective October 3, 2021, 2021 NE REG TEXT 568223 (NS) adopts final rules regarding home and community-based services.

New Mexico

Effective May 1, 2021, 2021 NM REG TEXT 572554 (NS) revises various Institutional Care and Home and Community-Based Services Waiver (HCBSW) Medicaid rules.

New York

On January 6, 2021, 2021 NY A.B. 161 (NS) was introduced. If adopted, it will adopt a section related to payments for home and community based long term care services.

On January 21, 2021, 2021 NY S.B. 2526 (NS) was introduced. If adopted, it will add a new section relating to payments for home and community based long term care services.

On January 21, 2021, 2021 NY S.B. 2543 (NS) was introduced. If adopted, it will add a section relating to payments for personal protective equipment for home and community based long term care services.

North Dakota

Effective January 1, 2021, 2021 ND REG TEXT 562332 (NS) adopts rules regarding informed choice referrals for home and community-based services.

On April 16, 2021, 2021 ND S.B. 2085 (NS) was adopted. It amends and reenacts certain sections relating to Medicaid waivers to provide in-home services and medical assistance and advanced practice registered nurses.

Ohio

Effective December 10, 2020, 2020 OH REG TEXT 565980 (NS) amends various provisions regarding Nursing Facility-Based Level of Care Home and Community-Based Services Programs, the ODM - Administered Waiver Program and the Home Care Waiver.

Effective January 1, 2021, 2020 OH REG TEXT 567821 (NS) amends provisions related to home and community-based service waivers.

• Effective June 17, 2021, 2021 OH REG TEXT 585919 (NS) amends various sections regarding HCBS waivers.

• Effective July 16, 2021, 2021 OH REG TEXT 581640 (NS) amends OH ADC 5160-31-03 (Eligibility for enrollment in the PASSPORT HCBS waiver program).

• Effective October 1, 2021, 2021 OH REG TEXT 586827 (NS) amends, adopts and rescinds various rules, including those related to HCBS waivers.

Effective October 15, 2021, 2021 OH REG TEXT 589566 (NS) adopts, amends and rescinds various rules regarding HCBS waivers.

• On October 15, 2021, 2021 OH REG TEXT 596548 (NS) proposed to amend rules regarding nursing facility-based level of care home and community-based services programs.

• On October 15, 2021, 2021 OH REG TEXT 596543 (NS) proposed to amend, adopt and rescind various rules regarding HCBS waivers.

• Effective November 1, 2021, 2021 OH REG TEXT 590964 (NS) adopts amendments regarding Home and Community-Based Service Waivers: PASSPORT; Home and Community Based Services (HCBS) Waivers: Assisted Living; Reimbursement Rates and Billing Procedures; Home Care Attendant Services Reimbursement Rates and Billing Procedures.

Oklahoma

Effective February 1, 2021, 2021 OK REG TEXT 578458 (NS) makes changes relating to supplemental room and board funding for persons receiving Home and Community-Based Services (HCBS) waivers.

On May 20, 2021, 2021 OK H.B. 2899 (NS) was adopted. It limits applications for certain home and community-based services.

• Effective September 1, 2021, 2021 OK REG TEXT 572478 (NS) changes the timeframe from 90 days to 1 calendar year for which a required physical health examination and medical evaluation can be completed when an individual is applying for the DDS Home and Community-Based Services waiver.

• Effective September 1, 2021, 2021 OK REG TEXT 575162 (NS) clarifies that adult members receiving In-Home Supports Waiver (IHSW) services can access individual placement in job coaching, stabilization, and employment training specialist services; however, not to exceed limits specified in OKDHS Appendix D-26 per Plan of Care year.

Pennsylvania

On August 21, 2021, 2021 PA REG TEXT 591382 (NS) provided notice that the Department of Human Services is making available for public review and comment the Office of Long-Term Living's proposed amendment to the Community HealthChoices waiver. The proposed amendment will be effective January 1, 2022.

Rhode Island

On January 25, 2021, 2021 RI H.B. 5115 (NS) was introduced. If adopted, it will extend eligibility of the Home Community Care Services Program to persons under the age of sixty-five (65) suffering from Alzheimer's disease or a related dementia confirmed by a licensed physician with income not exceeding two hundred fifty percent (250%) of the federal poverty level.

Effective September 2, 2021, 2021 RI REG TEXT 590453 (NS) increases the Home and Community Based Maintenance of Needs Allowance from 100% of the Federal Poverty Limit plus twenty dollars to 300% of the Federal Social Security Income.

Tennessee

Effective November 20, 2020, 2020 TN REG TEXT 570815 (NS) amends various provisions regarding Choices HCBS and PACE.

Texas

On November 13, 2020, 2020 TX REG TEXT 570114 (NS) provided notice of proposed payment rate changes for Home and Community-Based Services -- Adult Mental Health (HCBS-AMH) in-home respite.

Effective January 10, 2021, 2021 TX REG TEXT 563118 (NS) adopts amendments to s.355.112, concerning Attendant Compensation Rate Enhancement, and s.355.723, concerning Reimbursement Methodology for Home and Community-Based Services and Texas Home Living Programs.

On January 12, 2021, 2021 TX S.B. 322 (NS) was introduced. If adopted, it will add a section relating to presumptive eligibility of certain elderly individuals for home and community-based services under Medicaid.

Effective January 19, 2020, 2021 TX REG TEXT 566507 (NS) renews the effectiveness of emergency regulations regarding Home and Community-Based Services (HCS) Program and Community First Choice (CFC).

• On January 22, 2021, 2021 TX REG TEXT 575490 (NS) provided notice that the Health and Human Services Commission (HHSC) submitted a request to the Centers for Medicare and Medicaid Services (CMS) to amend the waiver application for the Home and Community-based Services (HCS) waiver program.

• On January 29, 2021, 2021 TX REG TEXT 575848 (NS) provided notice of a public hearing regarding proposed payment rates for HCBS—Adult Mental Health Supported Home Living and YES Waiver In-Home Respite.

On February 22, 2021, 2021 TX H.B. 1988 (NS) was introduced. If adopted, it will establish presumptive eligibility of certain elderly individuals for home and community-based services under Medicaid.

• Effective March 26, 2021, 2021 TX REG TEXT 572209 (NS) renews the effectiveness of an emergency rule for a 60-day period regarding changes to an individual's residential type and services in the HCBS program.

• Effective April 23, 2021, 2021 TX REG TEXT 580573 (NS) is withdrawing the emergency adoption of new sections regarding HCBS and Community First Choice (CFC).

• Effective April 30, 2021, 2021 TX REG TEXT 583601 (NS) adopts, on an emergency basis, a new section allowing home and community-based services program providers to submit a service claim for supervised living and residential support when an individual, whose residence is a program provider's three-person residence or four-person residence, is not receiving the service because the individual is living away from the residence during the COVID-19 public health emergency.

• On June 16, 2021, 2021 TX S.B. 910 (NS) was adopted. It implements options for the provision of community-based family preservation services and certain other health and human services by certain state agencies or contractors.

On June 25, 2021, 2021 TX REG TEXT 586493 (NS) provided notice that the Texas Health and Human Services Commission (HHSC) will conduct a public hearing on July 14, 2021, at 9:00 a.m., to receive public comments on proposed rate actions for the fiscal year 2020-21 quarter 4 biennial fee review and Home and Community-Based Waiver (HCS) and Texas Home Living Waiver (TxHmL) respite and day habilitation services.

On July 16, 2021, 2021 TX REG TEXT 588330 (NS) provides notice the Texas Health and Human Services Commission (HHSC) is submitting to the Centers for Medicare and Medicaid Services (CMS) a request to amend the waiver application for the Home and Community-based Services (HCS) waiver program authorized under s.1915(c) of the Social Security Act. CMS has approved the HCS waiver application through August 31, 2023. The proposed effective date for this amendment is August 31, 2021.

On September 24, 2021, 2021 TX REG TEXT 594426 (NS) provided notice that the Texas Health and Human Services Commission (HHSC) announces its intent to submit a list of certain Medicaid settings to the Centers for Medicare and Medicaid Services (CMS) for heightened scrutiny review, as described in 42 Code of Federal Regulations 441.301(c)(5)(v), to demonstrate that the settings are eligible for delivery of home and community-based services (HCBS).

Effective October 24, 2021, 2021 TX REG TEXT 590841 (NS) amends 1 TAC 355.727 (Add-on Payment Methodology for Home and Community-Based Services Supervised Living and Residential Support Services).

Utah

Effective November 10, 2020, 2020 UT REG TEXT 566799 (NS) provides notice of rule effective dates pertaining to R414-307. Eligibility for Home and Community-Based Services Waivers.

Effective November 24, 2020, 2020 UT REG TEXT 568006 (NS) provides notice of rule effective dates pertaining to R414-307. Eligibility for Home and Community-Based Services Waivers.

Vermont

On March 25, 2021, 2021 VT H.B. 153 (NS) was engrossed. If adopted, it will establish an annual inflation factor to be applied to the Medicaid rates for providers of home- and community-based service providers.

Virginia

Effective December 23, 2020, 2020 VA REG TEXT 570781 (NS) raises rates for agency and consumer directed personal care, respite, and companion services in the home and community-based services waivers and Early Periodic Screening, and Diagnosis and Treatment program by 5.0%.

Effective March 31, 2021, 2021 VA REG TEXT 436613 (NS) redesigns three existing home and community-based waivers.

Washington

Effective May 30, 2021, 2021 WA REG TEXT 576083 (NS) amends WA ADC 182-513-1215 (Community first choice (CFC)—Eligibility).

Effective July 1, 2021, 2020 WA REG TEXT 570317 (NS) provides notice that the state intends to file a 1915 (b)(4) waiver application for selective contracting, which will apply to various home and community-based services waiver programs.

• Effective October 8, 2021, 2021 WA REG TEXT 568056 (NS) makes changes to align chapter 388-845 WAC with Home and Community Based Services (HCBS) waiver amendments approved by the Centers for Medicare and Medicaid Services.

Effective October 12, 2021, 2021 WA REG TEXT 552057 (NS) amends WA ADC 388-845-2019 (What modifications to waiver services apply during the COVID-19 outbreak?).

Wyoming

On April 6, 2021, 2021 WY S.F. 139 (NS) was adopted. It subjects availability of the community based in-home services program to the availability of funds.

V. DISABLED PERSONS

On June 22, 1999, the U.S. Supreme Court held in *Olmstead v. L.C.* that unjustified segregation of persons with disabilities constitutes discrimination in violation of title II of the Americans with Disabilities Act (ADA). The Court held that public entities must 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 public entity and the needs of others who are receiving disability services from the entity. The Court explained that its holding 'reflects two evident judgments.' First, 'institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life." Second, 'confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." [FN38]

Ten years later, Judge Nicholas Garaufis of the Federal District Court in Brooklyn ruled that the state of **New York** had violated the ADA by leaving thousands of mentally ill citizens in privately-operated adult homes. Garaufis ruled that the state's housing of approximately 4,300 mentally ill residents in 28 adult homes in New York City is illegal because the homes constitute 'institutions that segregate residents from the community and impede resident's interactions with people who do not have disabilities." [FN39] The ADA required states to remove the mentally ill from psychiatric institutions and integrate them into the larger community so that they could learn independent living skills and gain self-sufficiency. Judge Garaufis ruled that the adult homes are essentially segregated institutionalized settings that prevent residents from interacting with others in their neighborhood, developing relationships, and minimizing their employment options. The judge also noted that supported housing for the mentally ill is less expensive for the state than adult homes. [FN40]

On March 1, 2010, Judge Garaufis released a plan for transitioning the adult home residents and ordered the state to begin moving them into their own apartments or homes. The plan requires the state to develop at least 1,500 supported housing units per year for the next three years. Judge Garaufis' plan is a rejection of the proposal issued by the state, which called for the development of 1,000 total units, to be made available over a five-year period. In his opinion, the judge noted that the court 'is disappointed and, frankly, incredulous that defendants sincerely believed this proposal would suffice. " [FN41] The transition order exempts individuals with severe mental illness who pose a danger to themselves or others. These individuals will continue to reside in large adult homes. According to a statement from the office of Gov. David Paterson (D), the state is considering an appeal.

The U.S. Department of Justice announced on May 25, 2010, that it had filed briefs in three separate court cases involving alleged violations of the ADA. The DOJ filings support two private lawsuits in **Florida** and **New Jersey** and a proposed class action settlement in **Illinois**. All three briefs argue that the three states are not complying with ADA and the Supreme Court's *Olmstead* decision, which bans unjustified institutionalization. In addition, **Georgia** officials have committed to spend $15 million in the current budget and an

additional $62 million in 2012 to help mentally ill and developmentally disabled people move out of state mental hospitals and receive services in their communities, under a settlement with the DOJ.

States find they face opposing mandates: while they must provide, within their resources, community-based services for the disabled, Medicaid rules require that they provide nursing home care—but not home care—to people with disabilities. In light of dwindling budgets, at least 17 states have cut into funding for assistance to the disabled since 2009 or are planning to do so this year. The cuts include cash, home nursing services, and grants to agencies that help the disabled live independently. Since home-based care is an optional service, states are opting to cut those services, observes Ann Kohler, executive director of the National Association of State Medicaid Directors. Not being able to afford the community-based services is not an excuse, says Thomas Perez, assistant attorney general for civil rights. He says the Justice Department has been working with the Department of Health and Human Services to find more funding for some of the states it is going up against in court. [FN42]

After a year-long investigation, Senate Health, Education, Labor and Pensions (HELP) Committee Chair Tom Harkin released a report showing that the ADA's promise of integration is not being met for many Americans with disabilities. Nearly 15 years ago, the Supreme Court ruled in Olmstead v. L.C. that unnecessary segregation of individuals with disabilities is a violation of the ADA. The HELP committee report finds, however, that states have yet to make adequate progress in ensuring independent living. Providing services for people with disabilities outside of an institution is most cost-effective option, yet more than 200,000 Americans with disabilities under age 65 remain unfairly segregated in nursing homes and the number of working-age Americans with disabilities confined to nursing homes is actually growing, the report says. The report, titled 'Separate and Unequal: States Fail to Fulfill the Community Living Promise of the Americans with Disabilities Act," is the result of requests for information sent by Chairman Harkin to all 50 states on the progress made to transition individuals out of institutions. While progress has been made nationally, by 2010 only 12 states spent more than 50 percent of Medicaid funds on community-based care instead of institutional care, the investigation found.

Delaware announced on July 6, 2011 that it has agreed to comprehensive reform of its mental health system under the terms of a five-year settlement with the Justice Department over allegations of ADA violations. The alleged violations were identified during a three-year federal investigation of the state psychiatric hospital and community services provided by the state for people with mental illness. The results of the investigation showed that the state was not in compliance with the ADA requirement to provide people with disabilities in the most integrated settings appropriate to their needs. Under the agreement, people with mental illnesses will be able to reside successfully in their homes and communities rather than entering costly segregated facilities, according to Thomas E. Perez, assistant attorney general for civil rights. He points out that in addition to satisfying ADA obligations and fulfilling its moral interest in serving people with mental illness, the agreement will save Delaware money. Where it costs the state an average of $220,000 to treat a person in the Delaware Psychiatric Center, that same person can be treated for $50,000 in the community, and the federal government picks up part of the tab. [FN43]

On January 24, a federal court approved a settlement resolving a lawsuit that charged **California**'s efforts to eliminate its Medicaid-supported Adult Day Health Care program violated the ADA. Filed in the U.S. District Court for the Northern District of California, the settlement calls for the ADHC program to be phased out and replaced on March 1 with the Community-Based Adult Services (CBAS) program. The state maintains that the CBAS program 'will provide necessary medical and social services to individuals with intensive health care needs." Former ADHC participants who do not qualify for CBAS will be eligible to receive enhanced case management and other services through the state's Department of Health Care Services and Medi-Cal managed care plans that contract with DHCS, the state said. Eligibility to participate in CBAS will be determined by state medical professionals on the basis of medical need and with the goal of ensuring a loss of services does not result in institutionalization. The state DHCS said it expects about half of the 35,000 former ADHC beneficiaries—mostly seniors and younger people with traumatic brain injuries or other cognitive disabilities—to qualify under CBAS. The other half will have case management services to help them find other, adequate, community-based services, DHCS said. The lawsuit alleged that eliminating the day care services without providing an adequate alternative would violate the ADA by placing former recipients at risk of institutionalization, hospitalization, injury, or death. [FN44]

State officials in **Illinois** agreed on August 30, 2011, to a proposed settlement to end the state's reliance on nursing facilities to house adults who have physical and mental disabilities. The proposed settlement, filed in federal court, would require state agencies to offer subsidized apartments to thousands of Cook County nursing home residents who can function independently and want to move out of the institutions. The settlement still requires court approval and a 'fairness hearing' to consider the comments and objections of interested parties before becoming state policy. Advocates have hailed the agreement as a civil rights victory for low-income people with disabilities, saying the new settlement would bolster other recent court agreements and legislative reforms aimed at reshaping long-term care system. State officials say the new agreement would not burden Illinois taxpayers because the state would recoup Medicaid dollars as it offers apartments and community housing to the former nursing home residents. ***[45]***

Hundreds of mentally ill people in **New York,** who have been confined to nursing homes, would move to apartments or other housing within three years under a legal settlement with the state. The settlement resolved a case that was filed in Brooklyn federal court in 2006 and that accused the state of violating the spirit of its own longstanding rules for housing mentally ill people. The plaintiffs found that psychiatric centers and nursing homes had developed 'turnaround agreements, which essentially were written agreements to transfer patients back and forth," Veronica S. Jung, senior staff attorney for New York Lawyers for the Public Interest said. Under

longstanding legal principle in New York and elsewhere, the mentally ill cannot be confined unless they are considered a threat to themselves or others, and should be housed in the least restrictive setting appropriate for their needs. [FN46]

Texas will expand community-based services for those with intellectual and developmental disabilities (IDD) as part of an interim settlement agreement with the U.S. Department of Justice announced on August 19. Under the interim settlement agreement filed with the U.S. District Court for the Western District of Texas, the state will begin to provide community alternatives to nursing facilities for thousands of people while the parties temporarily suspend their ongoing litigation as negotiations continue toward a comprehensive settlement. In a statement, DOJ called the interim agreement the 'first statewide settlement to vindicate the *Olmstead* rights of individuals in nursing facilities." The *Olmstead v. L.C.* [FN47] ruling requires states to eliminate unnecessary segregation of people with disabilities and to ensure that they receive services in the most integrated setting appropriate to their needs. A class action was filed against the state in December 2010 by private plaintiffs and DOJ filed a partial consent motion to intervene in the case in June 2011. Approximately 4,500 Medicaid-eligible individuals over 21 years old currently living in nursing facilities are considered to be inappropriately placed and could benefit from living in a community settlement, according to the 2011 filing. The litigation involves claims that the state violated the ADA and other federal laws 'both by segregating these individuals in nursing homes and by failing to provide them with the treatment and services they needed while there," according to an August 19 statement released by Disability Rights Texas, a federally designated legal protection and advocacy agency and nonprofit that formed part of the representation of the six private plaintiffs who brought the suit. [FN48]

News Highlights

Senators Call on Biden to Expand HCBS

A group of 31 U.S. senators are calling on President Biden to keep his campaign proposal to invest more in home and community-based services. [FN49] The Biden plan includes a commitment to spend $450 billion over 10 years to allow people to choose care in community-based settings. Biden wants to give states enough money to cover the full cost of providing HCBS to those with a disability currently on a waiting list.

The senators want to see the commitment come to fruition, arguing it will drive economic growth, create caregiving jobs and meet the needs of Americans with disabilities.

Stimulus Bill Contains HCBS Funds

President Biden has signed the $1.9 trillion pandemic relief bill, which will include billions for home and community-based services. [FN50] $12.67 billion will be allocated for HCBS over the next year. The funding will go to states in the form of a 10% rise in the federal spending share starting in April and extending through March 2022.

Advocates expect states will have significant discretion in how to use the extra dollars. The funds could go toward helping people with disabilities come off of waiting lists for services, increasing pay for direct support professionals or helping programs reopen safely, among other options. Disability advocates have been pushing for an infusion of cash like this since last spring when the pandemic forced providers to shutter programs resulting in reduced revenue at the same time that new expenses emerged.

Disability Service Providers Closing in Many States

According to a recent report from the Kaiser Family Foundation, 25 of 41 states surveyed through July 25 reported closing at least one home and community-based service provider. [FN51] 16 surveyed states saw multiple types of services shut their doors. Adult day programs were the most likely to be closed, followed by in-home care providers, supported employment and group homes.

The survey showed that the pandemic exacerbated existing workforce shortages, but there was also impact on providers from people with disabilities and their families declining to allow workers into their homes due to COVID concerns. Closures to comply with social distancing measures also affected day programs and supported employment.

Many states use retainer payments allowing providers to continue billing for approved services during temporary closures, but limitations meant this was insufficient for some. To address the fallout, federal lawmakers approved $12.67 billion over the next years for HCBS as part of the American Rescue Plan. President Biden has also proposed an additional $400 billion investment for HCBS as part of the reconciliation packages currently being debated in Congress, but it is unclear how much money will end up being in the bill.

North Dakota Settlement Will Increase HCBS Access

The Justice Department has reached a settlement agreement with North Dakota under the Americans with Disabilities Act (ADA). [FN52] It resolves complaints alleging that the state unnecessarily institutionalizes individuals with disabilities in nursing facilities instead of providing them with services to live in the community.

According to Assistant Attorney General Eric Dreiband for the Civil Rights Division, 'the settlement agreement will ensure that individuals with disabilities are no longer unnecessarily institutionalized in nursing facilities. Instead, these individuals will be able to choose to remain in their own home, near family and friends." Under the agreement, services will be expanded to individuals with disabilities in or at risk of entering a nursing facility to allow them to continue living in their homes. These services include assistance

in finding accessible housing and home health aides to help with daily activities such as bathing and dressing. Access to community service providers will also be increased.

Officials also cite this decision as being urgently needed considering the COVID-19 pandemic, given the high risk of virus transmission in congregate settings.

Highlights of Recent Activity

California

On October 22, 2021, 2021 CA REG TEXT 597082 (NS) provided notice that the Department of Health Care Services (DHCS) intends to submit a Home and Community Based Services Waiver (HCBS) amendment for federal approval. It would amend the California Medicaid 1915(c) Developmental Disabilities Waiver to implement rate changes funded in the 2021-22 budget act and informed by the 2019 service provider rate study.

Connecticut

On January 28, 2021, 2021 CT H.B. 6012 (NS) was introduced. If adopted, it will provide additional support for home and community-based services in long-term care facilities and require that state agencies explore alternative care options for senior citizens and people with disabilities.

District of Columbia

Effective November 24, 2020, 2020 DC REG TEXT 571751 (NS) provided notice of the adoption of, on an emergency basis, and the intent to adopt, on a permanent basis, amendments to Sections 1915-1916, 1920, 1922, 1929-1931, 1934, 1936, 1939, and 1941 of Chapter 19 (Home and Community-Based Services Waiver for Individuals with Intellectual and Developmental Disabilities), of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

Effective April 9, 2021, 2021 DC REG TEXT 517046 (NS) gives notice of the adoption of amendments to Section 989 (Long Term Care Services and Supports Assessment Process) of Chapter 9 (Medicaid Program); and Section 4201 (Eligibility) of Chapter 42 (Home and Community-Based Services Waiver for Persons who are Elderly and Individuals with Physical Disabilities) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR).

Hawaii

On March 31, 2021, 2021 HI S.R. 93 (NS) was adopted. It requests that the Department of Health change its eligibility criteria for the HCBS Medicaid waiver for individuals having intellectual or developmental disabilities or mental illnesses.

Kansas

On January 11, 2021, 2021 KS H.B. 2046 (NS) was introduced. If adopted, it will increase reimbursement rates for providers of home and community-based services under the intellectual or developmental disability waiver, making appropriations for such rates and providing for legislative review of the waiting list for such services.

• On February 12, 2021, 2021 KS H.B. 2382 (NS) was introduced. If adopted, it will make appropriations for the Kansas department for aging and disability services to provide services to individuals waiting to receive intellectual or developmental disability home and community-based services; lapsing state foundation aid and authorizing school districts to expend unencumbered cash balances.

On March 24, 2021, 2021 KS S.B. 154 (NS) was amended/substituted. If adopted, it will increase reimbursement rates for providers of home and community-based services under the intellectual or developmental disability waiver.

On September 30, 2021, 2021 KS REG TEXT 594778 (NS) requested comments regarding proposed renewal of the Kansas Medicaid 1915(c) Waivers for the HCBS Autism (AU) waiver program and HCBS Serious Emotional Disturbance (SED) waiver program.

Maine

Effective May 2, 2021, 2021 ME REG TEXT 572678 (NS) amends provisions regarding home and community benefits for the elderly and adults with disabilities.

On March 18, 2021, 2021 ME H.P. 835 (NS) was introduced. If adopted, it will ensure that MaineCare HCBS reimbursement rates for persons with intellectual disabilities or autism are adjusted in accordance with increases in state and municipal minimum wage. [FN53]

On June 22, 2021, 2021 ME H.P. 1104 (NS) was adopted. It improves Home and Community-based Services for Adults with Intellectual Disabilities, Autism, Brain Injury and other related conditions.

Maryland

• On January 29, 2021, 2021 MD REG TEXT 576002 (NS) provided notice that the Maryland Department of Health (MDH) will submit a 1915(c) home and community-based services waiver application for the Waiver for Adults with Brain Injury to the Centers for Medicare and Medicaid Services (CMS) to renew the waiver for 5 additional years effective July 1, 2021.

• On January 29, 2021, 2021 MD REG TEXT 575999 (NS) provided notice that the Maryland Department of Health will submit a 1915(c) home and community-based services waiver application for the Waiver for Adults with Brain Injury to the Centers for Medicare and Medicaid Services (CMS) to renew the waiver for 5 additional years effective July 1, 2021.

Massachusetts

Effective January 29, 2021, 2021 MA REG TEXT 577579 (NS) amends payment rates for certain MassHealth home and community-based waiver services provided under the following Home and Community-based Services (HCBS) Waivers: Acquired Brain Injury - Non-residential Habilitation (ABI-N) and Moving Forward Plan - Community Living (MFP-CL).

New Hampshire

On May 20, 2021, 2021 NH REG TEXT 584124 (NS) provided notice of proposed rules regarding eligibility criteria for services covered by, and provider requirements for, the Choices for Independence (CFI) program, which is a Medicaid 1915(c) waiver program for seniors and adults with disabilities, also known as the Home and Community Based Care program (HCBS-CFI) or CFI waiver program.

New Mexico

On September 28, 2021, 2021 NM REG TEXT 594756 (NS) provided notice of proposed rules amending requirements related to the Developmental Disabilities HCBS waiver.

On November 9, 2021, 2021 NM REG TEXT 598665 (NS) proposed to amend various sections regarding the developmental disabilities HCBS waiver.

North Dakota

Effective May 19, 2020, 2020 ND REG TEXT 555327 (NS) amends ND ADC 75-03-23-02 (Eligibility criteria) regarding home and community-based services under the service payments for elderly and disabled program and the Medicaid waiver for the aged and disabled program.

On August 14, 2021, 2021 ND REG TEXT 590746 (NS) provided notice that the North Dakota Department of Human Services will hold a public hearing to address proposed amendments regarding HCBS for the elderly and persons with disabilities.

Ohio

Effective February 8, 2021, 2021 OH REG TEXT 568375 (NS) amends OH ADC 5160-41-16 (Assistance to Enable a County Board of Developmental Disabilities to Pay Non-Federal Share of Medicaid Expenditures for Home and Community-Based Services).

• On July 30, 2021, 2021 OH REG TEXT 589566 (NS) amends, adopts and rescinds various sections regarding HCBS waivers for persons with disabilities.

Oklahoma

Effective January 1, 2021, 2021 OK REG TEXT 575092 (NS) establishes criteria for employment services provided through Developmental Disabilities services (In-Home Supports waiver).

Texas

• Effective April 23, 2021, 2021 TX REG TEXT 583182 (NS) adopts, on an emergency basis, COVID-19 response rules for HCBS intellectual disability service providers.

On June 16, 2021, 2021 TX H.B. 3720 (NS) was adopted. It relates to Medicaid waivers (i.e. HCBS, etc.) available to certain individuals, including individuals with intellectual and developmental disabilities.

Vermont

On March 25, 2021, 2021 VT H.B. 153 (NS) was engrossed. If adopted, it will establish an annual inflation factor to be applied to the Medicaid rates for providers of home- and community-based service providers. It would also direct the Department of Vermont Health Access and the Department of Disabilities, Aging, and Independent Living to study the Medicaid reimbursement rates paid to home- and community-based service providers, their adequacy, and the methodologies underlying the rates.

Washington

Effective June 23, 2021, 2021 WA REG TEXT 587290 (NS) amends sections regarding DDA HCBS waivers.

• Effective September 23, 2021, 2021 WA REG TEXT 552057 (NS) enacts WA ADC 388-845-2019 (What modifications to waiver services apply during the COVID-19 outbreak?) on an emergency basis to make temporary modifications to developmental disabilities administration's (DDA) home and community-based services (HCBS) waivers in order to control the spread of the COVID-19 virus and to meet immediate health and safety needs.

• Effective October 21, 2021, 2021 WA REG TEXT 568105 (NS) affects all five of developmental disabilities administration's (DDA) home and community-based services (HCBS) waivers and: update service definitions and service names; change some service limits; add services to various waivers; remove services from various waivers; change eligibility criteria for specific services; change qualified provider criteria for various services; and repeal several sections.

West Virginia

On February 10, 2021, 2021 WV H.B. 2127 (NS) was introduced. If adopted, it will add requirements regarding the Medicaid Home and Community-Based Services Intellectual/Developmental Disability Waiver.

VI. EXPANSION OF HCBS PROGRAMS

A state-by-state summary of assisted living regulations was released in March 2012, by The National Center for Assisted Living (NCAL). The study analyzes regulatory and legislative changes in 2011 and provides state-by-state highlights, along with contact information for state agencies that oversee assisted living activities and each agency's Web site address. According to the report, 16 states in 2011 reported making statutory, regulatory or policy changes impacting assisted living/residential care communities, and at least four of these (Georgia, South Dakota, Nevada, and North Carolina) made major changes. As of February 2012, Florida and several other states were also considering significant changes to assisted living regulation. Highlights of the report:

• A second level of licensure for Assisted Living Community standards—covering disclosure, required services, admission thresholds, resident assessment, medication management, physical plant, staffing, staff training, and fire safety requirements—was created by several other states.

• Education and training requirements for direct care workers were revised or added in six states and certification standards for home care aides established.

• Refined standards for disclosure of information, fire safety, infection control and TB testing, discharge/transfer between care sites, admission/retention thresholds, medication management, and physical plant were reported in several states, along with increased enforcement tools and incentives for higher quality ratings.

• Medicaid coverage of services for assisted living residents was impacted in several states, including choice of health care providers, home-like condition of assisted living center, and adjustment of supplemental security payment benefits. [FN54]

On November 4, 2013, the Office of Management and Budget received for review a final rule (CMS-2249-F) from CMS that will revise Medicaid regulations to define and describe State plan HCBS under the Affordable Care Act. The rule offers States flexibilities in providing necessary and appropriate services to elderly and disabled populations. The rule provides additional guidance to states offering HCBS under the so-called 1915(i) benefit which allows states to offer HCBS without first obtaining a waiver from the CMS. As a result, states can receive federal reimbursement for services that were previously eligible for federal funding only through a waiver and demonstration. In particular, the rule provides for a five-year approval or renewal period for certain Medicaid waivers. The time period will apply for demonstration and waiver programs in which a state provides services to enrollees who are eligible to receive both Medicare and Medicaid. The rule also eliminates the ‘direct payment” requirement that mandates Medicaid payments be made only to certain individuals or entities; the rule will allow the state to claim as a provider payment amounts that aren't paid directly to the provider but are withheld and paid to a third party on behalf of the provider for health and welfare contributions, training costs and other benefits. [FN55]

The AARP Public Policy Institute issued a report in February 2012 that examines the transformations of long-term services and supports (LTSS) taking place in many states. As a result of the lagging economy and increased demand for publicly funded LTSS, the report finds state policymakers are under pressure to find solutions. Many states either have or plan to implement Medicaid Managed LTSS, with 12 states having existing programs and another 11 with plans for implementation; at least 28 states are focusing on improved integration of care for people who are eligible for both Medicare and Medicaid. Many states used the economic downturn as an opportunity to balance services from institutional to noninstitutional settings, with 27 states reporting that the HCBS census increased from fiscal year (FY) 2010 to FY 2011, and 31 states reporting expected increases from FY 2011 to FY 2012.

The report found six clear patterns emerging from the states:

• States are transforming the financing and delivery of LTSS: a significant number of states either have or plan to implement Medicaid Managed LTSS, and a majority of states seeks better integration of Medicare and Medicaid services for ‘dual eligibles.”

• The aftermath of the Great Recession continues to impact state budgets; many made cuts to non-Medicaid LTSS funded services.

• Demand for publicly-funded services continues to increase due to rising numbers of older adults and persons with disabilities in need of these services.

• States continue to remain committed to HCBS; many states work to balance services from institutional to non-institutional settings and continue to make progress in serving more individuals with LTSS needs in their homes or communities, as opposed to nursing homes.

• Changes in LTSS state leadership are at record highs.

• Uncertainty around the constitutionality of the Affordable Care Act (ACA); while the ACA provides states with new options to expand HCBS, pending constitutionality litigation makes adoption of these options a challenge. [FN56]

In addition to a detailed analysis of the six common themes, the report also includes extensive state-by-state data on budgets, plans for LTSS expansion, integration of dual eligibles, Medicaid HCBS waivers, and nursing facility activities. [FN57]

In FY 2014 and FY 2015, 42 and 47 states, respectively, took actions that expanded the number of persons served in a home and community-based services (HCBS) setting, A Kaiser Family Foundation survey has found. [FN58] In contrast, just 26 states took such action in FY 2012 and 33 in FY 2013. The in-depth report examines Medicaid budgets in the 50 states, for fiscal years 2014 and 2015. While most states reported using Section 1915(c) waiver authority to expand HCBS, a significant number of states (13 in FY 2014 and 16 in FY 2015) reported that the incentives built into their managed long-term services and support (LTSS) programs were expected to increase the number of people served in community settings. Nineteen states had at least one of the new ACA LTSS options in place in FY 2013; an additional 12 states in FY 2014 and 15 states in FY 2015 plan to implement one or more of these options.

Additionally, the survey found a marked increase in the establishment of ‘health home” initiatives. The ACA provides a new state plan option for Medicaid programs to establish health homes, designed to be person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, and community-based LTSS, for beneficiaries who have at least two chronic conditions (or one and at risk of a second or a serious mental health condition). States may implement a health home program after gaining CMS approval. Then, a 90 percent federal match rate is available for qualified expenditures for health home services for the first eight quarters of a state's program. In the survey, 12 states said that health homes were ‘in place” in FY 2013, 14 states reported having adopted or expanded health homes in FY 2014 and 26 states reported plans to do so in FY 2015.

Federal Legislation

People younger than 55 would become eligible for a program to prevent unnecessary nursing home admissions if lawmakers pass a bill introduced on May 1 in the U.S. House of Representatives. These younger people currently are not allowed to participate in the Program of All-Inclusive Care for the Elderly (PACE), noted bill sponsor Rep. Earl Blumenauer (D-OR) in a press release. [FN59] The program, which now is running in 31 states, has been a ‘huge success,” Blumenauer said. As introduced by Blumenauer and Rep. Chris Smith (R-NJ), the ‘PACE Pilot Act” (2013 FD H.B. 4543 (NS)) would bring younger people ‘into the fold” in a budget-neutral manner, he said. PACE is designed for individuals who need a nursing home level of care. But instead of institutional care, it puts in place a health care team to enable participants to live in home- or community-based settings whenever possible. PACE is run through private health plans that receive capitated payments from the government. They are charged with providing coordinated care for people who otherwise would be billing Medicare and/or Medicaid for less integrated services. The measure would also eliminate the nursing home level of care requirement, which would widen access to preventative services and treatments for the ‘frailest members of our society,” Smith said.

BNA reports that a bipartisan group of senators urged the CMS to increase the regulatory flexibility of a program that allows the frailest and costliest Medicare and Medicaid beneficiaries to receive care at home. [FN60] The letter, dated September 17, was signed by Sens. Thomas R. Carper (D-Del.) and Patrick J. Toomey (R-Pa.), along with 11 others. The lawmakers urged the CMS to expand the Program of All-Inclusive Care for the Elderly (PACE), which they said can offer high quality, cost-effective care to seniors who are eligible for Medicare and Medicaid. The PACE program uses Medicare and Medicaid funds to cover all of a beneficiary's medically necessary care and services. An enrollee can have either Medicare or Medicaid or both to join PACE.

In the letter, lawmakers state that ‘current regulatory and statutory barriers have inhibited PACE growth and innovation,” and are calling on CMS to allow PACE to operate in a variety of community settings—such as adult day health centers or senior centers—as well as to offer concurrent reviews at the federal and state level to speed up the provider application process.

VII. CAREGIVERS AND DIRECT CARE WORKERS

In December 2009 the National Alliance for Caregiving (NAC), in conjunction with AARP, released a comprehensive study on caregiving in the United States. According to the study, nearly one-third of American adults served as a caregiver in 2009. For the purposes of the report, a caregiver is defined as an individual who provides unpaid care to an adult or child. The study revealed that 29 percent of American adults, comprising 65.7 million people, provided an average of 20 hours of care per week for disabled adults, the elderly and special-needs children. The report also found that the average age of caregivers is 48 years and the majority of them, 66 percent, are women. Furthermore, 86 percent provide care to a relative, 36 percent of which are the caregivers' own parents. The study also found that individuals who care for adults, as well as the recipients of such care, are on average older than they were five years ago. [FN61]

The AARP Public Policy Institute released a report showing that in 2009 there were 42.1 million people caring for an adult family member, partner, or friend with chronic conditions or disabilities. Their unpaid services amounted to the equivalent of $450 billion. At a time when government services for the elderly and disabled are being cut, both the nation and states are relying more and more on these unpaid caregivers. And the numbers are rising. The AARP report shows the value of the unpaid care in 2007 was $375 billion. About 57 percent of that increase was due to an increase in the number of family caregivers and hours of care, and about 43 percent was because of an increase in the estimated economic value per hour, from $10.10 in 2007 to $11.16 in 2009. [FN62]

Although previous studies have provided conflicting evidence on whether being a family caregiver is associated with increased or decreased risk of mortality, a recent study finds that family caregiving may be associated with modest survival benefits. The study examined whether 3,503 family caregivers enrolled in the national Reasons for Geographic and Racial Differences in Stroke

(REGARDS) Study showed differences in all-cause mortality from 2003 to 2012 compared with a matched sample of non-caregivers. During an average 6-year follow-up period, a proportional hazards model indicated that caregivers had an 18% reduced rate of death compared with non-caregivers, the study found. Subgroup analyses by race, sex, caregiving relationship, and caregiving strain failed to identify any subgroups with increased rates of death compared with matched non-caregivers. The authors conclude that public policy and discourse should recognize that providing care to a family member with a chronic illness or disability is not associated with increased risk of death in most cases, but may instead be associated with modest survival benefits for the caregivers. [FN63]

On November 8, 2012, CMS published a final rule that updates the Home Health Prospective Payment System rates, including the national standardized 60-day episode rates, the national per-visit rates, the low-utilization payment amount, the non-routine medical supplies conversion factor, and outlier payments under the Medicare prospective payment system for home health agencies effective January 1, 2013. Payments to home health agencies are estimated to decrease by approximately $10 million in calendar year 2013. According to a CMS fact sheet, payments under the home health prospective payment system (HH PPS) are estimated to be virtually unchanged in CY 2013, decreasing 0.01 percent.

The reimbursement cut reflects the combined effects of the home health marketbasket and wage index updates and previously finalized reductions to the home health prospective payment system rates to account for changes in coding practices, the agency said. In acute or post-acute care settings, the final rule provides additional flexibility in certifying patients as eligible for the home health benefit, CMS said. In addition, the rule makes changes that help ensure patients maintain access to therapy services, while reducing burden on home health agencies, according to CMS. [FN64]

Home health agencies would be given an opportunity to achieve compliance with federal health and safety standards, known as the conditions of participation (CoPs), through new methods, such as directed plans of correction or directed in-service training, and would allow CMS to impose alternative sanctions in addition to termination for agencies that do not maintain or achieve compliance with CoPs. According to CMS, the proposal would promote quality of care for patients by ensuring that home health agencies that are out of compliance with the CoPs could correct their performance and achieve prompt compliance. The proposal also would establish new survey and certification requirements for home health agencies including definitions for types of surveys, survey frequency, surveyor qualifications, and the opportunity for informal dispute resolution. [FN65]

A recent report from the HHS Office of Inspector General examining Medicaid personal care services (PCS) has found significant and persistent compliance, payment, and fraud vulnerabilities. CMS must take a more active role with States to combat these issues, the report urges. In 2011, Medicaid costs for PCS totaled approximately $12.7 billion, a 35-percent increase since 2005. Several Federal court decisions and Department of Health and Human Services policy initiatives aimed at providing more home- and community-based options to Medicaid beneficiaries contribute to the increase in PCS use. As more and more State Medicaid programs explore home care options like PCS, it is critical that adequate safeguards exist to prevent fraud, waste, and abuse in PCS and other important home care benefits, the report says. The document summarizes OIG's PCS work and, on the basis of the analysis of this work in the aggregate, offers recommendations to improve the integrity of Medicaid PCS. [FN66]

In a report released on May 15, 2013, the Health and Human Services Office of Inspector General recommended that CMS routinely conduct look-behind surveys for oversight of State agencies, which conduct most HHA recertification surveys. CMS concurred with OIG's recommendation and stated that its central office would work with the CMS regional offices to identify State agencies with the greatest need for look-behind surveys. State agencies and accreditation organizations conducted recertification surveys for nearly all home health agencies (HHAs) within the required 36-month timeframe and cited 12 percent of HHAs with ‘condition“-level deficiencies, the most serious type of deficiency, the report explained. Ninety-three percent of these HHAs corrected their condition-level deficiencies within the required 90-day timeframe; the remaining 7 percent corrected the deficiencies late or left Medicare. Fifteen percent of HHAs had complaints lodged against them; surveyors conducted complaint investigation surveys for nearly all of these HHAs and cited 7 percent of them with condition-level deficiencies, the report noted. With few exceptions, HHAs corrected all condition-level deficiencies cited during complaint surveys. State agencies exceeded the required number of look-behind surveys for oversight of accreditation organizations. According to the report, CMS rarely conducted look-behind surveys for oversight of State agencies' surveys of HHAs and that such look-behind surveys are not required by Federal regulation. [FN67]

The CMS has decided to use monetary penalties and payment suspension against home health agencies sparingly, and has lowered the penalty levels for second-level offenses. As outlined in the 2013 final pay rule for home health released on November 2, the policy keeps 2013 rates at approximately the same level as this year and establishes requirements for the home health and hospice quality reporting programs. In the final rule, CMS indicates that it expects to use monetary penalties only when deemed necessary to bring providers into compliance. The final rule also states that CMS will not use civil monetary penalties, payment suspensions and the informal dispute resolution until July 1, 2014. The rule establishes new survey and certification requirements, including definitions for types of surveys, survey frequency, surveyor qualifications, and the opportunity for informal dispute resolution, according to the rule. [FN68]

Under a recommendation approved by the Medicare Payment Advisory Commission (MedPAC) on January 16, home health providers with relatively high rates of hospital readmissions would see their Medicare payments reduced, beginning in FY 2015. About 29 percent of post-hospital home health services result in readmission, MedPAC staff said. The overall goal of the policy is to improve

care coordination beyond the inpatient setting, and establishing home health readmission penalties would align incentives with other entities, staff said. The recommendation is expected to cut Medicare spending between $50 and $250 million in FY 2015, through lower payments to home health providers that incur the penalty. Additional savings would be realized through reduced costs for inpatient care. [FN69]

Home health agencies have been filing more appeals related to Medicare Part A claim determinations since 2008, although the proportion of successful appeals has dropped significantly, according to a new report issued by the Office of Inspector General of the Department of Health and Human Services. After receiving a claim determination from a Medicare contractor, a provider has 120 days to file a first-level appeal, known as a redetermination. The OIG derived the figures from an analysis of a government database, and released the numbers in the report 'The First Level of the Medicare Appeals Process, 2008-2012: Volume, Outcomes, and Timeliness." [FN70] The number of appealed Part A home health claims grew dramatically, from 13,385 in 2008 to 112,844 in 2012, and increase of 700 percent. The rate of favorable redeterminations for appellants, however, dropped from 24 and 39 percent in 2008 and 2009, respectively, to just 4 percent in 2012. Taking into account all provider types, the number of redeterminations processed by Medicare contractors increased 33% for the four years leading up to 2012, the OIG found. However, the success rate of first-level appeals plummeted from 50% to 24%. The growth of the recovery audit contractor program is linked to these trends, the report indicates.

Home health care providers are urging CMS to create interim pay models focused on home health until other, value-based approaches catch on, saying that Medicare often isn't paying for home health services because there are not enough pay models that include home health. On February 26, 2013, at a panel sponsored by the Alliance for Home Health Quality and Innovation, home health representatives lamented the lack of payment models for home care services that they said can significantly cut down on costs and hospital readmissions. CMS is testing an alternative payment model called the Independence at Home demonstration. The health reform law lets CMS transition successful demonstrations to national programs, but it typically takes multiple years, including time to analyze the data, Peter Boling, chair of geriatric medicine at Virginia Commonwealth University, said. Although providers are grateful that CMS is running the demo, Boling said, the demonstration is not the only tool to increase shared-savings home health programs and stakeholders are considering pushing for legislation. For home care programs to reach their full potential, 'we must expand on the successful in-home medical care models and create responsible financing methods that control overall costs while rewarding providers appropriately,' Boling writes in a home care supplement to the Cleveland Clinic Medical Journal released at the panel. The medical community must figure out what works across transitions. Standardizing patient hand-offs is the most important policy to reducing readmissions, he said. [FN71]

Wage and overtime issues: BNA is reporting that state Medicaid directors and home health care advocates are at opposite sides of a proposed rule issued by the Department of Labor that would extend minimum wage and overtime protections to home health care workers. The National Association of Medicaid Directors (NAMD) has asked the Office of Management and Budget, which is reviewing the proposed rule, for a meeting to discuss the costs and burdens they think the rule would impose on state Medicaid programs, Matt Salo, NAMD's executive director, told BNA April 16. Medicaid directors are concerned that the proposed rule would adversely affect the close, personal relationships that are required between caregivers and Medicaid beneficiaries in need of home health services, Salo said. The DOL proposed rule, issued Dec. 27, 2011 (76 Fed. Reg. 81,190), would limit FLSA's domestic companion exemption, extending the minimum wage and overtime requirements to home health care workers. Labor rights advocates in favor of the proposed rule say the objections expressed by opponents are not supported by research or on-the-ground evidence in the 15 states (and the District of Columbia) that already have implemented overtime and minimum wage rights for home health care workers. Edelstein noted that the proposed rule generated more than 20,000 public comments during the comment period, which ended March 21, 2012, with more than three-quarters of the comments supporting the DOL proposal. [FN72]

The U.S. Supreme Court ruled on June 30, 2014, that home health care workers cannot be forced to pay union fees if they are not in a union. By a 5-to-4 vote, the court's conservative justices said an Illinois requirement that home health aides help cover a union's cost of collective bargaining violates their First Amendment right to free speech. The case had prompted widespread concern among public-sector unions because Illinois had deemed the aides, who are paid by the state, to be public employees. But the court said the aides are only quasi-public because their real employers are their patients. 'If we accepted Illinois' argu?ment" that the workers can be forced to pay the union fees against their will, Justice Samuel A. Alito Jr. wrote for the majority, 'we would approve an unprecedented violation of the bedrock principle that, except perhaps in the rarest of circumstances, no person in this country may be compelled to subsidize speech by a third party that he or she does not wish to support." [FN73]

In another case, the U.S. Supreme Court refused to review a decision holding that two group home caregivers were employees, rather than independent contractors, and therefore entitled to be paid for overtime. [FN74] ASUI sought review of a Fifth Circuit decision, which, after applying the 'economic reality" test, concluded that ASUI controlled all meaningful aspects of its employment relationship with Vera Chapman and Krystal Howard. In concluding the two caregivers weren't independent contractors, the Fifth Circuit found that ASUI and a vice president and program manager hired the caregivers, assigned them to group homes, set their work schedules and determined their rates of compensation. The Fifth Circuit also found that FLSA's companionship services exemption (29 U.S.C. Section 213(a)(15)) didn't apply in the case because Chapman and Howard weren't working in a 'private home" within the meaning of the FLSA.

Surety bonds are not required of home health agencies (HHAs), but the HHS Office of Inspector General says that CMS could have collected at least $39 million in Medicare overpayments from agencies between 2007 and 2011 if it had required them to obtain a

surety bond to participate in the program in a report issued on September 28. As of February, HHAs still owed CMS about $408 million in Medicare overpayments made to them between 2007 and 2011, the OIG said in *Surety Bonds Remain an Unused Tool to Protect Medicare from Home Health Overpayments* (OEI-03-12-00070). [FN75] If home health agencies had been required to take out $50,000 surety bonds to participate in the program, CMS could have recovered at least $39 million of that money, the report says, and recommended that CMS implement a surety bond regulation. In 1998, CMS had issued a final rule requiring surety bonds, but later suspended it following concerns of some Congressional members, according to the report. CMS concurred with the recommendation to issue a new regulation, and is drafting a proposed rule that, among other topics, addresses the issue of surety bonds for HHAs, the OIG said. As of July, the agency did not have an estimate as to when this proposed rule will be completed, the report added. In addition, the Affordable Care Act (ACA) states that the amount of the surety bond can be based on an HHA's billing volume. [FN76]

Federal Legislative Actions

In an effort to help improve the care offered by direct-care workers and lower care costs for both older Americans and the health care industry, a new bill would test models of care that use direct-care workers (DCWs) in advanced roles. The 'Improving Care for Vulnerable Older Citizens through Workforce Advancement Act of 2014" (2013 FD S.B. 2251 (NS) and 2013 FD H.B. 4445 (NS)) was introduced on April 10 by Rep. Matt Cartwright (D-PA) and Sen. Bob Casey (D-PA). The measure would establish six three-year demonstration projects, according to the press release:

• Two will use the abilities of DCWs to promote smooth transitions in care and help to prevent unnecessary hospital readmissions. DCWs will be incorporated as essential members of interdisciplinary care coordination teams.

• Two will focus on maintaining the health and improving the health status of older adults with multiple chronic conditions and long-term care needs by helping in monitoring health status, follow prescribed care, and educating the consumer and family caregiver(s).

• Two will train DCWs to take on deeper clinical responsibilities related to specific diseases, such as Alzheimer's, dementia, congestive heart failure, and diabetes.

Long-term care and rehabilitation facilities, home health agencies, managed care entities and hospitals would be among the organizations eligible to participate in the demonstration projects. The Paraprofessional Healthcare Institute (PHI) and the Caregiver Action Network have both endorsed the bill. Participants would receive funding to plan, carry out, and report on the outcomes of the projects. Outcome measures would include effects on direct-care worker job satisfaction and turnover, and patient/resident hospitalization rates.

Additional federal legislation related to caregivers includes:

• 2013 FD S.B. 851 (NS), introduced on April 25, 2013, the 'Caregivers Expansion and Improvement Act," would extend to all veterans with a serious service-connected injury eligibility to participate in the family caregiver services program.

• 2013 FD S.B. 1485 (NS), referred to Committee on August 1, 2013, would amend the Internal Revenue Code to provide an income tax credit for elder-care expenses.

VIII. TRANSITION OF CARE SERVICES

On September 14, a bipartisan group of lawmakers introduced legislation that would reimburse providers for coordination of care services. The legislation (2011 FD H.B. 6413 (NS)), called the Medicare Transitional Care Act of 2012, seeks to improve the transition of care for beneficiaries transferring into a skilled nursing facility or back into their own homes from the hospital. The bill would have Medicare provide a specific payment based on performance metrics and improved outcomes to providers performing coordination activities. The legislation was sponsored by Reps. Earl Blumenauer (D-OR), David Loebsack (D-IA), Thomas Petri (R-WI), Allyson Schwartz (D-PA), and Jan Schakowsky (D-IL). The legislation comes as hospitals prepare to face penalties beginning on October 1 for failing to prevent readmissions for conditions such as pneumonia and heart failure.

IX. COMMISSION ON LONG-TERM CARE RECOMMENDATIONS

With the elimination of the CLASS program, the American Taxpayer Relief Act of 2012 (2011 CONG US HR 8) established the Commission on Long-Term Care, which was charged with recommending to Congress, within 6 months, 'a plan for the establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system that ensures the availability of long-term services and supports (LTSS)." The Commission was established with 15 members: three members each were appointed by the President, the majority leader of the Senate, the minority leader of the Senate, the Speaker of the House of Representatives, and the minority leader of the House of Representatives. The Commission convened its first meeting on June 27, 2013, and subsequently held four pub?lic hearings, solicited extensive comments from the general public, and met in 9 executive sessions, according to the Commission's Final Report. [FN77] The Commission met on Sep?tember 12, 2013 and voted, by a vote of 9 to 6, in favor of putting this Final Report forward as the broad agreement of the Commission.

The Commission's recommendation focused more on the provision of LTSS, as opposed to institutional setting, and has garnered support for its emphasis on HCBS. Among the recommendations enumerated in its Final Report, the Commission proposes the following:

• Balanced array of LTSS: promote services for persons with functional limitations in the least restrictive setting appropriate to their needs—building a system, including Medicaid, with options for people who would prefer to live in the community.

• Uniform assessment: completion of a simpler and more usable standard assessment mechanism across care settings (acute, post-acute, and LTSS).

• Consumer access/assistance: expand the 'No Wrong Door" approach to provide en?hanced counseling options for individuals to navigate LTSS, provide sup?port to make this approach effective nationally; provide information and assistance to consumers and family caregivers in advance of transition from one setting to the next; and improve access to information technology to enable better access to information.

• Quality: improve focus on—with par?ticular attention to home and community-based services.

• Payment reform: advocate for new models of public payment that pay for post-acute and long-term services and supports on the basis of the service rather than the setting.

• Family caregiving: maintain and strengthen a person- and family-centered LTSS system with both the patient and the family caregiver as a focus for services and supports; include family caregivers and their needs in assessment and care planning processes; include family caregivers in patients' records and as a mem?ber of the care team; ensure family caregivers have access to relevant information; and encourage caregiver interventions, including respite op?tions, and integration with volunteer efforts.

• Paid workforce: revise scope of practice to broaden opportunities for profes? sional and direct care workers; enable national criminal background checks.

• Direct care workforce: provide opportunities for career advancement and im?proved compensation; integrate direct care workers into care teams; improve standards and establish a certi?fication process for home-care workers.

The Commission failed to offer a recommendation on how to address the issue of financing LTSS, and five of the Commissioners felt that the Commission failed to fulfill its mandate. On September 23, they offered their own set of recommendations in an 'alternative report." Like those put forth by the full Commission, several recommendations in the alternative report address issues related to home- and community-based services:

• Direct-care workers are paid a living wage, are well trained, and have opportunities for career advancement, to ensure high-quality services for individuals and their families in all service settings.

• Family caregivers are engaged, and their needs addressed; integrate family caregivers into a comprehensive LTSS system.

• Medicare program must be adapted to reduce counterproductive, outdated, and unreasonable barriers to outpatient therapies, home health, and skilled nursing facility care.

• Medicaid: existing financial incentives to states for quality HCBS must be extended and streamlined to make it easier to rebalance Medicaid LTSS; benefits must be improved for people who rely on Medicaid's services.

• tax-preferred savings accounts must be provided for people and their families who are not currently receiving LTSS through the Medicaid program, to provide new ways to access LTSS for persons with disabilities;

• Medicaid buy-in program for workers with modest earnings must be expanded, and a new program for workers with significant disabilities who have higher earnings must be piloted.

The authors of the alternative report were Democratic appointees to the Commission. Full text of the alternative report is available online, on the Center for Medicare Advocacy, Inc.'s website. [FN78]

X. HCBS EXPERIENCE SURVEYS AND STUDIES

Patients who receive home health care as the first care setting following hospital discharge tend to have lower overall Medicare episode payments, compared with patients who receive care from other facility-based settings, a study released on May 22 found. The study, 'Use of Home Health Care and Other Care Services Among Medicare Beneficiaries," was published in a working paper, [FN79] the third in a series of four that are part of the Clinically Appropriate and Cost-Effective Placement (CACEP) Project. The study was conducted by consulting group Dobson DaVanzo and Associates on behalf of the Alliance for Home Health Quality and Innovation.

The study examined the care pathways patients receive for three distinct episode types: post-acute, pre-acute, and non-post-acute. A pathway refers to the care processes an individual receives in the health care delivery system during an episode of care. When looking at post-acute care, those patients who used home health as a first setting had episodes that were less costly for Medicare, the study found. According to the study, 10 of the most common pathways consist solely of home health care and community (physician and outpatient) care—and rarely involve hospital admissions—suggesting that home and community-based services may be effectively helping patients to prevent avoidable facility-based care. 'This working paper provides a tangible example to lawmakers and healthcare

policy leaders as they begin to contemplate the basic architecture for a bundled payment system in the Medicare program," Allen Dobson, CACEP lead researcher and president of Dobson DaVanzo & Associates, said in a statement. [FN80]

When home health care is used as the first post-acute care setting after a hospital stay, it was found to be the most cost-effective care setting, new research suggests. In the study, conducted by Dobson DaVanzo and Associates, investigators examined Medicare claims data for 24,239,080 total post-acute episodes and a total of $472.8 billion in Medicare payments. Post-acute settings included skilled nursing facilities, inpatient rehab facilities, and long-term care hospitals. The investigators also looked at acute care hospital readmissions after a major joint replacement, finding that it was around double the percentage for patients who went to a skilled nursing facility or inpatient rehab instead of home health. While the findings are preliminary, the study concludes that: post-acute care episodes show high Medicare payments for post-acute care settings (in facility-based care settings or home health, as opposed to ambulatory care settings); the pre-acute episodes on the other hand, show very little Medicare episode payments for home health or facility-based care settings; and in the non-post-acute care community-based episodes, there is a significant reliance on home heath following discharge from the index home health episode, and a significantly lower proportion of payments for acute care hospitals or other facility-based settings. These preliminary findings suggest that prior to admission into formal care settings—facility-based care or home health—patients typically rely on their physicians to keep them clinically stable. However, once a patient is admitted to a facility, such as an acute care hospital, they are generally more likely to remain in facility-based care. This finding has significant implications for Medicare episode payments. [FN81]

Nationally the 2013 median hourly cost of homemaker services and home health aide services is $18 and $19 respectively, the Genworth 2013 Cost of Care Survey has found. Homemaker costs have risen just 1.4 percent since 2012 and 0.8 annually over the past five years, the report says. Home health aide services have risen 2.3 percent since 2012 and 1.0 percent annually over the past five years. The vast majority prefer care in their own homes. Genworth finds that 70% of Genworth's first-time long-term care claimants choose in-home care where the costs have remained more manageable.

By contrast, the cost of receiving long-term care in a setting such as an assisted living facility or nursing home continues to rise steadily while the cost to receive care at home through homemaker services or a home health aide is rising at a much more gradual pace, The median annual cost for a private nursing home room rose 3.6 percent from 2012 to 2013, to $83,950, or 4.5 percent annualized over the past five years. The comparable cost for care in an assisted living facility is $41,400, representing an increase of 4.6 percent since 2012 and a 4.3 percent annual increase over the past five years. National private nursing home costs over the past 10 years have gone up from $65,200 to $83,950, increasing at more than four percent a year.

Genworth's Cost of Care Survey covered nearly 15,000 long term care providers nationwide, including 437 regions that cover all Metropolitan Statistical Areas defined for the 2010 U.S. Census. The survey was conducted during January and February 2013. [FN82]

CMS is requesting comments on the proposed information collection 'The Home and Community-Based Service (HCBS) Experience Survey," in accordance with the Paperwork Reduction Act of 1995, according to a notice published on July 24 in the *Federal Register*. The survey is a one-time pilot field test involving individuals who receive HCBS from Medicaid programs. According to the notice, the field test will be conducted for the following purposes:

• To assess survey methodology—to determine how well a face-to-face survey and telephone survey performs with individuals who receive HCBS services;

• Psychometric Analysis—to provide information for the revision and shortening of the survey based on the assessment of the reliability and construct validity of survey items and composites; and

Case mix adjustment analysis—to assess the variables that may be considered as case mix adjusters.

These preliminary research activities are not required by regulation, and will not be used by CMS to regulate or sanction its customers. They will be entirely voluntary and the confidentiality of respondents and their responses will be preserved. The information collected will be used to revise and test the survey instrument described in the Background section of the PRA package's Supporting Statement. The end result will be an improvement in information collection instruments and in the quality of data collected, a reduction or minimization of respondent burden, increased agency efficiency, and improved responsiveness to the public. Interested persons should send comments to the Office of Management and Budget by August 23.

XI. NATURALLY OCCURRING AND CONTINUING CARE RETIREMENT COMMUNITIES

HHS defines a naturally occurring retirement community (NORC) as 'a community with a large proportion of older people residing within a defined geographic area" that differs from assisted living or continuing care retirement communities because it was not specifically designed for older people. [FN83] Continuing care retirement communities, on the other hand, are communities that contain various living options on one campus, including housing for those who live very independently, assisted living facilities that offer more support and nursing homes for those needing skilled care. [FN84]

The issue of financial stability of CCRCs is examined in a recent report by the Government Accountability Office. The GAO was asked to describe the risks CCRCs and their residents face and how state laws address the risks. The GAO found that CCRCs offer a range of contract types and fees that are designed to provide long-term care and transfer different degrees of the risk of future cost increases

from the residents to the CCRC. Once operational, risks to long-term viability include declining occupancy and unexpected cost increases. Seven of the eight states examined by the GAO had CCRC-specific regulations, with varying measures addressing risks of CCRC viability. Financial difficulties faced by CCRCs can lead to unexpected increases in residents' monthly fees. Although rare, bankruptcies or closures could force residents to lose all or part of their entrance fees. Most states reviewed by the GAO take steps to protect the interests of the residents, such as requiring escrow of entrance fees and mandated disclosures. [FN85]

Continuing-care retirement communities in **New Jersey** are offering new services and incentives to entice senior citizens as they sell their homes and look for new ones. These services include personal moving consultants, lists of preferred real estate agents and cash loans, all offered to seniors, who make up about 20 percent of the sellers market. The continuing-care retirement communities are part independent living, part assisted living and part skilled nursing homes, providing care that progresses as the needs of an individual resident increase. In New Jersey there are 27 such communities, according to a state report. There are no statistics tracking the market for these continuing-care communities, but as more homes sell across the state, sales directors report increased interest.

Some of this trend has as much to do with real estate sales as it does with demographics. From 2000 to 2010, New Jersey's population grew by 4.5 percent, according to the U.S. Census. But the 55-and-older population grew by nearly 20 percent. The demographic realities and some improvement in the real estate market have breathed new life into the continuing-care industry, which is still trying to rebound from the worst of the recession. [FN86]

XII. VETERANS

A new effort launched by the Department of Veteran Affairs (VA), Administration on Aging, and National Resource Center for Participant-Directed Services (NRCPDS) uses participant-directed services to keep veterans in their communities and out of nursing homes. The NRCPDS, the only national center of its kind, helps people of all ages and disabilities get the support they need to live as independently as possible and offers a range of training and technical assistance to staff at VA Medical Centers for Veterans enrolled in the Veteran Directed Home and Community-Based Services Program (VD-HCBS). Known as ‘participant direction,” the new program will allow veterans to manage their own flexible spending budgets for their personal care services—deciding for themselves which goods and services best meet their needs, hiring and supervising their own workers, including family and friends, and purchasing items or services that will help them live more independently. [FN87]

The VA also has additional programs to help veterans stay in their homes:

• *The Housebound Aid and Attendance Allowance Program* provides cash to eligible veterans with disabilities and their surviving spouses to purchase home- and community-based long-term care services such as personal care assistance and homemaker services. The cash is a supplement to the eligible veteran's pension benefits

• *Veteran Directed Home and Community Based Services program*—developed in 2008 for eligible veterans of any age, provides veterans with a flexible budget to purchase services. Counseling and other supports for veterans are provided by the Aging Network in partnership with the Veterans Administration

• *Program of Comprehensive Assistance for Family Caregivers*—In May 2010, Congress required VA to establish a program to support family caregivers of seriously injured post-9/11 veterans, and in May 2011, the Veterans Health Administration (VHA) implemented its Family Caregiver Program at all VAMCs across the country, offering caregivers an array of services, including a monthly stipend, training, counseling, referral services, and expanded access to mental health and respite care. In fiscal year 2014, VHA obligated over $263 million for the program. On September 18, 2014, GAO released a report that examines how VHA is implementing the program, including the types of issues that have been identified during initial implementation. GAO found that the VHA significantly underestimated the demand for services, and recommended that the VA and VHA: (1) expedite the process for implementing a new IT system that will enable officials to obtain workload data; (2) identify solutions to alleviate VAMCs' workload burden in advance of obtaining a new IT system, and (3) use data from the new IT system, once implemented, and other relevant data, to re-assess the program and implement changes as needed. VA has agreed with GAO's recommendations. [FN88]

The VA has delayed the effective date to April 1, 2014 of a final rule to change the billing methodology for non-VA providers of home health services and hospice care. The rulemaking makes the VA regulation governing payments for certain non-VA health care applicable to non-VA home health services and hospice care. It provides, among other things, that the CMS fee schedule or prospective payment system amounts will be paid to certain non-VA providers, unless VA negotiates other payment amounts with such providers. [FN89]

XIII. CONCLUSION

The need for long-term care in the United States will only increase as large numbers of baby boomers age. Lawmakers at the federal level, recognizing the importance of this issue, have responded by including HCBS provisions in the national health care reform legislation. At the state level, legislators over the last two years have introduced and adopted numerous bills intended to expand and regulate HCBS. Long-term care experts note that HCBS are a much less expensive form of care for the elderly and disabled than

nursing facilities. At a time when most states are facing budget shortfalls, the transition from institutionalized long-term care to HCBS could prove to be a particularly cost-effective and attractive option.

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