The Evidence
Evidence points to improved outcomes and cost savings when individuals with complex functional and medical needs have access to home and community-based services (HCBS). Compared with institutional care, HCBS results in lower per-person costs, slower cost growth, and fewer adverse events.\textsuperscript{4, 5} HCBS also can enhance an individual’s independence and ability to remain and age safely at home.

The Opportunity
Federal policymakers are investing in an expansion of Medicaid-based HCBS, providing unprecedented funding to states to improve services and access and to build a stronger workforce. Given the time-limited nature of some of this funding, states and health plans should consider their options for new or revised HCBS programs.

• The American Rescue Plan Act of 2021 provides a temporary 10-percentage point increased federal medical assistance percentage (FMAP), through March 2022, to states for HCBS expenditures, and requires that states use this funding to supplant, not supplement, existing spending. This creates an opportunity for states to test short-term pilots, temporary benefit expansions, and service professional models that improve access to HCBS and emphasize Medicaid-recipient independence in the home.

• The American Jobs Plan proposes to expand HCBS and create a stronger infrastructure for caregiving and home health workers by infusing $400 billion in Medicaid HCBS over eight years.

STATE AND HEALTH PLAN TIP SHEET
The Issue
• On average, 33% of state Medicaid costs are attributable to long-term services and supports (LTSS)\textsuperscript{1}

• The population needing LTSS is growing, with estimates suggesting as many as 70% of 65-year-olds will need LTSS during their lifetime\textsuperscript{2}

• A large portion of the Medicaid LTSS spend goes to providing care in institutions, particularly for older adults and those with physical disabilities (54% in 2016)\textsuperscript{3}

• Access to HCBS is limited by waitlists, service caps, eligibility restrictions, and lack of understanding “what works” for different individuals

A full compendium of the research is available HERE.
Using this Tip Sheet

This Tip Sheet builds on research to help inform state and health plan investment in expanding access to services and supports that help individuals live and age at home and in the community. Examples include near-term (<1 year) and longer-term (1+ year) opportunities.

---

**Background**

Approximately 5 million individuals enrolled in Medicaid use LTSS, with a large portion of the services provided in institutional settings. HCBS offer an opportunity to these individuals to remain at home, and research suggests these services can save state Medicaid programs money. However, many individuals continue to find themselves on HCBS waitlists, or experiencing gaps in access or eligibility.

---

This Tip Sheet was produced following a literature review of available evidence on HCBS efficacy and is intended to help states and health plans identify near-term and longer-term opportunities to invest in approaches that are successful, and that can expand access to HCBS.

---

**Existing Research Limitations**

Existing research on HCBS tends to be service-focused and typically is not reflective of individuals’ unique circumstances or cultural preferences. This can lead to program design that creates inequitable access to services based on race, gender, age, and urbanicity.

Research typically explores individual services rather than the broader “benefit package.” This leads to a lack of understanding how different services might interact to produce better (or worse) outcomes.

---

**Near-term Opportunities**

Through the American Rescue Plan Act (ARPA) of 2021, CMS is providing states with a temporary 10-point FMAP increase for Medicaid HCBS. This increase is available from April 1, 2021 until March 31, 2022 and must supplement (not supplant) a state’s current level of spend as of April 1, 2021.

- States can use the temporary FMAP increase in various ways that strengthen Medicaid HCBS, such as services/eligibility expansion and workforce development.
- States should use part of the enhanced FMAP to provide seed investment for novel approaches to existing services.

**Initial steps will vary by state but may include:**

- Engage actuaries to determine rate impacts
- Clarify whether waiver changes are needed via CMS
- Confirm whether state legislation is required
- Determine health plan contract changes
- Identify opportunity for aging services infrastructure (e.g., AAA) to execute program changes

---

**Longer-term Opportunities**

The American Jobs Plan would provide $400b in funding over eight years to expand access to Medicaid HCBS and improve workforce infrastructure. States and health plans should consider how this capital will/could impact their approaches to HCBS.

- States can build on experiences gained through the temporary ARPA funding to inform longer-term and more permanent program design.
- Rather than being services-focused, program design and care plans should reflect an individual’s cultural, racial, familial, community, and social realities.
- States and health plans should develop value-based models that promote appropriate balance between HCBS and institutional settings, as well as between Medicare and Medicaid for the subset of LTSS-users who are dually eligible for both programs.
Near-term Approaches and Opportunities

States and Medicaid health plans should use temporary FMAP funding and in lieu of services to seed investment in new programs, and potentially inform longer-term opportunities to expand access to services and eligibility, improve Medicaid recipient independence, and cut program costs. This Tip Sheet includes four near-term examples that states and health plans should consider.

1 | CAPABLE/ Handyperson Services

The Community Aging in Place, Advancing Better Living for Elders (CAPABLE) program couples handyperson services with an occupational therapist (OT) and nurse, and at a small cost has been found to result in significant Medicaid savings, reduced falls, and improved functional performance. This program focuses on minor modifications to the home making it safer for an individual to live independently.

**States with handyperson and OT coverage should consider coupling these services in a CAPABLE approach, targeted in a culturally competent manner.**

**SPOTLIGHT**

After a successful pilot of the CAPABLE program in select HCBS waiver sites, Michigan Medicaid is expanding the program statewide through its MiChoice Waiver.6,7

Studies have found CAPABLE to decrease the number of activities of daily living (ADLs) with which an individual has difficulty by up to 50%. $3,000 in program costs can result in more than $20,000 in medical costs savings as a result of reduced inpatient and outpatient expenditures.8,9

2 | Caregiver Supports and Structured Family Caregiving

Consultation services for caregivers can delay patient placement in a nursing home, decrease emergency department use, and decrease caregiver and patient depression and strain. Models are emerging to provide technology, telephonic, and mail-based coaching to caregivers.

**States and health plans should consider programs that provide caregiver coaches and targeted education, to empower caregivers and extend the reach of the workforce.**

**SPOTLIGHT**

BRI Care Consultation and the related Partners in Dementia Care intervention have produced positive outcomes for caregivers and patients and at low cost. They have been implemented in at least 8 states by providers, managed care organizations, and other stakeholders.10

Results show up to a 65% decrease in perceived unmet needs of patients with functional impairment, and up to a 30% decrease in depressive symptoms in patients with cognitive impairment. Caregiver/care recipient relationship strain decreased by up to 15%.
Near-term Approaches and Opportunities (contd.)

3 | Companion, Socialization, and Chore

Social isolation significantly increases the risk of dementia, heart disease, stroke, depression, and other poor health outcomes, and a quarter of adults aged 65+ are considered socially isolated. Programs have emerged to address social isolation, alongside other services such as chore, personal care, and respite. States and health plans should leverage emerging platforms and programs to reduce social isolation among Medicaid recipients.

**SPOTLIGHT**

Hawaii Medicaid offers Senior Companion and Respite Companion programs that pair low-income seniors (paid a stipend) with frail elders and their caregivers to provide companionship, limited personal care, and respite. Companionship programs positively affect the care recipients and caregivers through services received, as well as the senior companions themselves. One study found that companion participants experienced reduced social isolation, improved quality of life, increased understanding of aging, and greater purpose.

4 | Transportation and Mobility Managers

Lack of transportation is a key contributor to social isolation, missed appointments, and the ability to age safely at home. Mobility managers are an emerging approach to coordinating transportation by using a “one-stop shop” resource center that considers the unique challenges of an individual. States and health plans should work with and invest in mobility management programs to improve individual-level access to medical and non-medical services.

**SPOTLIGHT**

The Wisconsin Association of Mobility Managers (WAMM) is a mobility manager network that has invested heavily in training managers across Centers for Independent Living, Aging and Disabilities Resource Centers, and other entities. More than 45 WAMM mobility managers operate out of Wisconsin community organizations such as Aging and Disability Resource Centers, Centers for Independent Living, and transit agencies. WAMM programs include volunteer driver programs, voucher programs, car repair loans, and ADA paratransit.
Longer-term Investment in Person-Centered Approaches

States and Medicaid health plans should build on lessons learned from research and short-term pilot programs to expand HCBS in an effective, person-centered manner. Longer-term investments in HCBS should leverage data and insights on specific populations and their needs in order to target interventions most effectively.

Current Approaches to Covering HCBS

Currently LTSS eligibility and program design tend to be centered around functional and cognitive assessments, and may not appropriately reflect unique circumstances and cultural preferences of an individual. This can contribute to lack of access among certain individuals.

Moving HCBS Forward

Person-centered care planning, program design, and research should be comprehensive in nature, considering the interaction of services with one another (e.g., the success of programs like CAPABLE) as well as the interaction with the individual’s circumstances. Individuals conducting assessments and developing person-centered care plans should be trained in the various cultural, gender-specific, age-specific, and familial circumstances that impact an individual’s decision-making and utilization behaviors.

Example: Understanding the Caregiver

Adult day services that provide community-based support for persons with dementia may also have the effect of decreasing the likelihood of caregivers missing physician appointments. These effects were found to be smaller, however, in young caregivers and Black caregivers. A person-centered approach would explore the unique needs of caregivers based on age, race, and other circumstances to identify the most effective caregiver supports and maximize care recipient outcomes.

Example: Understanding the Care Recipient

Research shows Asian Americans significantly underutilize HCBS. One study of HCBS needs in Korean Americans found a significant proportion of caregivers and recipients were not using services due to knowledge, values, and personal barriers. Respondents commonly reported that they were not aware of services available to them, felt embarrassed or did not want to ask for help, or refused services. A person-centered approach would include targeted and culturally-appropriate education, including identifying the services with which the individual would feel most comfortable and most willing to accept.
Other Considerations

States and health plans should also consider the role for payment policy to address misaligned incentives, which can contribute to individuals receiving care in settings that may not be the best suited to that person’s unique circumstances. Value-based and shared-savings models have the potential to align these incentives and maximize the likelihood of an individual receiving the right care, at the right place, at the right time.

Value-Based Arrangements

States and health plans should consider value-based models that promote appropriate balance between institutional and community-based LTSS settings. Value-based models should include community and institutional providers, long-term care pharmacies, and other providers, with the goal to modernize the services and delivery models in both community and facility-based settings. Incentives and models could be tied to delaying nursing facility placement and improving transitions back to the community, building on Money Follows the Person. In addition to reinvesting in expanded HCBS, states could use savings from value-based arrangements to modernize community and facility infrastructure and/or provide technical assistance to facility-based providers to help right-size and diversify these settings of care (e.g., helping a local nursing home understand the steps to becoming a Greenhouse program, or repurpose units to meet the needs of low-income seniors).

Medicare-Medicaid Alignment

Various opportunities exist for states and health plans to improve alignment between Medicare and Medicaid for dual eligibles, which enhances care coordination and integration that helps to delay nursing facility placement and improve transitions into community-based settings. States should work with CMS and their Medicaid and Medicare plans to design and implement strong programs, for example:

- Leverage CMS Financial Alignment Initiative (FAI) Authority to test shared Medicare savings between CMS and the state as part of a Dual-eligible Special Needs Plan (DSNP);
- Engage with Institutional Special Needs Plans (ISNPs) (and CMS as needed through FAI) to determine potential for engagement between Medicaid plans and ISNPs to promote integration, community balance, and shared savings; and,
- Work with CMS to determine opportunity to modernize PACE, including implementing virtual PACE models and sharing in Medicare savings.
References


8. Szanton et al. (June 2014). Improving unsafe environments to support aging independence with limited resources, Nurs Clin North Am, 49(2), 133–145.


To view the companion Excel tool with additional detail and data on research findings, visit www.atiadvvisory.com