MEMORANDUM

To: Interested Parties

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Date: December 15, 2021

Subject: Policy Agenda Brief on Opportunities for Expanding Home-Based Care within the Center for Medicaid and CHIP Services and State-Based Programs

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Executive Summary

This policy agenda brief is the second of two briefs providing directional guidance on ways to increase access to home-based care for people with complex health and social needs. The policy recommendations included in the first policy agenda brief addressed home-based care supported through the Center for Medicare (CM) and the Center for Medicare and Medicaid Innovation (CMMI), while this brief focuses on practical, timely policy opportunities for the Center for Medicaid and CHIP Services (CMCS) and states to leverage their Medicaid and other state-based programs.

This brief aims to inform policy activities that may be leveraged in the short term to address the unmet need for home-based care, especially given CMCS' recently announced strategic refresh. Recommendations included in this brief explore policy mechanisms available for states and Medicaid programs to expand home-based care through value-based arrangements. The following recommendations were informed by a literature scan of existing home-based care programs; Medicaid waivers (home- and community-based services and others); and feedback from a diverse group of experts, policymakers, and practitioners. These recommendations include:

1. Leverage American Rescue Plan Act (ARPA) Funding to Invest in Home-Based Care Infrastructure
2. Expand Home-Based Care Value-Based Payments through Section 1115 Demonstration Waivers
3. Provide Additional Services and Payment Models for Home-Based Care through Section 1915(c) Home and Community-Based Services (HCBS) Waivers
4. Use State Plan Amendments to Expand Home-Based Care
5. Leverage Medicaid Managed Care Contracts to Implement Home-Based Care Payment Reforms
6. Provide Additional Home and Community Based Service Options to Support Home-Based Care for People Traditionally Needing Institutional-Level Care
7. Strengthen the Home-Based Care Workforce to Expand Home-Based Care
8. Improve Data Infrastructure to Enhance Home-Based Care

Introduction

This brief focuses on opportunities at the state level to advance home-based care. In recent years, interest in providing care in the home setting has gained resonance due in part to patient preference for home-based care, technological advancements that increasingly enable providers to offer services in the home setting, and changing payment models that better support home-based care services. The COVID-19 pandemic further accelerated momentum for home-based care, with providers and policymakers quickly responding to support the delivery of care outside the clinical setting. These factors have contributed to a unique policy window for expanding and scaling home-based care at the state and federal level.

In particular, this brief focuses on state-specific policy activities that can leverage this momentum for home-based care. Through Medicaid and other policy vehicles, states have significant ability to expand access to home-based care. Increased federal funding for home- and community-based services (HCBS), in conjunction with potential additional funding for home-based care services through Medicaid, creates further opportunities for states to invest in and scale home-based care.

This policy agenda brief also considers how new payment models can help advance home-based care. As noted in the first brief, the predominant fee-for-service (FFS) payment model is unsustainable for many home-based care providers, who are often small, independent, and resource-limited, given that FFS often undercompensates provider travel time and does not reimburse for many home-based care services. Value-based payment (VBP) models may help overcome these challenges by affording providers broader flexibilities in rendering services and investing in the capabilities necessary to scale and expand service lines. Transitioning to VBP also aligns with part of CMCS' recent strategic refresh, which aims to move a majority of Medicaid beneficiaries into an accountable care relationship by 2030. Given the number of beneficiaries served through Medicaid, achieving CMCS' goal of transitioning Medicaid beneficiaries to accountable care relationships would significantly advance the move to paying for value.

The following recommendations serve to address the unmet need for home-based care for people with complex health and social needs, which helps advance CMCS' goals. Specifically, this policy agenda brief outlines practical, short-term opportunities to expand home-based care value-based payments through Medicaid and other state-based initiatives.

1. Leverage American Rescue Plan Act (ARPA) Funding to Invest in Home-Based Care Infrastructure

Section 9817 of the ARPA provides state Medicaid programs with a 10 percent federal medical assistance percentage (FMAP) increase to be used for HCBS, which presents states with a unique opportunity for larger home-based care infrastructure investments (e.g., data analytic capabilities, increased direct care workforce wages, ability to provide round-the-clock care) that states do not normally pay for through Section 1115 and 1915 waivers. The Centers for Medicare and Medicaid Services (CMS) issued a *Dear State Medicaid Directors* letter to

encourage states to leverage ARPA funding (and provide guidance on how to effectively do so) to make long-term investments to state HCBS infrastructure, expand eligibility, and address social determinants of health to name a few. Table 1 illustrates the various ways states plan to leverage ARPA funding.

Table 1. Examples of State Spending Plans for ARPA Funds

State	Description
Indiana	Supports a Community Aging in Place - Advancing Better Living for Elders (CAPABLE) pilot program in the state.
North Carolina	Funds the state's Special Assistance In-Home program (which supports Medicaid beneficiaries at risk of institutionalization) to provide technology that will support telehealth and socialization with the goal of helping people remain at home.
New Hampshire	Establishes a payment pool for which funds will be used to support direct care workers for targeted home-based care providers.

Recommendations:

- States should use ARPA funds to build home-based care infrastructure, including workforce development (e.g., skills-based training) and access to data (e.g., admission-discharge-transfer feeds through health information exchanges for home-based care providers). While states may be hesitant to use ARPA for increased services or eligibility because they will assume financial responsibility after temporary federal funding is gone, a one-time investment can be useful for infrastructure development.
    - *Workforce development and data infrastructure are discussed in more detail below.*
- States should use ARPA funds to invest in the organizational capacity of home-based care providers (e.g., ability to accurately measure provider performance) to help drive uptake of value-based arrangements.

2. Expand Home-Based Care Value-Based Payments through Section 1115 Demonstration Waivers

States have substantial flexibility (and sometimes significant federal dollars) to test innovative delivery reforms through their Medicaid programs using waivers authorized by Section 1115 of the Social Security Act. For example, states have used 1115 waivers to expand eligibility to their Medicaid programs or expanded benefits for their Medicaid beneficiaries. While no state has implemented a Section 1115 waiver solely focused on home-based care reforms, states have incorporated home-based care initiatives in their waivers (see Table 2). Given the substantial flexibility of Section 1115 waivers, they not only serve as a policy lever to expand home-based care for people with complex health and social needs but also as a mechanism to drive uptake of VBP arrangements within Medicaid programs. However, there are limitations on 1115 waivers, notably that the waivers must be budget neutral.

During project interviews, stakeholders noted that many states are unaware or uncertain of the specific home-based care activities possible through 1115 waivers. To give states further clarity, CMS should provide additional guidance around what activities are permissible through 1115 waivers and disseminate innovative home-based care VBP approaches to date. Guidance is further needed on how the Medicaid program specifically supports home-based care services for people dually eligible for Medicaid and Medicare.

Table 2. Examples of Home-Based Care Components of State 1115 Waivers

State	Description
Minnesota	Expands HCBS eligibility to older adults requiring nursing facility level of care whose incomes exceed the state requirement to qualify for Medicaid.
Massachusetts	Uses 1115 waiver, specifically via a Delivery System Reform Incentive Payment (DSRIP) demonstration program, to invest in provider partnerships and establish ACOs to serve sub-populations of their Medicaid population.
California	Includes a new provision through their Community-Based Adult Services (CBAS) initiative, which allows for "remote" care for people during emergencies, including national or state disasters as well as personal emergencies (e.g., care transitions between settings), with the goal of preventing/delaying institutionalization.

Recommendations:

- CMCS should provide technical and operational guidance to states on the ability to leverage home-based care and telehealth in their 1115 programs, such as through a *Dear Medicaid Directors letter* or through a model 1115 waiver. This may include the structure of VBP models that can be used, either implemented directly by the state or through contracting with managed care plans, that allow greater flexibility for home-based care.
- States should consider pursuing 1115 waiver applications that focus on testing VBP models that can increase access to home-based care services.
- In order to facilitate collaboration, CMCS should create bi-directional learning channels to better identify state challenges and lessons learned.

3. Provide Additional Services and Payment Models for Home-Based Care through Section 1915(c) Home and Community-Based Services (HCBS) Waivers

Another mechanism for states to expand home-based care is through HCBS authorities as outlined in Section 1915(c) of the Social Security Act. Medicaid is the largest payer for long-term services and supports (LTSS), which includes HCBS. In recent years, the proportion of Medicaid spending on HCBS has exceeded spending on LTSS in institutional settings, with the majority of HCBS funding provided through 1915(c) waivers. HCBS serve as an opportunity to drive Medicaid towards more value-based arrangements given the influx of federal dollars from

the American Rescue Plan Act (and additional funds expected from the Build Back Better Act) that can be used for HCBS infrastructure investments and CMCS' strategic vision to drive Medicaid beneficiaries into accountable care relationships.

Medicaid programs have substantial histories in providing home-based care through HCBS, which have been crucial for helping people with complex health and social needs as well as people with functional limitations. Although HCBS is just one aspect of home-based care, HCBS play a vital role in meeting beneficiaries where they are to provide high-value, whole-person care. HCBS are often fundamental to a variety of home-based care models, like home-based primary care, as HCBS support many of the functional needs that allow people to remain in the home.

The services covered by 1915(c) waivers vary widely across states and encompass a diversity of benefits (e.g., home modifications, meal delivery, transportation). It is important to note that states are not required to offer HCBS and have broad discretion to use 1915 authorities. Given this, there is not a core set of HCBS available to populations with complex health and social needs requiring home-based care.

Although states are not restricted by the HCBS they can provide, 1915(c) waivers must be cost effective compared to institutional-level care. The cost neutrality requirement for 1915(c) waivers can present operational challenges in designing a payment model for home-based care (in that the model must prove the cost will be lower than institutional care). However, the 1915(c) waiver still provides an opportunity to address the unmet need of people with complex health and social needs by expanding HCBS needed for overall home-based care.

The expansive flexibility allowed through Section 1915(c) waivers serves as a vehicle for expanding home-based care to people with complex health and social needs. However, states may be hesitant to take advantage of the flexibilities because of uncertainty regarding permissible benefits and/or the administrative complexity required to utilize waivers. Given this, states may require technical guidance on drafting and implementing 1915 authorities.

Table 3. Examples of State 1915(c) Waivers to Enhance Home-Based Care

State	Description
Kansas – Home and Community Based Services for the Frail Elderly Waiver	Covers home-based care services that enhance a person's ability to age in place, including telehealth services, medication reminder services (and installation), and wellness monitoring.
Minnesota – Community Alternative Care Waiver	Includes services that enhance a person's ability to remain in their home, such as housing access coordination and independent living skills training.

Recommendation:

- CMCS could provide further guidance on the core set of services that should be available for special populations (e.g., homebound population) and provide additional technical

guidance for waiver implementation. To do this, CMS could build off existing resources including guidelines for permitted services, templates for emergency 1915 waivers, and preprint application forms for Section 1915(c) waiver.
- CMCS should establish learning communities on best practices for leveraging 1915(c) waivers in supporting broad types of home-based care models.
- CMCS should release guidance on how states can prepare to use proposed HCBS increases expected in the Build Back Better Act.

4. Use State Plan Amendments to Expand Home-Based Care

Sections 1915(i) and 1915(k) of the Social Security Act allow states to use a State Plan Amendment (SPA) to provide HCBS benefits without requiring a federal waiver. Section 1915(i) SPAs allow states to target services to older adults and people with disabilities who have specific needs and risk factors. Given this, states could use SPAs to target services to Medicaid beneficiaries with complex health and social needs who require home-based care. Section 1915(k), known as Community First Choice, allows states to provide home- and community-based attendant services and supports through their state plans. States using the Community First Choice benefit receive a six percent FMAP increase for HCBS funding. The increase in funding is for individuals requiring an institutional level of care, which includes needing assistance with Activities of Daily Living (ADLs). The Community First Choice benefit prioritizes person-centered care, a component of the HCBS Setting Rule, by encouraging consumer-driven decision making. Table 4 provides examples of state actions to amend HCBS through SPAs.

Table 4. Examples of State Plan Amendments altering Payment for Home Care

State	Description
Kansas	Uses Disaster Relief SPA to allow for the dissemination of at-home COVID-19 vaccinations for Medicaid beneficiaries "who have difficulty leaving their homes" through the duration of the public health emergency.
Iowa	Increases home health reimbursements using Medicare low utilization payment adjustment (LUPA) methodology.
New Hampshire	Targets home-based services for a specific population by allowing for a 3.1% increase to home- and community-based care for "high-risk children with Severe Emotional Disturbance rates."

Recommendation:
- CMCS should establish learning communities on best practices for leveraging SPAs to support broad types of home-based care models.

5. Leverage Medicaid Managed Care Contracts to Implement Home-Based Care Payment Reforms

States have significant flexibility in what they can require through Medicaid managed care contracts, especially in regard to VBP. At present, managed care is the predominant delivery system for Medicaid programs, covering 70 percent of Medicaid beneficiaries. Managed care involves state Medicaid agencies contracting with managed care organizations (MCOs) to cover their state's Medicaid population through per member per month (PMPM) capitated payments. This financing structure provides financial flexibility that would benefit home-based care providers and help expand home-based care for Medicaid beneficiaries. Further, states have the authority to require contracting MCOs to participate in VBP arrangements with targeted providers. Table 5 outlines examples of states using managed care contracting to drive Medicaid programs to more value-based arrangements.

Additionally, states can structure their Medicaid managed care contracts to include in-lieu-of services and value-added services. In-lieu-of services serve as cost-effective alternatives states may offer in place of services covered in a Medicaid State Plan. For example, California uses in-lieu-of services as a way to address social determinants of health (SDOH), improve health equity, and allow beneficiaries to get community-based care. Valued-added services refers to extra services offered outside of the covered contracted services (which are also not included in the plan's capitation rate).

For states with integrated care models using MCOs and dual-eligible special needs plans (D-SNPs) to serve people who are enrolled in both Medicare and Medicaid, there is opportunity for states to drive home-based care transformation through the benefits covered through their State Medicaid Agency Contracts and Medicare Improvements for Patients and Providers Act (MIPPA) contracts. This is notable considering 70 percent of Medicaid beneficiaries using LTSS are dual-eligible beneficiaries.

Table 5. Examples of States Leveraging Medicaid Managed Care Contracts to Drive Value-Based Purchasing

State	Description
Tennessee	Established a Quality Improvement in Long Term Services and Supports (QuILTSS) initiative to provide outcome-based rewards for high-quality LTSS.
New York	Uses the Health Care Payment Learning and Action Network framework creating a roadmap to drive the move to value. Plans use MLTSS contracts to engage providers in level 1 VBP arrangements by a specified time.
Texas	Uses a Quality Incentive Payment program to reward nursing facilities with additional payments if a facility achieves pre-specified performance measures.

Recommendations:

- States should leverage their Medicaid managed care contracts to incentivize VBP models that support people with complex health and social needs, like home-based care.
    - States could require or highlight options for MCOs to develop pathways within existing VBP models customized for people with complex health and social needs that would benefit from greater home-based services. These pathways can adapt model components (e.g., attribution, risk adjustment) to support the more intensive care needed to meet the needs of this population. This concept is explored in more detail in the first policy agenda brief.
    - States should ensure that the quality measures included in Medicaid managed care contracts account for care provided in the home setting as many existing quality measures do not.
    - States should use Medicaid managed care contracting to enhance diversion efforts and incentivize appropriate transitions of people with complex health and social needs out of nursing home facilities and into home- and community-based settings when those individuals desire to do so (see more in the next section).
    - CMCS should provide a model managed care contract that includes common VBP and delivery reforms applicable for people with complex health and social needs and functional limitations, such as through home-based care.
- CMCS should update its Medicaid and CHIP Managed Care rule to establish common measures that capture care delivered in the home and gauge the quality of home-based care.
- CMCS should reduce administrative obstacles to help managed LTSS plans so they can more easily access Medicare data, which will help ensure coordination of home-based care services between Medicaid and Medicare.

6. Provide Additional Home- and Community-Based Service Options to Support Home-Based Care for People Traditionally Needing Institutional-Level Care

While Medicaid has, since the original authorizing legislation, supported institutional-based long-term care (e.g., nursing homes), there has been a broader push to allow people to age in place in home- and community-based settings. One mechanism states can use to provide options for long-term care for people at home is the Money Follows the Person (MFP) program. MFP has successfully helped Medicaid beneficiaries who want to transition from LTSS institutions back to the community. The Consolidated Appropriations Act of 2021 extended MFP funding through 2023. However, MFP is not a permanently authorized program. In addition to MFP, there are additional vehicles available to states and their Medicaid programs, such as leveraging managed LTSS contracts, to provide more home-based LTSS efforts (see Table 6).

Ensuring that a person moving from an institutional to a community setting has access to safe, accessible, and affordable housing is a barrier that many states face. This challenge is exacerbated in rural areas with less robust provider networks and direct care workforce. A

home-based care model supported by VBP may alleviate the challenges associated with accessing care in the community by affording providers financial flexibility to address SDOH (e.g., home modifications).

Table 6. Examples of VBP State Initiatives for LTSS in home

State	Description	Mechanism
Florida	State managed care contracts set payment rates with a "transition target" to incentivize the shift of Medicaid beneficiaries living in institutions to home- and community-based settings. By the fourth year of implementation, more LTSS users resided in community settings compared to nursing facilities.	MLTSS contracting
Massachusetts	The Commonwealth's program, called Senior Care Options, for people dually eligible for both Medicare and Medicaid programs, sets capitated payment rates to incentivize community-based care and divert long-stay nursing home admittance.	MLTSS contracting

Recommendation:

- States should leverage flexibilities through the MFP demonstration, such as supplemental services, demonstrations, and other approaches, to provide infrastructure for home-based care models, like internet and computer access, as well as for services needed in home-based care models.
- States with Medicaid managed care should leverage managed care contracts to enhance efforts to transition individuals from institution-based settings back to the community, making access to home- and community-based care more accessible for people with complex health and social needs.

7. Strengthen the Home-Based Care Workforce to Expand Home-Based Care

There was a national direct care workforce shortage impacting the delivery of home-based care that has been exacerbated by the COVID-19 public health emergency. Key contributors to the workforce shortage include inadequate wages, with the median wage for home health workers being $13.02; high rates of part-time employment; and high turnover rates. For example, many states set LTSS workforce rates through Medicaid budgets, which may result in a HCBS provider receiving the same wage throughout their career.

There is opportunity for states to invest in their home-based care workforce by leveraging FMAP increases as part of ARPA and through the proposed Build Back Better plan (e.g., enhance skills-based training opportunities or raise wages). States have also used section 1115 and

1915(c) waivers to address temporarily the workforce shortage amidst the public health emergency. For example, Maine used a 1915(c) waiver to temporarily allow home health agencies to "hire" spouses to provide personal care support during the public health emergency. VBP models can also help address workforce shortages by providing more sustainable financing arrangements. State actions to address workforce through VBP initiatives are outlined below.

Table 7. Examples of VBP State Initiatives to Bolster Workforce

State	Description	Mechanism
New York	New York's Managed Long Term Care Workforce Investment Program serves to train, recruit, and retain a long-term care workforce that aligns with the state's larger VBP strategy. New York managed LTC plans are required to contract with direct care workforce organizations participating in the state's workforce investment program.	Section 1115 waiver
Tennessee	As part of the state's VBP strategy, the Bureau of TennCare included comprehensive LTSS workforce development into its QuILTSS initiative. The initiative aligns LTSS training with performance measures to reward program completion and high-quality LTSS.	CMS State Innovation Models (SIM) Initiative

Recommendation:

- States should leverage ARPA funding to invest in the home-based care workforce, including enhanced provider reimbursements and investments in skill-based training to enhance retention efforts.
- States should include turnover rates in home-based care quality measures tied to incentive-based payments in contracts with agencies providing HCBS. This can help enhance retention efforts for the direct care workforce.

8. Improve Data Infrastructure to Enhance Home-Based Care

There is limited data on home-based care services. This data gap is particularly evident for populations under the age of 65, given that older adults are captured in national Medicare data sources. Experts cited a need for a standardized home-based care data strategy that includes interoperability standards. This strategy should also include improvements to the type of data collected for home-based care, such as who is receiving HCBS, what services are currently provided, and quality measures appropriate for the patient population served through home-based care.

Further investments in data infrastructure are also needed. Improving data infrastructure – including health information exchange (HIE) and admissions, discharge, and transfer (ADT)

systems – aligns with CMCS's goals of enhancing data quality, addressing disparities in data access within Medicaid, and improving data transparency across stakeholders.

Table 8. Examples of State Initiatives to Improve Home-Based Care Data Infrastructure

State	Description	Mechanism
Rhode Island	Created an all-payer claims database (APCD) as part of their SIM initiative, which has been expanded and is now state-owned. Data from the APCD is now being used to help enhance community-based health care transformation efforts.	State Innovation Model initiative
Colorado	Invests in data infrastructure systems by establishing recruitment, retention, and turnover tracking with employee/employer matching capabilities for the purpose of expanding home-based care workforce.	ARPA Funding

Recommendations:

- CMCS should establish data dashboards that show the number of people accessing home-based care services and the quality of such services.
- States should leverage ARPA funding to enhance their data infrastructure to support home-based care data collection and sharing.

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Disclosures

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