Tracking Health Reform

Medicaid Home and Community-Based Services in the Wake of the COVID-19 Pandemic

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Abstract The need to bolster Medicaid home and community-based services (HCBS) became more evident during the COVID-19 pandemic. This recognition stemmed from the challenges of keeping people safe in nursing homes and the acute workforce shortages in the HCBS sector. This article examines two major federal developments and state responses in HCBS options as a result of the pandemic. The first initiative entails a one-year increase of the federal Medicaid matching rate for HCBS included in the American Rescue Plan Act championed by the Biden administration. The second initiative encompasses administrative flexibilities that permitted states to temporarily expand and modify their existing Medicaid HCBS programs. The article concludes that the effects of the pandemic flexibilities and enhanced federal funding on most state HCBS programs will be limited without continued investment and leadership on the part of the federal government, which is a Biden administration priority. States that make the American Rescue Act and COVID-19 flexibilities initiatives permanent are states that have the fiscal resources and political commitment to expanding HCBS benefits that other states lack. States' different approaches to bolstering Medicaid HCBS during the pandemic may contribute to widening disparities in access and quality of HCBS across states and populations who depend on Medicaid HCBS.

Keywords home and community-based services, COVID-19, Medicaid, long-term services and supports, federalism

The COVID-19 pandemic has had a far-reaching impact on long-term services and supports (LTSS). The high rates of deaths and serious illness in nursing homes highlighted the risks of institutional care and the need for more home and community-based service (HCBS) options. Fifteen percent

Journal of Health Politics, Policy and Law, Vol. 49, No. 2, April 2024
DOI 10.1215/03616878-10989703

of the nation's 1.1 million COVID-19 deaths as of mid-2023 occurred among nursing home residents, even though they constituted less than 0.05% of the total US population (CDC 2023; CMS 2023d).

Most older adults and people with disabilities prefer to remain in their own homes and communities as they age (Binette 2022). HCBS can assist with activities of daily living, such as bathing, dressing, and eating, and with instrumental activities of daily living, such as shopping, meal preparation, or housework, to enable individuals to remain in the community and avoid a nursing facility or other institutional setting. However, there is considerable unmet need for LTSS, with the demand for such care well exceeding the supply of HCBS (Casado, van Vulpen, and Davis 2011; Chong et al. 2022).

COVID-19 had a disproportionate impact on older adults and individuals with disabilities who depend on Medicaid HCBS. Although the virus did not pose as prominent a threat to this population as it did to the nursing home population, many individuals who rely on HCBS benefits to remain in the community were at high risk of serious complications and death from contracting COVID-19. This risk is well illustrated by a study of Medicaid HCBS recipients enrolled in 14 managed LTSS plans in 12 states, which found that younger and older adult Medicaid HCBS recipients' excess mortality was 26.6 and 5.7 times greater, respectively, than that of the general population during 2020 (Kaye and Caldwell 2023). This higher risk of death among HCBS recipients may be attributable to challenges in accessing personal protective equipment, living or receiving care in congregate settings (e.g., group homes, adult day programs), or going without needed services during the pandemic.

In addition to the impact on HCBS recipients, the COVID-19 pandemic exacerbated already acute workforce shortages, as evidenced by a turnover rate in the industry of about 65% in the years leading up to and in the immediate aftermath of the pandemic (Holly 2021a). The risk of exposure to COVID-19, school and day care closures, and reduced demand for services—compounded by the exacerbation of systemic factors such as low pay, demanding working conditions, and limited opportunities for career advancement—contributed to home care provider difficulties recruiting and retaining direct care staff (Tyler et al. 2022). Due, in part, to workforce shortages, most states have reported HCBS provider closures during the pandemic (Watts, Burns, and Ammula 2022).

This article examines federal developments and state responses in HCBS options in the wake of the COVID-19 pandemic. We begin with a primer on Medicaid HCBS. This is followed by a review of federal legislative efforts

to bolster HCBS policies during the Biden administration. The key legislative accomplishment was a one-year increase of the federal Medicaid matching rate for HCBS included in the American Rescue Plan Act (P.L. 117–2), a $1.9 trillion COVID-19 economic relief and recovery package signed into law by President Joe Biden on March 11, 2021. Subsequent efforts to expand Medicaid HCBS benefits stalled in Congress. Next we examine efforts within the executive branch to support Medicaid HCBS. The first federal initiative encompasses flexibilities authorized by the Centers for Medicare and Medicaid Services (CMS) that permitted states to temporarily expand and modify their existing Medicaid HCBS programs. More recent efforts have included proposed rule changes around Medicaid HCBS and executive orders issued by the Biden administration to support caregivers and the care workforce.

We conclude with an examination of whether these policy developments are making significant or modest changes to existing Medicaid HCBS programs. We argue that the effects of the CMS flexibilities and the American Rescue Plan Act on most state HCBS programs will be limited without continued investment and leadership on the part of the federal government. Given roadblocks in Congress, this investment and leadership are most likely to be evidenced by the Biden administration continuing to draw on the tools of the administrative presidency to further its agenda of supporting state expansion of Medicaid HCBS (Gusmano and Thompson 2020).

Medicaid HCBS

In 2020, the United States spent more than $286 billion on HCBS for older adults and individuals with intellectual or developmental disabilities and physical disabilities (Watts, Musumeci, and Ammula 2022). Medicaid, the joint federal-state health insurance program for people with low income, accounts for 57% of this spending. States have a variety of options to provide Medicaid-funded HCBS benefits. While states are required to cover home health services for eligible individuals under their state Medicaid plans, all other HCBS programs are optional for states. In 2020, optional Medicaid HCBS programs accounted for more than 95% of Medicaid HCBS spending (Watts, Musumeci, and Ammula 2022).

States have significant discretion to offer HCBS programs within federal regulations. The most widely used Medicaid HCBS option for states are 1915(c) waivers, which allow states to provide benefits to specific populations, such as older adults or individuals with intellectual or developmental

disabilities. Individuals receiving services through a 1915(c) waiver must require a nursing facility level of care, and states can have multiple 1915(c) waivers for different populations. 1915(c) waivers are attractive to states because federal regulations allow states to cover nonmedical, social, and supportive services, target specific populations or geographic areas, set the number of slots, and impose waiting lists to manage costs. In 2021, 37 states had waiting lists for 1915(c) waiver programs totaling 656,000 people who must wait an average of 45 months before receiving waiver services (Watts and Ammula 2022). Also used to provide HCBS are 1115 research and demonstration waivers, which allow states to experiment with new approaches to deliver Medicaid services including HCBS benefits. 1115 waivers are attractive to states for the same reasons as 1915(c) waivers, but 1115 waivers permit more comprehensive program restructuring (e.g., having all HCBS recipients receive services through Medicaid managed care).

In 2020, 1.9 million people received HCBS through 1915(c) waivers across 47 states, and 1.1 million people received HCBS through 1115 waivers in 12 states (Watts, Musumeci, and Ammula 2022). Moreover, states can provide Medicaid HCBS benefits through the state plan personal care benefit, section 1915(i) HCBS benefit, and Community First Choice. Through the personal care benefit, 1.2 million people received HCBS in 37 states in 2020, whereas 165,800 people received HCBS through the section 1915(i) benefit in 13 states, and 458,700 received HCBS through Community First Choice in nine states (Watts, Musumeci, and Ammula 2022).

Federal 1915(c) and 1115 waivers have played a critical role in federal efforts to spur growth in Medicaid HCBS spending and utilization (Thompson and Burke 2007, 2009). This expansion has been driven by care recipient preferences (Binette 2022) and the promise of savings deriving from substitution of less expensive HCBS for institutional services (Berish et al. 2019; McGarry and Grabowski 2023). Expansion also has been driven by the 1999 US Supreme Court decision in *Olmstead v. LC* (527 U.S. 581), which established the right of individuals with disabilities to receive care in the most integrated setting appropriate under the Americans with Disabilities Act. Subsequent to *Olmstead*, federal administrative and legislative options, incentives, consultation, and supports have helped spur state rebalancing efforts over the past several decades (Beauregard and Miller 2020; Hudson 2010).

Nationally, considerable progress has been made in rebalancing Medicaid LTSS spending away from institutions and toward HCBS. Between fiscal year (FY) 1989 and FY2019, the proportion of total Medicaid LTSS spending directed toward HCBS increased from 10% to 59% (Murray et al.

2021b). Substantial variation is evident across states, however. In FY2019, for example, some states devoted more than 75% of Medicaid LTSS spending to HCBS (Oregon, Minnesota, New Mexico, Arizona, Wisconsin), whereas other states devoted less than 40% to Medicaid HCBS (Michigan, Florida, Louisiana, Indiana, Mississippi). Substantial variation also exists across population subgroups. In FY2018, for example, a higher proportion of Medicaid LTSS was devoted to HCBS among people with autism spectrum disorder and intellectual or developmental disabilities (78.9%) than among older adults and people with physical or other disabilities (32.9%) (Murray et al. 2021a).

The federal government matches state Medicaid program spending according to the Federal Medicaid Assistance Percentage (FMAP). The FMAP is inversely related to state per capita income; in FY 2024 it ranges from 50% for nine states (e.g., New York, Colorado, California) to 73.1% and 77.27%, respectively, for Alabama and Mississippi (KFF 2023a). These percentages apply to most Medicaid services, including HCBS, although some benefits such as Community First Choice receive an enhanced federal matching rate (in this case, +6 percentage points). In March 2020, the Families First Coronavirus Response Act (P.L. 116–127) provided states with a 6.2 percentage point increase in the FMAP for all Medicaid benefits through the end of the COVID-19 public health emergency (PHE).

Because most HCBS are optional, in contrast to the mandatory nursing home benefit, state Medicaid spending and utilization are particularly vulnerable to retrenchment during economic downturns, such as the one resulting from the COVID-19 pandemic. COVID-19, however, placed a spotlight on prevailing deficits in the nation's HCBS infrastructure. The pandemic's negative ramifications for LTSS helped shape the Biden administration's goals of spurring states to expand Medicaid HCBS benefits and supporting paid and unpaid caregivers. During the 2020 presidential election, Biden's campaign distributed a press release stating that "people in nursing homes have been hit especially hard by the coronavirus, shining a bright light on the fact that many would prefer to be in a home or community based setting. . . . [Biden intends] to make it easier for aging relatives and loved ones with disabilities to have quality, affordable home- or community-based care" (APP 2020). As president, Biden reaffirmed his administration's commitment to HCBS during his 2023 State of the Union address and during speeches promoting his 2024 budget proposal (White House 2023b, 2023c). His administration has sought to advance these goals through both legislative efforts and executive actions.

HCBS Legislative Efforts by the Biden Administration

The Biden administration's most significant accomplishment in HCBS programs has been the 2021 American Rescue Plan Act (ARPA). Section 9817 of the act, "Additional Support for Medicaid home and community-based services (HCBS) during the COVID-19 emergency," increased federal matching rates for state Medicaid HCBS programs by 10 percentage points for a one-year period: April 1, 2021, to March 31, 2022. Based on spending levels at that time, the Congressional Budget Office estimated that ARPA would provide states with an additional $12.7 billion in federal funding for Medicaid HCBS benefits during the designated period (Allen 2021).

The 10-percentage point FMAP increase could be added to other FMAP enhancements, but ARPA limited the cumulative FMAP for HCBS to no more than 95% during the one-year implementation period. In FY 2021, baseline FMAPs ranged from 50% in 13 states to 77.76% in Mississippi (KFF 2023a). Thus, accounting for states' baseline FMAPs and the 6.2% enhancement under the Families First Coronavirus Response Act, the 10-percentage point increase under ARPA provided states with FMAPs ranging from 66.2% to 93.96% for most HCBS. The 95% limit accounts for potential additional enhancements that could result in aggregate federal matching of more than 100% for certain benefits and populations. The addition of the 10-percentage point ARPA FMAP enhancement on top of the 6.2 percentage point Family Frist Coronavirus Response Act enhancement likely created a greater incentive for states to maintain and increase HCBS relative to other Medicaid services.

ARPA requires states to use the increased federal funding to "supplement, and not supplant, the level of state funds expended for [HCBS] for eligible individuals" as of April 1, 2021, and for states to "implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen" HCBS. Moreover, ARPA granted states substantial discretion in using the enhanced federal match to expand or strengthen Medicaid HCBS, as long as they do not draw back on existing state commitments by substituting the additional federal revenue for state expenditures. Specifically, the law did not limit states to addressing issues stemming from the COVID-19 pandemic. Moreover, it incorporated broad definitions of HCBS and "eligible individual" for purposes of enhancing, expanding, or strengthening HCBS.

CMS (2021a) provided implementation guidance in a May 13, 2021, letter to state Medicaid directors. The letter clarified requirements for states

to receive and use the enhanced funding. The letter explained that states would have until March 31, 2024, to expend the "state funds equivalent to the amount of federal funds attributable to the increased FMAP" obtained from April 1, 2021, to March 31, 2022. This deadline for expending the "state funds equivalent" in enhanced federal funds was subsequently extended to March 31, 2025, in a second CMS (2022) letter to provide states with more time in light of challenges that make it difficult to implement the activities proposed to expend state funds by the original deadline. As such, CMS is providing states with up to four years to spend the additional revenue deriving from the 10-percentage point increase in year one on approved services and activities under ARPA.

State Medicaid HCBS eligibility standards, provider payment levels, and covered HCBS services must be no more restrictive than those in place as of April 1, 2021, until the "state funds equivalent" in federal revenue deriving from ARPA has been exhausted. CMS has facilitated implementation by granting states broad flexibility to bolster Medicaid HCBS under ARPA. A wide range of options to enhance, expand, or strengthen HCBS were provided in the first CMS letter, which addresses COVID-related HCBS concerns during the PHE and discusses building the capacity of the HCBS system more generally.

CMS established a process for states to accept and use the enhanced federal match with the aim of simplifying state reporting requirements to "expedite the release of funds and to minimize state administrative burdens" (CMS 2021a). This process involved submission of an initial state spending plan projection and narrative for approval by CMS within 30 days of the May 13, 2021, guidance letter. CMS also required states to provide assurances that they were supplementing and not supplanting state spending; funding activities to enhance, expand, or strengthen HCBS; and maintaining eligibility, benefits, and payments at no less than existing levels. Approval of state spending plans and spending plan narratives were retroactive to the April 1, 2021, start of the funding period. Initially, states provided quarterly updates on their spending plans and narratives to CMS, but this was subsequently made semiannual to further reduce state reporting burden (CMS 2022).

Although submitting initial state spending plans and narratives was optional, all states and the District of Columbia submitted those materials, and CMS subsequently approved them, thus enabling states to claim the enhanced FMAP provided under ARPA. Based on these submissions, CMS estimated total federal and state Medicaid HCBS spending under the law to be $25 billion, with additional spending ranging from $31.6 million to $4.6

billion across states (CMS 2021b). States have continued to hone their ARPA plans by adding and dropping proposed activities, sometimes in response to CMS feedback about provisions that did not meet statutory requirements (ADvancing States 2023). The latest estimates project $35 billion in total federal and state Medicaid HCBS spending under ARPA through March 31, 2025 (ADvancing States 2022).

States' activities vary considerably under ARPA. Some states have adopted a limited number of initiatives; other states have pursued a broad range of proposals. Some states have only committed to proposals based exclusively on the state funding equivalent in enhanced federal funds through the conclusion of the PHE (e.g., temporary wage increases, bonus payments, one-time costs for transition from nursing home to community); other states have committed to longer-term investments in Medicaid HCBS that will require ongoing state funding allocations (e.g., new services, shorter wait lists, permanent wage increases). Table 1 summarizes state initiatives under ARPA across 10 general areas of activity.

Bolstering the provider workforce and expanding beneficiary access to services are prime targets for state action under ARPA. Nearly all states plan to strengthen the provider workforce by increasing compensation for workers and agencies (48 states) and improving provider recruitment and training (46). Increasing compensation most commonly entails rate increases, including requirements for funds to be passed on to direct care staff as well as one-time bonus payments and rate/actuarial studies. Improving provider recruitment and training most commonly includes training and certification programs and bonuses tied specifically to recruitment and retention, followed by opportunities for career advancement among the direct care workforce. Most states (44) also plan to implement new or expanded services such as caregiver supports, institution-to-community transition services, behavioral health/mental illness services, home modifications, and assistive technology. An array of initiatives pursued by most states (35) seeks to broaden eligibility and enrollment by, for example, changing the way eligibility assessments are conducted, facilitating access through single-point-of-entry/no-wrong-door initiatives, and reducing wait lists by adding waiver slots.

States have sought to improve the underlying infrastructure for providing Medicaid HCBS through technology applications, capital/structural improvements, and quality assurance initiatives. Technology applications proposed to better support HCBS providers include telehealth improvements, health information technology development/integration, electronic

Table 1 State Medicaid Home and Community-Based Services Initiatives under the American Rescue Plan Act

	Service expansions	Eligibility and enrollment activities	Provider payment increases	Provider recruitment, retention, and training	Technology for providers	Technology for state agencies	Capital/structural improvements	Quality initiatives	Strengthening state administration	Other activities
Alabama	X	X	X	X	X	X	X			X
Alaska			X	X						X
Arizona	X	X	X	X	X	X	X	X	X	X
Arkansas	X	X	X	X	X	X	X	X	X	
California	X	X	X	X	X	X	X	X	X	X
Colorado	X	X	X	X	X	X	X	X	X	X
Connecticut	X	X	X	X		X		X	X	X
Delaware	X	X	X	X		X				X
District of Columbia	X	X	X	X	X	X		X	X	X
Florida	X	X	X	X			X		X	X
Georgia	X		X	X		X			X	
Hawaii	X		X	X	X	X		X	X	X
Idaho			X							
Illinois	X	X	X	X						X
Indiana	X	X	X	X	X	X	X	X	X	X
Iowa	X	X		X	X		X		X	X
Kansas	X	X		X					X	X
Kentucky			X			X				
Louisiana	X	X	X	X				X	X	X
Maine	X	X	X	X	X	X	X	X	X	X
Maryland	X		X		X				X	
Massachusetts	X	X	X	X	X	X		X		X
Michigan	X	X		X			X		X	X
Minnesota	X		X	X	X	X		X	X	X
Mississippi	X		X	X		X			X	X
Missouri	X	X	X	X	X	X		X	X	X
Montana			X							
Nebraska			X		X		X		X	X
Nevada	X	X	X	X		X	X	X	X	X
New Hampshire	X	X	X	X						X
New Jersey	X	X	X	X			X	X		X
New Mexico	X	X	X	X	X	X	X	X	X	X

(*continued*)

Table 1 State Medicaid Home and Community-Based Services Initiatives under the American Rescue Plan Act (*continued*)

	Service expansions	Eligibility and enrollment activities	Provider payment increases	Provider recruitment, retention, and training	Technology for providers	Technology for state agencies	Capital/structural improvements	Quality initiatives	Strengthening state administration	Other activities
New York	X	X	X	X	X	X	X		X	X
North Carolina	X	X	X	X	X	X		X	X	X
North Dakota	X		X	X	X	X		X	X	X
Ohio	X		X	X	X	X		X	X	X
Oklahoma	X	X	X	X	X	X	X	X	X	
Oregon	X	X	X	X	X	X	X	X	X	X
Pennsylvania	X	X	X	X	X	X	X	X	X	X
Rhode Island	X	X	X	X	X	X	X	X	X	X
South Carolina	X	X	X	X	X	X	X	X		
South Dakota			X	X						X
Tennessee	X		X	X				X	X	
Texas	X	X	X	X	X	X	X		X	X
Utah	X		X	X	X	X	X		X	X
Vermont	X	X	X	X	X	X	X	X	X	X
Virginia			X	X		X		X		
Washington	X	X	X	X	X		X		X	X
West Virginia	X	X	X	X	X	X		X	X	X
Wisconsin	X	X	X	X				X	X	X
Wyoming	X	X	X	X		X		X		
Total	**44**	**35**	**48**	**46**	**30**	**34**	**24**	**30**	**37**	**40**

Source: ADvancing States (2023).

visit verification, and devices for providers. Capital/structure improvements to HCBS systems in 24 states include providing funds to increase provider capacity and to increase COVID safety and emergency preparedness through, for example, funds to purchase personal protective equipment and testing supplies and to assist providers and individual care recipients in planning for future emergencies. Proposals to improve quality in 30 states focus largely on developing outcome-based payment initiatives (e.g., pay for performance) and on developing/refining quality measures and surveying beneficiaries about their experiences.

States also have sought to improve the underlying infrastructure for administering Medicaid HCBS by strengthening state administrative capacity and technology applications. Investments have been proposed to bolster 37 states' administrative capacity to conduct program evaluation, strategic planning, consumer/stakeholder outreach, project management, and policy analysis/development. Technology applications have been proposed to better support state administration too (34 states). Beyond general technology improvements, these include implementing or enhancing case management systems and health and welfare systems and investing in electronic health records. Other initiatives states plan to pursue under ARPA fall in the areas of substance abuse disorders (10), children (17), social determinants of health (10), brain injury (8), and diversity, equity, and inclusion (14). States are providing housing supports (15), such as increasing access to affordable housing and providing medical and supportive services in the home.

ARPA poses challenges for states because it requires development and implementation of plans to spend substantial sums of money in a short period (Miller and Beauregard 2023). CMS responded to these challenges in part by extending the timeline and limiting reporting requirements. CMS approval, however, only provides authorization to use revenue deriving from the enhanced match for the purposes indicated. Changes to state and local statutes, regulations, and guidance could be required. Furthermore, permanent programmatic changes require Medicaid state plan and waiver amendments, which may not result in approval as quickly as temporary emergency/disaster-related changes tied to the PHE (ADvancing States 2022).

The breadth and depth of actions proposed by states and their ability to implement actions in a timely manner depend on state resources, administrative capacity (especially dedicated staff), and earlier policy decisions prioritizing planning and investment in building Medicaid HCBS program and infrastructure (Miller and Beauregard 2023). States have been assisted in program design and implementation through the provision of clear and frequent guidance by CMS, both initially and in response to state updates (CMS 2021a, 2022, 2023a). Consistent with CMS's expectations (CMS 2021a), states have sought and incorporated input and feedback from community stakeholders (Kashen et al. 2023), which has been shown to promote successful reform in Medicaid HCBS (Beauregard and Miller 2021). Opportunities for interstate learning and technical assistance through organizations such as the National Academy for State Health Policy and ADvancing States have been evident as well (ADvancing States 2022, 2023; Manz 2022).

Critically, the breadth and depth of state actions depend on state willingness and ability to dedicate additional resources to Medicaid HCBS after exhausting the increased funds stemming from ARPA. Thirty-five states report proposing time-limited HCBS initiatives with high startup costs to avoid high continuing costs; of these, just 10 states report both time-limited and ongoing initiatives (Watts, Burns, and Ammula 2022). Confidence in continued state investment after ARPA has been an important consideration for states pursuing permanent or temporary changes in Medicaid HCBS.

While states have until 2025 to expend the "state funds equivalent" in enhanced federal funds acquired under ARPA, temporary Medicaid provisions enacted under the Family First Coronavirus Response Act are ending, which will have impacts on some HCBS recipients. Under this act, states were required to keep Medicaid recipients continuously enrolled during the PHE in exchange for higher federal matching funds. As of March 31, 2023, states could disenroll Medicaid recipients who no longer meet the eligibility criteria. According to the Kaiser Family Foundation, an estimated 8 to 24 million Medicaid recipients could lose coverage (Tolbert and Ammula 2023). As of August 8, 2023, nearly 4 million Medicaid enrollees were disenrolled across 42 states and the District of Columbia, ranging from 8% in Wyoming to 82% in Texas (KFF 2023b). Those at greatest risk of gaps in coverage include people with disabilities and older adults because they may encounter barriers or challenges completing the renewal process.

In March 2021, the Biden administration proposed an ambitious expansion of Medicaid HCBS benefits through the American Jobs Act, which included an additional $400 billion for Medicaid HCBS and a permanent 10 percentage point increase in states' FMAP for HCBS. States would need to submit and receive approval for plans to expand and strengthen HCBS to receive the permanent 10 percentage point increase. To attract legislative support, the Biden administration revised the proposal in the Build Back Better Act, which included $150 billion for HCBS and a permanent increase of 6 percentage points in the federal match for Medicaid HCBS. While less ambitious than the administration's initial proposal, the investment in HCBS through the Build Back Better Act received widespread support from HCBS advocates and providers (Holly 2021b; Donlan 2021). This legislation passed the House of Representatives but stalled in the Senate. Negotiations within the Senate resulted in the passage of the Inflation Reduction Act of 2022, which included several components of the Build Back Better Act but not the HCBS provisions.

Executive Action and HCBS Programs

In addition to legislative developments, the Biden administration used executive branch flexibilities and actions in response to the COVID-19 pandemic to bolster HCBS. Federal regulations allow states to make changes to existing Medicaid HCBS benefits in response to emergency situations, including pandemics, natural disasters, national security emergencies, or environmental emergencies, with CMS's approval. These flexibilities existed before COVID-19, and the federal government encouraged states to leverage these options in response to the challenges posed by the pandemic. The emergency response changes were intended to be temporary during the PHE to meet the needs of older adults and individuals with disabilities who depend on HCBS benefits.

States could use a variety of options to make temporary changes to their Medicaid programs, including appendix K of 1915(c) waivers, 1115 waivers, 1135 waivers, and Medicaid disaster relief state plan amendments. Appendix K permits states to implement emergency or disaster-related modifications to 1915(c) and 1115 waivers. 1115 waivers can be used to extend pandemic-related flexibilities available under appendix K to state plan HCBS services (e.g., Community First Choice, 1915(i)). Once declared, 1135 waivers can be used to waive or modify certain program requirements during the public health emergency. Disaster relief state plan amendments permit states to make disaster-related changes to their Medicaid state plans. States were quick to use these authorities in early 2020 in response to the unfolding COVID-19 pandemic. By November 3, 2020, CMS had approved 132 1135 waivers, 154 1915(c) appendix K amendments, 139 Medicaid disaster state plan amendments, and 33 1115 demonstration actions (CMS 2020). The specific mechanisms used to make changes varied depending on the authority.

The types of changes CMS approved through these flexibilities with respect to HCBS programs fit into several broad categories, as shown in table 2. Many of the changes that states adopted focused on how to adjust the provision of Medicaid HCBS benefits in light of the risks and challenges posed by COVID-19. For example, as part of Medicaid HCBS eligibility, states are required to routinely assess program eligibility through in-person assessments. In response to COVID-19, the most frequent changes states made were allowing virtual assessments or revaluations instead of requiring them to be performed in person, and extending the due dates for revaluation (KFF 2021).

As discussed earlier, states also faced acute workforce shortages during the pandemic, and many states used the flexibilities to address this

Table 2 State Medicaid Home and Community-Based Services Flexibilities Adopted in Response to COVID-19

	Eligibility	Covered services	Service planning and delivery	Settings	Providers	Oversight
Alabama	X	X	X	X	X	X
Alaska	X	X	X	X	X	X
Arizona	X	X	X	X	X	
Arkansas	X		X	X	X	X
California	X	X	X	X	X	X
Colorado	X	X	X	X	X	X
Connecticut	X	X	X	X	X	X
District of Columbia	X	X	X	X	X	X
Delaware	X	X	X	X	X	X
Florida	X	X	X	X	X	X
Georgia	X	X	X	X	X	X
Hawaii	X	X	X	X	X	X
Idaho	X	X	X	X	X	X
Illinois	X	X	X	X	X	X
Indiana	X	X	X	X	X	X
Iowa	X	X	X	X	X	
Kansas	X	X	X	X	X	X
Kentucky	X	X	X	X	X	X
Louisiana	X	X	X	X	X	X
Maine	X	X	X	X	X	X
Maryland	X	X	X	X	X	X
Massachusetts	X	X	X	X	X	X
Michigan	X	X	X	X	X	X
Minnesota	X	X	X	X	X	
Mississippi	X	X	X	X	X	X
Missouri	X	X	X	X	X	X
Montana	X	X	X	X	X	X
Nebraska	X	X	X	X	X	
Nevada	X	X	X	X	X	X
New Hampshire	X	X	X	X	X	X
New Jersey	X	X	X	X	X	X
New Mexico	X	X	X	X	X	X
New York	X	X	X	X	X	X
North Carolina	X	X	X	X	X	X
North Dakota	X	X	X	X	X	X

Table 2 (*continued*)

	Eligibility	Covered services	Service planning and delivery	Settings	Providers	Oversight
Ohio	X	X	X	X	X	
Oklahoma	X	X	X	X	X	X
Oregon	X		X	X	X	X
Pennsylvania	X	X	X	X	X	X
Rhode Island	X	X	X	X	X	
South Carolina	X	X	X	X	X	X
South Dakota	X	X	X	X	X	X
Tennessee	X	X	X	X	X	X
Texas	X	X	X	X	X	X
Utah	X	X	X	X	X	X
Vermont	X		X	X	X	
Virginia	X		X	X	X	X
Washington	X	X	X	X	X	X
West Virginia	X	X	X	X	X	X
Wisconsin	X	X	X	X	X	X
Wyoming	X	X	X	X	X	X
Total	**51**	**47**	**51**	**51**	**51**	**44**

Source: KFF (2021).

challenge in several different ways. Most states (40) increased payment rates to providers with the hope of avoiding closures of provider agencies and attracting workers to provide care. States also permitted the payment of retainer payments to providers to help organizations, such as adult day health centers, remain in business during the COVID-19 shutdowns. Some states also expanded the ability of family caregivers to be paid caregivers. While states had the option to elect to allow family members to be paid caregivers before COVID-19, not all states permitted this for all Medicaid HCBS programs. Given HCBS workforce shortages and concerns about exposure to COVID-19, 41 states expanded the ability of family members to be paid by Medicaid for providing HCBS during COVID.

Other changes that states made pertained to the types of services, amount of services, and methods of service delivery. Within HCBS waivers, each state must specify the services that are provided and the allowable amount or duration of services. Under the COVID-19 flexibilities, more than half

of states added new services such as home-delivered meals or assistive technology. Most states (45) made modifications to the amount or duration of services in response to COVID. These types of changes included permitting up to two home-delivered meals per day and increasing the maximum number of days for respite care. In addition, nearly all states (47) permitted electronic delivery of services. For example, some states allowed personal care services for verbal cueing, habilitation, or adult day health services to be provided virtually.

With the end of the federal PHE in 2023, the flexibilities CMS approved have expired. Depending on the nature of these flexibilities, states may decide, with CMS's approval, to make some of the temporary changes permanent. COVID-19 flexibilities that states cannot continue include providing services in an institutional setting, modifying person-centered planning requirements, extending revaluations and assessments, suspending quality-improvement activities, limiting visitors to residential group homes, and waiving case management entities' conflict of interest provisions (permitting them to also be the providers of services). On the other hand, states have significant discretion to make many other changes permanent through waiver amendments, including modifying or adding new services, allowing virtual revaluations and assessments, permitting the electronic delivery of services, expanding the ability of family members to be paid caregivers, and changing eligibility requirements (CMS 2023b; NAMD 2023).

When determining whether to make temporary policies permanent, states could consider several factors. These factors include the demand for new services or service-delivery methods by recipients of HCBS benefits, the associated costs of new services or offerings, the availability of providers, and the impact on recipients if temporary changes enacted during COVID-19 are repealed. In a survey of states, many states indicated that they intended to continue some flexibilities, with other states indicating that they will end the flexibilities or are unsure of their course of action. The most common flexibilities that states said they would continue were providing HCBS via telehealth (29 states), allowing family members to be paid caregivers (20 states), allowing virtual evaluations of eligibility or needs (19 states), and adding new HCBS (16 states) (Burns, Mohamed, and Rudowitz 2023).

The temporary flexibilities implemented in response to COVID-19 are contributing to some modest changes in states' Medicaid HCBS programs. Before the pandemic, states had limited options to temporarily offer new services or change eligibility. As a result, states may have been reluctant to

adopt changes that could have sustained unintended impacts on programs and spending. With the emergency flexibilities, states had the opportunity to be innovative without permanently committing to programmatic changes. This allowed states to experiment and test out new services, service-delivery methods, eligibility requirements, or provider types without necessarily implementing the changes permanently.

The COVID-19 flexibilities were effective in accelerating the adoption of technology and of paid family caregivers in the delivery of HCBS, consistent with care recipient and family preferences and anticipated improvements in system performance (Nanda and Sharma 2021; Nadash, Tell, and Jansen 2023). Even after the end of COVID-19 restrictions, some HCBS recipients may prefer to receive case management or services in a hybrid or remote manner. Increased use of technology may thus promote more person-centered HCBS service planning and delivery (Friedman 2022). Although the number of states permitting payment to family members has increased concomitantly with growth in consumer-directed programs (Thompson et al. 2016), many states, concerned by the fiscal implications, have been reluctant to allow family members to be paid for care they would otherwise provide, including prohibitions on the types of family members who could be hired as caregivers (e.g., spouses). Continuation of paid family caregiving following the expiration of the COVID-19 flexibilities enables states to better meet beneficiaries' needs, given acute shortages in direct care staff (Murray et al. 2021).

In addition to the administrative flexibilities permitted during the public health emergency, the Biden administration has used executive orders and proposed rulemaking to influence HCBS policy. These changes are largely in response to the lack of legislative commitment to improving and expanding Medicaid HCBS options. In September 2022, the Administration for Community Living (2022) published the National Strategy to Support Family Caregivers, developed by advisory councils established by the RAISE Family Caregiving Act and the Supporting Grandparents Raising Grandchildren Act. This strategy document lists close to 350 actions 15 federal agencies plan to take within the subsequent three years to support family caregivers, and more than 150 suggested actions for state, communities, and other stakeholders to do the same. In April 2023, the Biden administration announced an executive order to address the direct care workforce and caregivers (White House 2023a). The executive order included strengthening HCBS benefits through the Department of Veterans Affairs and regulations that improve the quality of direct care work. The executive order also proposes testing a dementia care model and providing respite care to support family caregivers.

At the federal level, the Biden administration is also proposing regulatory changes to improve Medicaid HCBS benefits in fee-for-service and managed care programs. In April 2023, CMS put forward rules titled "Ensuring Access to Medicaid Services" and "Managed Care Access, Finance, and Quality" (CMS 2023c). The former focuses on fee-for-service HCBS programs and proposes strengthening oversight through new grievance processes and critical incident reporting, implementing standardized quality improvement metrics, requiring 80% of Medicaid HCBS payments for certain services (homemaker, home health aide, and personal care) to be spent on compensation rather than overhead or profit, and requiring states to report on waiting lists for 1915(c) HCBS waivers. The latter focuses on Medicaid managed care programs and includes requiring states to conduct an annual survey of enrollees and to implement an annual analysis of managed care rates compared to payment rates for fee-for-service Medicaid HCBS benefits. These two proposed regulatory changes would promote greater transparency and consistency of HCBS programs across states. Nevertheless, these changes will not necessarily result in states expanding HCBS options to meet the needs of individuals reliant on Medicaid-funded LTSS.

Looking Forward

The initiatives and programs that states adopted under the PHE flexibilities and that the ARPA enhanced federal funding paid for were wide-ranging. Some states invested in temporary initiatives, while other states have developed new programs that will continue now that the PHE has expired and ARPA funding has ended. Some states focused narrowly on a limited number of projects, while other states used the funding more broadly. Common policy initiatives across states included workforce training and certification, HCBS provider rate increases or bonus payments, technology enhancements, and new or enhanced services.

The recent federal and state developments in HCBS policies and programs will have a modest impact on the provision of HCBS benefits for older adults and individuals with disabilities. The establishment of a new or enhanced benefit often leads to the formation of organized constituencies, which makes it difficult to reduce or eliminate the benefit in question (Campbell 2003; Pierson 1993). In this case, however, establishment of enhanced HCBS offerings during the COVID-19 pandemic was spurred by temporary flexibilities and funding provided by the federal government. That fact, the optional nature of most Medicaid HCBS, the disparate

populations served by multiple types of providers, limited political constituencies that have developed around caregiving (Levitsky 2014), and continuing concerns about aggregate increases in spending as a result of the "woodwork effect" (i.e., growth in HCBS enrollment that negates reductions in institutional spending; Doty 2000) pose impediments to the continuation of states' pandemic-related HCBS initiatives. Without a sustained federal fiscal investment in Medicaid HCBS, state officials will need to come up with additional state funding or face challenges in making pandemic-era enhancements to Medicaid HCBS permanent.

Federal legislative actions and the Biden administration's executive initiatives around the direct care workforce, caregivers, quality improvement, and transparency may lead to new standards and regulations. However, absent enhanced resources, the low pay in this field will continue to pose a challenge to recruiting and retaining needed staff and to supporting family caregivers. To make significant changes in the LTSS system, policy makers need to commit to substantially greater financial investments in HCBS options. The Build Back Better HCBS proposal—which did not make it into the Inflation Reduction Act—would have made it more attractive for states to offer HCBS benefits and to increase payments to providers to address workforce shortages through a permanent higher federal matching rate. Without additional federal investments in Medicaid HCBS, those in the direct care workforce who provide Medicaid HCBS will continue to face low wages, resulting in high turnover rates and insufficient supply to meet the demand for Medicaid HCBS.

To fundamentally transform Medicaid LTSS, federal policy should also remove the institutional bias of care and encourage states to provide more Medicaid HCBS options. While all Medicaid programs must pay for institutional care for individuals who meet functional and financial eligibility requirements, the same stipulation does not exist for needed HCBS. In March 2023, Congresswoman Debbie Dingell, Congressman Jamaal Bowman, and Senator Bob Casey introduced the HCBS Access Act, which would make HCBS a mandatory Medicaid benefit and eliminate waiting lists for HCBS. CMS's proposed regulatory changes to reporting on 1915(c) waiting lists may lead to improvements by enabling the federal government to better document how accessible HCBS is across states; however, to address the unmet need for community-based LTSS, federal officials should remove the institutional bias of Medicaid and incentivize states to offer HCBS benefits through a higher federal match rate for these services. The cost of increasing HCBS FMAP rates would be substantial. The estimated cost of the Biden administration's proposed permanent 10 percentage point increase in Medicaid HCBS FMAP rates would cost

approximately $400 billion over 10 years. According to a recent study of state Medicaid expansion from 1999 to 2017, however, investments in HCBS may not increase total Medicaid LTSS expenditures as much as anticipated (McGarry and Grabowski 2023). Results indicate that growth in Medicaid HCBS did not lead to a rise in Medicaid enrollment among adults 65 years and older, and aggregate savings resulted because growth in HCBS spending was offset by reductions in nursing home utilization (McGarry and Grabowski 2023).

Conclusion

The flexibilities in response to COVID-19, the 10-percentage point ARPA enhancement, and the Biden administration's executive orders and proposed regulatory changes around caregiving and HCBS have had a modest impact on expanding and improving Medicaid HCBS benefits. A key drawback of recent initiatives is their temporary nature. States that make the COVID-19 flexibilities or ARPA initiatives permanent are states that have the fiscal resources and political commitment to expanding HCBS benefits, which other states may lack. States' different approaches over the last several years may contribute to additional disparities in access to and quality of HCBS across states and across different populations who depend on Medicaid HCBS. The Biden administration's proposed rulemaking around caregiving, the direct care workforce, quality improvement, and transparency could help to highlight weaknesses and areas for improvement. Yet without greater federal investment in HCBS there is likely to be only limited improvement in HCBS availability and access across most states.

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References

ACL (Administration for Community Living). 2022. "2022 National Strategy to Support Family Caregivers." September 21. https://acl.gov/sites/default/files/RAISE_SGRG/NatlStrategyToSupportFamilyCaregivers.pdf.

ADvancing States. 2022. "State Implementation of American Rescue Plan Act Initiatives to Increase Wages and Expand Career Opportunities for Direct Service Workers: Summary of a State Affinity Group." August. http://www.advancingstates.org/sites/nasuad/files/u34188/ADS%20ARPA%20DSW%20Affinity%20Group%20Report%20August%202022%20-%202.pdf.

ADvancing States. 2023. "ARPA HCBS Spending Plan Analysis." March 24. http://www.advancingstates.org/sites/nasuad/files/u34188/3-28-2023%20Updated%20ARPA%20Spending%20Plan%20Analysis%203.pdf.

Allen, Kristin. 2021. "Federal Funding for Home and Community-based Services (HCBS): Enacted and Proposed Investments." Health Management Associates (blog), April 15. https://www.healthmanagement.com/blog/federal-funding-for-home-and-community-based-services-hcbs-enacted-and-proposed-investments/.

APP (American Presidency Project). 2020. "Biden Campaign Press Release—The Biden Plan for Mobilizing American Talent and Heart to Create a 21st Century Caregiving and Education Workforce." https://www.presidency.ucsb.edu/documents/biden-campaign-press-release-the-biden-plan-for-mobilizing-american-talent-and-heart (accessed October 12, 2023).

Beauregard, Lisa, and Edward A. Miller. 2020. "Why Do States Pursue Medicaid Home Care Opportunities? Explaining State Adoption of the Patient Protection and Affordable Care Act's Home and Community-based Services Initiatives." *RSF: The Russell Sage Foundation Journal of the Social Sciences* 6, no. 2: 154–78. https://www.rsfjournal.org/content/6/2/154.

Beauregard, Lisa, and Edward A. Miller. 2021. "A Comparative Case Analysis of Barriers and Facilitators to Implementing the Affordable Care Act's Balancing Incentive Program." *Research on Aging* 44, nos. 3–4: 276–85. https://doi.org/10.1177/01640275211020795.

Berish, Dian, Ian Nelson, Shahla Mehdizadeh, and Robert Applebaum. 2019. "Is There a Woodwork Effect? Addressing a 200-Year Debate on the Impacts of Expanding Community-Based Services." *Journal of Aging and Social Policy* 31, no. 1: 85–98. https://doi.org/10.1080/08959420.2018.1528115.

Binette, Joanne. 2022. "2021 Home and Community Preference Survey: A National Survey of Adults Age 18+ Chartbook." AARP, September. https://www.aarp.org

/content/dam/aarp/research/surveys_statistics/liv-com/2021/2021-home-community-preferences-chartbook.doi.10.26419-2Fres.00479.001.pdf.

Burns, Alice, Maiss Mohamed, and Robin Rudowitz. 2023. "Ending the Public Health Emergency for Medicaid Home- and Community-Based Services." Kaiser Family Foundation, April 19. https://www.kff.org/policy-watch/ending-the-public-health-emergency-for-medicaid-home-and-community-based-services/.

Campbell, Andrea L. 2003. *How Policies Make Citizens*. Princeton, NJ: Princeton University Press.

Casado, Banghwa Lee, Kimberly S. van Vulpen, and Stacey L. Davis. 2011. "Unmet Needs for Home and Community-Based Services among Frail Older Americans and Their Caregivers." *Journal of Aging and Health* 23, no. 3: 529–53. https://doi.org/10.1177/0898264310387132.

CDC (Centers for Disease Control and Prevention). 2023. "COVID Data Tracker." https://covid.cdc.gov/covid-data-tracker/#datatracker-home (accessed October 12, 2023).

Chong, Natalie, Ilhom Akobirshoev, Joseph Caldwell, H. Stephen Kay, and Monika Mitra. 2022. "The Relationship between Unmet Need for Home and Community-Based Services and Health and Community Living Outcomes." *Disability and Health Journal* 15, no. 2: article ID 101222. https://doi.org/10.1016/j.dhjo.2021.101222.

CMS (Centers for Medicare and Medicaid Services). 2020. "Innovations in Medicaid: State Home and Community-Based Services Pandemic Response and Unwinding COVID-Related Waivers." http://www.advancingstates.org/sites/nasuad/files/u24453/Innovations%20in%20Medicaid%20State%20HCBS%20PHE%20and%20Unwinding%20COVID%20Final.pdf (accessed November 14, 2023).

CMS (Centers for Medicare and Medicaid Services). 2021a. Letter to State Medicaid Directors. May 13. https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf.

CMS (Centers for Medicare and Medicaid Services). 2021b. "American Rescue Plan Act of 2021 (ARP) Section 9817: Overview of State Spending Plans." November 30. https://www.medicaid.gov/medicaid/home-community-based-services/downloads/arp-sec9817-overview-infographic.pdf.

CMS (Centers for Medicare and Medicaid Services). 2022. Letter to State Medicaid Directors. June 3. https://www.medicaid.gov/federal-policy-guidance/downloads/smd22002.pdf.

CMS (Centers for Medicare and Medicaid Services). 2023a. "ARP Section 9817 State Spending Plans and Narratives and CMS Approval Letters." https://www.medicaid.gov/medicaid/home-community-based-services/guidance/arp-section-9817-state-spending-plans-and-narratives-and-cms-approval-letters/index.html (accessed October 12, 2023).

CMS (Centers for Medicare and Medicaid Services). 2023b. "All State Medicaid CHIP Call." February 28. https://www.medicaid.gov/resources-for-states/downloads/covid19allstatecall02282023.pdf.

CMS (Centers for Medicare and Medicaid Services). 2023c. "Summary of CMS's Access-Related Notices of Proposed Rulemaking: Ensuring Access to Medicaid Services (CMS 2442-P) and Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P)". April 17.

https://www.cms.gov/newsroom/fact-sheets/summary-cmss-access-related-notices-proposed-rulemaking-ensuring-access-medicaid-services-cms-2442-p.

CMS (Centers for Medicare and Medicaid Services). 2023d. "COVID-19 Nursing Home Data." June 11. https://data.cms.gov/covid-19/covid-19-nursing-home-data.

Donlan, Andrew. 2021. "Home-Based Care Advocates Celebrate Build Back Better Plan's House Passage, Urge Senate to Follow Suit." *Home Health Care News*, November 21. https://homehealthcarenews.com/2021/11/home-based-care-advocates-celebrate-build-back-better-plans-house-passage-urge-senate-to-follow-suit/.

Doty, Pamela. 2000. "Cost-Effectiveness of Home and Community-Based Long-Term Care Services." US Department of Health and Human Services, May 31. https://aspe.hhs.gov/basic-report/cost-effectiveness-home-and-community-based-long-term-care-services.

Friedman, Carli. 2022. "Telehealth Service Delivery in Medicaid Home- and Community-Based Services for People with Intellectual and Developmental Disabilities." *International Journal of Telerehabilitation* 14, no. 1: article ID e6478. https://doi.org/10.5195/ijt.2022.6478.

Gusmano, Michael K., and Frank J. Thompson. 2020. "The Administrative Presidency, Waivers, and the Affordable Care Act." *Journal of Health Politics, Policy and Law* 45, no. 4: 633–46. https://doi.org/10.1215/03616878-8255553.

Holly, Robert. 2021a. "'A Huge Victory': Home Care Turnover Remains Stable at 65.2%." *Home Health Care News*, May 19. https://homehealthcarenews.com/2021/05/a-huge-victory-home-care-turnover-remains-stable-at-65-2/.

Holly, Robert. 2021b. "Gutted Version of Biden's 'Build Back Better' Plan Still Includes $150 Billion for In-Home Care." *Home Health Care News*, October 28. https://homehealthcarenews.com/2021/10/gutted-version-of-bidens-build-back-better-plan-still-includes-150-billion-for-in-home-care/.

Hudson, Robert B., ed. 2010. "Advancing Home and Community-Based Services: Transforming Policies, Programs, and Service Delivery in Long-Term Care." Special issue, *Public Policy and Aging* 20, no. 1. http://www.advancingstates.org/sites/nasuad/files/hcbs/files/193/9616/PP&AR.pdf.

Kashen, Julie, Anna Wadia, Choua Vue, and Allison Cook. 2023. "Implementing Care Policy Equitably: Lessons from the American Rescue Plan Act." May 16. https://production-tcf.imgix.net/app/uploads/2023/05/16144331/CARE_fund_commentary-23.pdf.

Kaye, H. Stephen, and Joseph Caldwell. 2023. "Excess Deaths of Medicaid Home and Community-Based Services Recipients during COVID-19." *Health Affairs* 42, no. 1: 115–20. https://doi.org/10.1377/hlthaff.2022.00457.

KFF (Kaiser Family Foundation). 2021. "Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19." July 1. https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/.

KFF (Kaiser Family Foundation). 2023a. "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier." https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (accessed October 12, 2023).

KFF (Kaiser Family Foundation). 2023b. "Medicaid Enrollment and Unwinding Tracker." August 8. https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-and-unwinding-tracker/.

Levitsky, Sandra R. 2014. *Caring for Our Own*. New York: Oxford University Press.

Manz, Jodie. 2022. "States Use American Rescue Plan Act Funds to Strengthen Home and Community-Based Services Workforce." National Academy for State Health Policy, April 1. https://nashp.org/states-use-american-rescue-plan-act-funds-to-strengthen-home-and-community-based-service-workforce/.

McGarry, Brian E., and David C. Grabowski. 2023. "Medicaid Home and Community-Based Services Spending for Older Adults: Is There a 'Woodwork' Effect?" *Journal of the American Geriatrics Society*, June 16. https://doi.org/10.1111/jgs.18478.

Miller, Edward A., and Lisa Beauregard. 2023. "Enhancing Federal Revenue under the American Rescue Plan Act: An Opportunity to Bolster State Medicaid Home and Community-Based Services programs." *Journal of Aging and Social Policy* 35, no. 3: 287–301. https://doi.org/10.1080/08959420.2021.2022952.

Murray, Caitlin, Alena Tourtellotte, Debra Lipson, and Andrea Wysocki. 2021a. "Medicaid Long-Term Services and Supports Annual Expenditures Report: Federal Fiscal Years 2017 and 2018." Centers for Medicare and Medicaid Services, January 7. https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures-2017-2018.pdf.

Murray, Caitlin, Alena Tourtellotte, Debra Lipson, and Andrea Wysocki. 2021b. "Medicaid Long-Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2019." Centers for Medicare and Medicaid Services, December 9. https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf.

Murray, Kate, Merle Edwards-Orr, Highsmith Rich, Molly Morris, and Kathleen Ujvari. 2021. "Paying Family Caregivers to Provide Care during the Pandemic." AARP, February 4. https://www.aarp.org/content/dam/aarp/ppi/2021/02/ltss-choices-paying-family-caregivers-to-provide-care-during-the-pandemic-and-beyond.pdf.coredownload.pdf.

Nadash, Pamela, Eileen J. Tell, and Taylor Jansen. 2023. "What Do Family Caregivers Want? Payment for Providing Care." *Journal of Aging and Social Policy*, January 23. https://doi.org/10.1080/08959420.2022.2127599.

NAMD (National Association of Medicaid Directors). 2023. "The End of Pandemic-Era Flexibilities in Medicaid Home- and Community-Based Services: What Agency Leaders Need to Know." March 29. https://medicaiddirectors.org/resource/the-end-of-pandemic-era-flexibilities-in-medicaid-home-and-community-based-services-what-agency-leaders-need-to-know/.

Nanda, Mehak, and Rajesh Sharma. 2021. "A Review of Patient Satisfaction and Experience with Telemedicine: A Virtual Solution during and beyond COVID-19 Pandemic." *Telemedicine Journal and E-Health* 27, no. 12: 1325–31. https://doi.org/10.1089/tmj.2020.0570.

Pierson, Paul. 1993. "When Effect Becomes Cause: Policy Feedback and Political Change." *World Politics* 45, no. 4: 595–628. https://doi.org/10.2307/2950710.

Thompson, Frank J., and Courtney Burke. 2007. "Executive Federalism and Medicaid Demonstration Waivers: Implications for Policy and Democratic Process." *Journal of Health Politics, Policy and Law* 32, no. 6: 971–1004. https://doi.org/10.1215/03616878-2007-039.

Thompson, Frank J., and Courtney Burke. 2009. "Federalism by Waiver: Medicaid and the Transformation of Long-Term Care." *Publius: The Journal of Federalism* 39, no. 1: 22–46. https://doi.org/10.1093/publius/pjn026.

Thompson, Frank J., Pamela Nadash, Michael K. Gusmano, and Edward A. Miller. 2016. "Federalism and the Growth of Self-Directed Long-Term Services and Supports." *Public Policy and Aging Report* 26, no. 4: 123–28. https://doi.org/10.1093/ppar/prw020.

Tolbert, Jennifer, and Meghanna Ammula. 2023. "10 Things to Know about the Unwinding of the Medicaid Continuous Enrollment Provision." Kaiser Family Foundation, June 9. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/.

Tyler, Denise A., Marie R. Squillace, Kristie A. Porter, Melissa Hunter, and William Haltermann. 2022. "COVID-19 Exacerbated Long-Standing Challenges for the Home Care Workforce." *Journal of Aging and Social Policy*, November 3. https://doi.org/10.1080/08959420.2022.2136919.

Watts, Molly O'Malley, and Meghana Ammula. 2022. "A Look at Waiting Lists for Home and Community-Based Services from 2016–2021." Kaiser Family Foundation, November 28. https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-home-and-community-based-services-from-2016-to-2021/.

Watts, Molly O'Malley, Alice Burns, and Meghanna Ammula. 2022. "Ongoing Impacts of the Pandemic on Medicaid Home and Community-Based Services (HCBS) Programs: Findings from a 50-State Survey." Kaiser Family Foundation, November 28. https://www.kff.org/medicaid/issue-brief/ongoing-impacts-of-the-pandemic-on-medicaid-home-community-based-services-hcbs-programs-findings-from-a-50-state-survey/.

Watts, Molly O'Malley, MaryBeth Musumeci, and Meghana Ammula. 2022. "Medicaid Home and Community-Based Services: People Served and Spending during COVID-19." Kaiser Family Foundation, March 3. https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-issue-brief/.

White House. 2023a. "Remarks of President Joe Biden—State of the Union Address as Prepared for Delivery." February 7. https://www.whitehouse.gov/briefing-room/speeches-remarks/2023/02/07/remarks-of-president-joe-biden-state-of-the-union-address-as-prepared-for-delivery/.

White House. 2023b. "Remarks by President Biden on His Budget for Fiscal Year 2024." March 9. https://www.whitehouse.gov/briefing-room/speeches-remarks/2023/03/09/remarks-by-president-biden-on-his-budget-for-fiscal-year-2024/.

White House. 2023c. "Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers." April 18. https://www.whitehouse.gov/briefing-room/presidential-actions/2023/04/18/executive-order-on-increasing-access-to-high-quality-care-and-supporting-caregivers/.