Medicaid's Critical Role in Funding HCBS

Alliance for Health Policy
Recent Trends and Policy Making Impacting Medicare and Medicaid's Home and Community Services

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HCBS are a vital part of the LTSS continuum

Medicaid is the primary payer of HCBS

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Covering HCBS aligns many interests

Consumers want to remain at home, to have meaningful choices, and to live with dignity.

AARP's 2021 Home and Community Preferences survey found that over three-quarters (77%) of adults age 50+ want to remain in their homes as they age. This is a shared value across the lifespan, reflecting the preference of 63% of all adults.

To the extent they will remain available, family caregivers will want more help.

Caregiving obligations affect self-report of overall well-being, including physical and mental health, sleep, and chronic conditions. "Informal" caregivers will likely be less available in successive generations.

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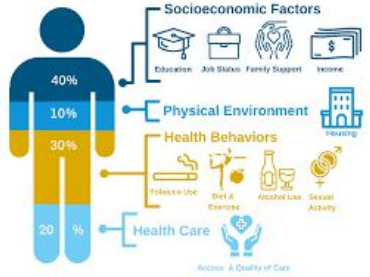

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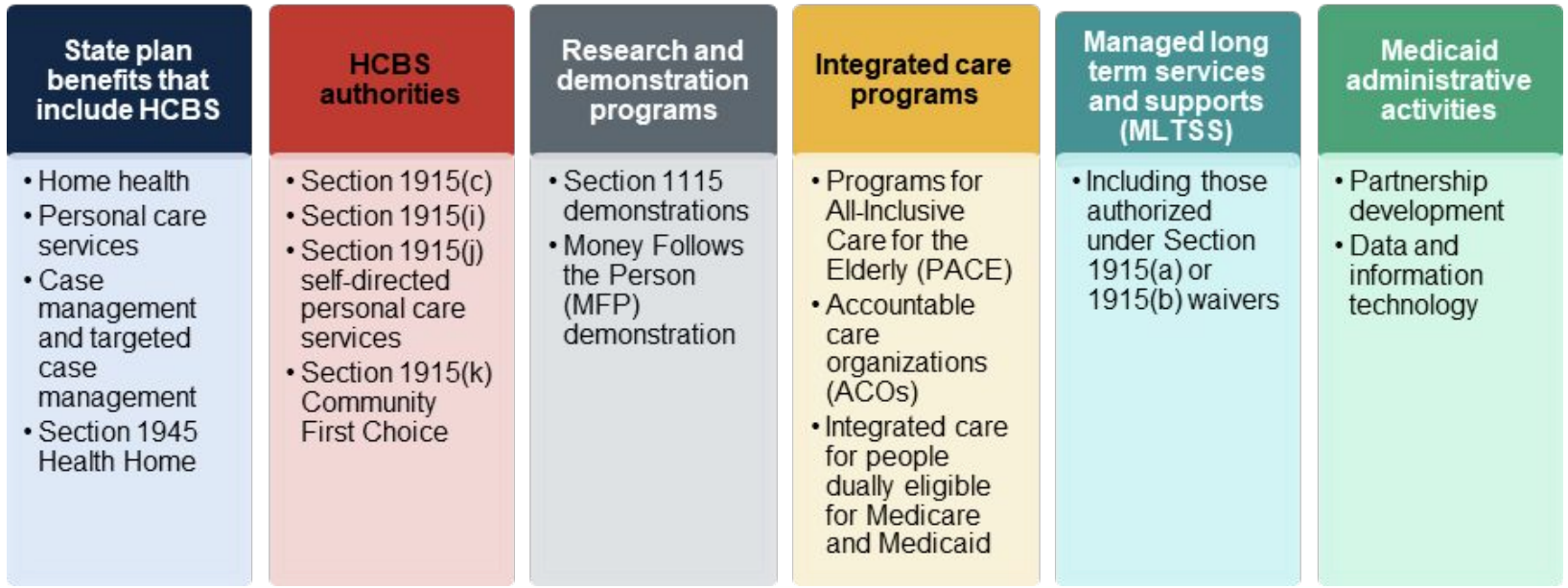
Medicaid Authorities

While Medicaid remains structurally biased in favor of nursing home care (a mandatory Medicaid benefit), states are using a range of State Plan and other authorities to cover many types of HCBS and almost 60% of Medicaid LTSS spending is non-institutional.



CMS Long-Term Services and Supports Rebalancing Toolkit

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Leading Challenges

- **Constructive tension over who bears the costs.** Policymakers continue to grapple with the extent to which HCBS should be publicly versus privately funded.

- **Workforce constraints.** The predominantly female, substantially BIPOC workforce that provides LTSS faces serious challenges around adequacy of wages and benefits, lack of defined career pathways, and the many stressors of living at low income. The current shortage of people to provide direct LTSS will only be exacerbated by increasing numbers of older adults in the population and reduction in the incidence of working age people. Turnover rates (variously estimated to be least 40 to 60%) are also a major challenge, compromising relationship building and continuity of care.

- **Capacity and consistency across states.** While all Medicaid programs have opted to cover HCBS, the breadth of coverage and level of appropriations associated with each vary significantly across the country.

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Key HCBS Features in the Access Rule

Responding to some of these challenges, the Centers for Medicare and Medicaid Services has released major proposed rule-making, Ensuring Access to Medicaid Services [CMS-2442-P], which focuses on:

- **Improving the quality of Medicaid-funded HCBS** through adoption and reporting on a standardized set of performance measures, enhancement of person-centered planning and incident management systems, and establishment of service delivery timeliness for key services (personal care, home health aide, homemaker)

- **Enhancing transparency, public literacy and engagement** through publication of performance on quality measures, rates for key services, service timeliness and waitlists; as well as requiring states to include stakeholders in the rate-setting process

- **Addressing workforce constraints** by requiring that at least 80% of Medicaid payments for key services be spent on compensation for the direct care workforce (as opposed to administrative overhead or profit)

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