American Association of People with Disabilities

SUPPORT AMERICANS WITH DISABILITIES IN THEIR HOMES AND COMMUNITIES

What are Home and Community-Based Services (HCBS)?

HCBS are long-term services and supports (LTSS) funded under Medicaid – the state and federal partnership that covers healthcare for very low-income people – to support people with disabilities in their home and community rather than in an institutional setting like a nursing home.[1] The vast majority of people prefer HCBS over institutional care which not only allows them to live independently but provides these services in a more cost-effective way.

HCBS FACTS

- Although there has been growth in the number of HCBS users from 2.1 to 3.2 million since 2000, states still spend only 36.8% of their LTSS budgets for aging and physical disability populations on HCBS; the majority is still spent in institutional settings.
- States vary widely with the highest performing state spending 62% and the lowest 10% on HCBS. Only 7 states spend more than 50% on HCBS (AARP 2011 Scorecard).
- Across the country, an estimated 400,000 individuals are on waiting lists to receive HCBS; many of whom are children who will require these supports over their lifetime.

Ending the institutional bias in Medicaid: Increasing HCBS for those who rely on it

Services under Medicaid are either mandatory or optional for states to cover. Unfortunately, institutional care remains a mandatory benefit while HCBS remain optional. Despite efforts to reduce institutional care or rebalance Medicaid, the program still essentially entitles people with disabilities only to care in nursing homes, instead of living in their homes and communities.

THE MOMENTUM TO REBALANCE IS GROWING

1981	Omnibus Budget and Reconciliation Act enacted Section 1915(c) of Title XIX of the Social Security Act to begin delivering HCBS in Medicaid through the HCBS waiver program
1999	The Supreme Court held in *Olmstead v. L.C.* that public entities must provide HCBS to persons with disabilities under certain conditions
2001	Real Choice Systems Change Grant Program (RCSC) awarded states for ten years to increase HCBS and has since expired
2005	Deficit Reduction Act (DRA) created the Money Follows the Person (MFP) program
2010	Affordable Care Act (ACA) expanded MFP and enacted the Balancing Incentive Program (BIP), Section 1915(k) Community First Choice (CFC) State Plan Option, Health Home Services State Plan Option, and modified the Section 1915(i) State Plan Option

The time to build on HCBS reforms is now

The Affordable Care Act provides states with options for expanding HCBS and the primary focus is on implementing the Medicaid expansion. This focus, combined with the administrative challenges of managing a fragmented LTSS system, makes it difficult for states to fully utilize all of the HCBS options to rebalance Medicaid and end the institutional bias.

We have a window of opportunity to act now. Efforts to expand access to HCBS have led to a proliferation of options for states. We must make it easier for states to take advantage of additional federal funds to rebalance Medicaid to help people live in the community. We need to examine how these authorities can be stitched together to make it easier to provide HCBS. Any solution must have increased federal incentives to address variations in program design across states and the unique challenges state budgets face in managing enrollment.

[1] These services are known as long-term services and supports (LTSS) which is generally defined as personal care services (i.e., help transferring from a wheelchair, dressing, going to the bathroom, etc), transportation services, assistive technology, durable medical equipment and other daily assistance to support an individual living with a functional impairment due to disability or health condition. HCBS refers to LTSS being served in the home and community rather than an institution.

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Recommendations to improve access to HCBS

- Consolidate the specific HCBS provisions in the Medicaid statute into one authority without losing their unique characteristics and retain the HCBS waiver program in Section 1915(c)
- Retain the best features of the BIP and MFP (scheduled to expire in 2015 and 2016 respectively)
    - Make permanent most features of the BIP
    - Make permanent the MFP feature of full federal match for HCBS costs for one year after relocation from an institution where a person has resided for more than 90 days and pay for certain start-up costs
- Extend the 6% enhanced federal match for all HCBS, subject to approval by the HHS Secretary. Currently this match is only for attendant services and supports offered under Section 1915(k) from Community First Choice (CFC).
- Establish different level of care (LOC) requirements for HCBS and institutional settings. Set level of care for eligibility for HCBS lower than institutional so that institutional settings are reserved for the most needy who also lack access to the community infrastructure for HCBS. Currently this authority resides in Section 1915(i).
- Review and refine Medicaid eligibility groups that have been established for accessing LTSS. This must be done in a manner that does not result in certain groups losing access to the Medicaid program.
- Manage enrollment growth by tying targets to specific rebalancing benchmarks that permanently decrease the state's institutional footprint.

These modest recommendations to increase and enhance HCBS will:

- Help states continue to make progress in rebalancing their programs to end Medicaid's institutional bias
- Prevent costly institutionalization
- Help states fulfill their obligations under the Americans with Disabilities Act (ADA) and *Olmstead*
- With the right supports, this reform helps individuals avoid unnecessary doctor visits and expensive hospitalizations
- Help Americans get the support they need so they can live independent, productive lives in their homes and communities

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