Home and Community Based Services (HCBS) Access Act

Section-by-Section

The Home and Community Based Services (HCBS) Access Act updates Medicaid to require coverage of home and community-based services, establish a broad HCBS benefit and eligibility framework, provide enhanced federal funding for qualifying State HCBS investments, require State implementation plans and quality measurement, strengthen protections for beneficiaries and families, recognize the role of direct support professionals, and fund direct care workforce and family caregiver support activities.

SECTION-BY-SECTION

Section 1. Short title; table of contents.

Section 2. Definitions.

- Defines "demographics" for purposes of the Act to include race, ethnicity, gender, sexual orientation, gender identity, geographic location, income, primary language, type of service setting, and disability type.

TITLE I. REQUIRING AND EXPANDING ACCESS TO HCBS COVERAGE UNDER MEDICAID

Section 101. Purpose.

- States that the purpose of Title I is to require coverage of HCBS under state Medicaid plans and expand access to those services for individuals with disabilities and older adults.
- The goals are to eliminate HCBS waiting lists, support community inclusion under the Americans with Disabilities Act, streamline access to HCBS by eliminating the need for State waiver application, expand community service capacity, address disparities in access, support family caregivers, and improve direct care workforce standards.

Section 102. Requiring coverage of home and community-based services under the Medicaid program.

- Adds home and community-based services to the definition of "medical assistance" under Medicaid.
- Creates a new Medicaid definition for HCBS which is covered services furnished to an eligible individual based on an individualized assessment in a qualifying home or community-based setting consistent with federal HCBS settings requirements.
- Specifies covered HCBS benefit categories, including supported employment and integrated day services; personal assistance; services that enhance independence and community inclusion; non-emergency, non-medical transportation; respite; caregiver and family supports; case management; self-direction supports; direct support during acute hospitalizations; necessary medical and nursing services; intensive behavioral health and crisis intervention services; peer support; housing supports; home modifications and assistive technology; transition services; nutrition services; assisted living; and other services approved by the Secretary.
- Requires the Secretary to convene an HCBS advisory panel within 6 months after enactment, and at least every 5 years after, to recommend additional covered HCBS services. The panel must include at least 50 members and be majority-composed of people receiving or needing HCBS, beneficiary-led disability rights organizations, and disability-led organizations, with additional representation from family, aging, workforce, provider, Medicaid, Tribal, and federal stakeholders.
- Requires the advisory panel to submit recommendations to the Secretary and Congress within 2 years after convening. The Secretary must consider the panel's recommendations, use a public notice and comment process, and issue a State Medicaid Director Letter identifying any additional approved HCBS services.

- Defines "eligible individual" to include: individuals determined by an approved health care provider to have a functional impairment expected to last at least 90 days; individuals already receiving or determined eligible for HCBS as of enactment and the 5-year implementation period if they continue meeting applicable level-of-care requirements; and individuals who are eligible under the State plan or a waiver and are under age 21.
- Defines "functional impairment" based on inability to perform, without assistance, either 2 or more activities of daily living (ADLs), 2 or more instrumental activities of daily living (IADLs), or 1 ADL and 1 IADLs.
- Requires individualized assessments to determine needed services and supports, identify needed medical and non-medical services within 30 days of eligibility determination which will be reassessed at least annually and as needed,
- Creates the presumption that eligible individuals can be served in their own home and community with the option to self-direct services.
- Requires the Secretary to establish individualized assessment standards addressing conflict-of-interest protections, assessor qualifications, transparency, evidence-based methodology, public availability and independent validation of assessment tools, language access, low-vision and low-hearing accessibility, nondiscrimination, and identification of services needed for community integration.
- Makes HCBS a mandatory Medicaid benefit beginning on 5 years after enactment and requires coverage for Medicaid-eligible individuals who meet the HCBS eligibility definition and elect to receive HCBS.
- Provides a 100 percent federal medical assistance percentage for HCBS expenditures, including services furnished under section 1915 or 1115 waivers, for States that meet specified access and infrastructure requirements. These requirements include lowering access barriers, operating a "No Wrong Door" program, providing presumptive eligibility and HCBS counseling, supporting family caregivers, ensuring adequate payment rates, passing rate increases through to direct care workers, updating provider qualification and training standards, and establishing infrastructure for self-directed care models.
- Provides an 80 percent federal match for specified administrative costs related to expanding and enhancing HCBS for the first year during which the enhanced HCBS FMAP subsection is implemented and the succeeding four years. Eligible administrative costs include Medicaid data and technology infrastructure, rate-setting processes, quality reporting, training programs, and self-directed care infrastructure.
- Requires States to establish or contract with nonprofit entities for a program supporting self-directed models of care. The program must register qualified direct care workers, help beneficiaries find workers, recruit and train independent providers, conduct background checks and address complaints, coordinate public health and program communications, support payroll and claims functions, facilitate enrollment of family caregivers where permitted, and maintain policies that cooperate with or remain neutral toward labor organizations representing direct care workers.

Section 103. Medicaid eligibility modifications.

- Creates a new mandatory Medicaid eligibility category for eligible individuals under this bill's new HCBS definition, who are not otherwise eligible for Medicaid and income does not exceed the greater of 150 percent of the federal poverty line (FPL) or 300 percent of the Supplemental Security Income (SSI) benefit rate, beginning 5 years after enactment or earlier at State option.
- Creates a new optional Medicaid eligibility category for eligible individuals who would qualify under the new mandatory category except that their income exceeds the mandatory income threshold but is below a higher income level established by the State.

- Revises retroactive eligibility rules for HCBS so covered services can be available in or after the third month before the month of application when the individual was, or would have been, eligible at the time services were furnished. The provision also clarifies that services may be available regardless of whether a service plan or similar document was developed before or after the services were provided.
- Makes conforming amendments to alternative benefit plan provisions so individuals in the new HCBS eligibility categories are treated consistently for purposes of medical frailty and benefit protections.

Section 104. Home and community-based services implementation plan.

- Requires States, before mandatory HCBS coverage takes effect or earlier at State option, to submit an HCBS implementation plan to the Secretary.
- Requires each plan to explain how the State will operationalize the eligible individual definition and functional impairment determinations.
- Requires each plan to describe the State's direct care workforce, including number of workers, wages or service payments, benefits, turnover and vacancy rates, and steps to ensure a stable, high-quality workforce with sufficient compensation and worker supply.
- Requires each plan to compare current State Medicaid HCBS coverage and utilization by demographic group against the services required by the Act, and to set numerical goals to increase access where differences exist.
- Requires States to describe how they will integrate existing disability and aging agencies into a unified HCBS system; conduct outreach and education, including a No Wrong Door program; coordinate with housing, transportation, child welfare, food and income security, and employment agencies; and consult with Indian tribes, Indian health programs, and urban Indian health organizations where applicable.
- Requires States to describe how they will build capacity before implementation so services are available to every eligible individual, ensure adequate provider networks and provider choice, comply with HCBS setting requirements, prioritize individuals already on waiting lists, protect medically frail individuals in alternative benefit plans, coordinate with other disability eligibility programs, set data and milestone requirements for community integration, and evaluate and address disparities.
- Provides a 100 percent federal match for State costs attributable to developing the required implementation plan.

Section 105. Quality of services.

- Requires the Secretary, within 1 year after enactment and in consultation with State Medicaid Directors, to develop standardized State-level metrics regarding access to and satisfaction with providers for Medicaid enrollees, including primary care and specialist providers.
- Requires the metrics to be broken down by demographics and to include the number of Medicaid enrollees who required the level of care provided in a nursing facility, intermediate care facility for individuals with intellectual disabilities, institution for mental disease, or similarly restrictive or institutional setting.
- Requires the Secretary to develop the metrics through a public process with stakeholder participation and to update the metrics at least every 3 years.
- Allows the Secretary to award State implementation funding for the metrics and appropriates $200 million for fiscal year 2027, to remain available until expended.

Section 106. Reports; technical assistance; other administrative requirements.

- Requires the Secretary to submit an interim report to Congress within 2 years after enactment describing State efforts to develop HCBS implementation plans and funds awarded for related administrative costs.
- Requires a first implementation report within 4 years after enactment describing approved implementation plans, national gaps in HCBS coverage and access, disparities and barriers, utilization, and the national direct care workforce landscape, including compensation, benefits, and workforce availability challenges.
- Requires subsequent reports within 7 years after enactment and every 3 years thereafter describing State funding, progress in expanding HCBS and the direct care workforce, quality measure outcomes, beneficiary and family caregiver survey results, challenges, and best practices.
- Requires the Secretary to provide technical assistance to States on implementation plans, HCBS access requirements, benchmarks, quality reporting, and tracking availability of HCBS over time, and to issue necessary guidance or regulations.
- Requires the Secretary, in coordination with the Secretary of Labor and CMS, to issue recommendations within 18 months after enactment on strengthening the direct care workforce, including federal workforce classification, competitive wages and benefits, and training opportunities.
- Requires stakeholder consultation for the workforce recommendations, including recipients of HCBS, family caregivers, providers, health plans, direct care workers, chosen worker representatives, educational agencies, and aging, disability, and workforce advocates. The consultation must include at least one meeting solely with current and potential HCBS recipients and family caregivers, and seek parity between those voices and other stakeholder categories.
- Appropriates $10 million for fiscal year 2027, to remain available until expended, to carry out this section.

Section 107. Quality measurement and improvement.

- Requires the Secretary to identify and publish core and supplemental sets of HCBS quality measures for use by State Medicaid programs, Medicaid managed care entities and health plans, and providers.
- Requires the Secretary to review and update the measure sets at least annually, in collaboration with appropriate subagency heads and with stakeholder input. The bill sets a goal that at least half of the input come from current and potential HCBS recipients and family caregivers.
- Requires the measure sets to reflect the full array of HCBS and recipients, including adults and children, and to include outcomes-based measures, service availability, provider capacity and availability, person-centered care, self-directed care, transitions to and from institutional care, beneficiary and family caregiver surveys, and measures related to disparities by race, ethnicity, language, sex, gender identity, geography, and other demographic factors.
- Requires the measure sets to allow data collection disaggregated by demographics and appropriates $10 million for fiscal year 2027, to remain available until expended, to develop the measures.
- Requires State Medicaid programs, within 2 years after publication of the measure sets and annually thereafter, to use the core and supplemental measure sets, or an alternative set approved by the Secretary, to report HCBS quality information in a standardized format.
- Requires States to make reported quality information publicly available each year and provides an 80 percent federal match for State costs attributable to HCBS quality reporting.
- Requires each State to establish an independent HCBS ombudsman office to assist beneficiaries and families with access to HCBS and report systemic problems to State officials, the public, and the Secretary.

Section 108. Making permanent the extended protection under Medicaid for recipients of home and community-based services against spousal impoverishment.

- Makes permanent Medicaid spousal impoverishment protections for HCBS recipients by applying the protection to individuals who are eligible individuals under the new HCBS definition.
- Makes a conforming amendment to replace the current statutory expiration date with the date of enactment of the HCBS Access Act.

Section 109. Permanent extension of Money Follows the Person Rebalancing Demonstration.

- Permanently extends the Money Follows the Person Rebalancing Demonstration by providing funding for fiscal year 2024 and each fiscal year thereafter.

Section 110. Liens, adjustments, and recoveries for medical assistance.

- Requires States, within 90 days after enactment, to withdraw certain Medicaid liens imposed before enactment and notify affected individuals or legal representatives of the withdrawal.
- Prohibits States from initiating, maintaining, or collecting adjustments or recoveries for medical assistance correctly paid on behalf of an individual under the State plan on or after enactment.
- Requires States, within 90 days after enactment, to withdraw any lien in effect with respect to correctly paid medical assistance and notify affected individuals or legal representatives of both the withdrawal and the prohibition on adjustment or recovery.

Section 111. HCBS provider tax.

- Adds home and community-based services as a class of health care items and services for purposes of Medicaid provider tax rules.
- Clarifies that certain provider tax transition rules apply to classes of health care items and services other than the newly added HCBS class.

Section 112. Medicare amendment.

- Amends the Medicare Part D low-income subsidy provision to update cross-references related to Medicaid HCBS eligibility and waiver or State plan amendment authorities.

TITLE II. RECOGNIZING THE ROLE OF DIRECT SUPPORT PROFESSIONALS

Section 201. Findings.

- Recognizes the critical role of direct support professionals in care for children and adults with intellectual and developmental disabilities.
- States that HCBS providers face difficulty hiring and retaining direct support professionals, including a 39 percent national turnover rate identified in a 2023 National Core Indicators study, and that high turnover can destabilize care and undermine independent living goals.
- Finds that a discrete occupational category for direct support professionals would improve federal and State understanding of workforce shortages, support data collection on turnover, correct inaccurate representation in the Standard Occupational Classification system, recognize the distinct work of direct support professionals, and better align workforce classification systems.

Section 202. Revision of Standard Occupational Classification system.

- Requires that the Director of the Office of Management and Budget, as part of the first Standard Occupational Classification revision process after enactment, to consider establishing a separate code for direct support professionals as a subset of healthcare support occupations.
- Requires the OMB Director to report to Congress within 30 days after announcing the final revision decision if the Director decides not to establish the separate code, explaining why the code was not established.

TITLE III. SUPPORT FOR THE DIRECT CARE WORKFORCE

Section 301. Definitions.

- Defines terms used in Title III, including apprenticeship program, community college, direct care professional, direct care workforce, eligible entity, employer, family caregiver, Indian Tribe, Tribal organization, institution of higher education, older adult, person with a disability, project participant, Secretary, self-directed care professional, supportive services, urban Indian organization, Workforce Innovation and Opportunity Act terms, and work-based learning.
- Defines "direct care professional" broadly to include workers who, in exchange for compensation, provide services to a person with a disability or older adult that promote independence, community inclusion, self-expression, personal goals, independent living, employment or volunteer participation, activities of daily living, support in community settings, and health and wellness.
- Clarifies that direct care professionals include providers supporting people with intellectual disabilities, developmental disabilities, or other disabilities; HCBS managers or direct support professional managers; self-directed care workers; personal care service workers; direct care workers as defined in the Public Health Service Act; and other home care or direct care workforce positions determined by the Secretary in consultation with CMS and the Department of Labor.
- Defines eligible entities to include States; labor organizations, joint labor-management organizations, and employers of direct care professionals; organizations or nonprofits with aging, disability, direct care, or family caregiver expertise; Indian Tribes, Tribal organizations, and Urban Indian organizations; community colleges and institutions of higher education; and consortia of these entities.
- Requires eligible entities, as applicable, to include older adults, people with disabilities, direct care professionals, and family caregivers as advisors and trainers, and to consult with relevant State Medicaid agencies unless the agency is the eligible entity.

Section 302. Authority to establish a technical assistance center for building the direct care workforce.

- Requires that the Secretary, in consultation with the Secretary of Labor, the Secretary of Education, CMS, and other appropriate entities, establish a national technical assistance center.
- Directs the Center to support direct care workforce creation, training and education, recruitment, retention, and advancement, and to support family caregivers as a critical part of the support team for older adults and people with disabilities.
- Requires that the Secretary establish an advisory council to provide recommendations to the Center and allows the Secretary to engage individuals and entities described in the project plan provisions for service on the advisory council.
- Authorizes the Center to develop recommendations for direct care training and education curricula, higher education curricula, postsecondary credentials, and community college programs; develop learning and dissemination strategies for grant-supported activities and related best practices; support family caregiver curricula and strategies; explore national workforce data gaps and shortage areas; recommend a Standard Occupational Classification category for direct care professionals; recommend career development and advancement opportunities such as occupational frameworks, national standards, recruitment campaigns, pre-apprenticeships, on-the-job training, apprenticeships, career ladders, certifications, and other activities; and develop strategies to assist grant reporting and evaluation.

Section 303. Authority to award grants.

- Requires that the Secretary, within 12 months after enactment of Title III and in consultation with CMS, the Department of Labor, and the Department of Education, award grants to eligible entities.

- Establishes four grant categories: direct care professional grants; direct care professional manager grants; self-directed care professional grants; and family caregiver grants.
- Allows grants to support recruiting, retaining, and providing advancement opportunities, including through education and training programs, for direct care professionals, direct care professional managers or supervisors, and self-directed care professionals.
- Allows family caregiver grants to support paid or unpaid family caregivers through education, training, self-care, and other resources, including resources for individuals newly in a caregiving role or seeking additional support.
- Requires at least 30 percent of projects assisted under Title III to provide career pathways that offer professional development and advancement opportunities to direct care professionals.
- Allows eligible entities already carrying out qualifying activities before receiving a grant to use grant funds to continue those activities, with those activities treated as grant-supported projects.

Section 304. Project plans.

- Requires eligible entities seeking grants to submit project plans to the Secretary in the form and manner required by the Secretary.
- Requires project plans to describe demographics and projected long-term care needs in the State or relevant geographic area; projections of unmet need for direct care services; relevant direct care workforce data, including vacancy and separation rates; and the number of direct care professionals and managers in the region.
- Requires information on an advisory committee to advise on the activities the entities will do.
- Requires plans to describe current or projected job openings or labor market information, geographic scope, strategies to reduce barriers to recruitment, retention, and advancement, and assessments of wages, compensation, benefits, workplace safety issues, and personal protective equipment.
- Requires education or training projects for direct care professionals to incorporate CMS core competencies, curricula, models, standards, and credentials where applicable, and to provide training on HCBS recipient rights, integrated settings, self-determination, freedom from abuse, neglect, and exploitation, person-centered planning, recognizing and reporting abuse, and culturally and disability competent supports.
- Requires applicable programs to include apprenticeship, work-based learning, or on-the-job training opportunities; supervision or mentoring; and, for on-the-job training, a progressively increasing wage schedule tied to skills or credentials and not below applicable federal, State, or collectively bargained wage requirements.
- Requires plans to describe innovative retention and advancement models, supportive services and benefits, career planning, workforce data collection and reporting, safe equipment and facilities, remote and technology-supported training opportunities, adult learner and universal design practices, recipient participation in curriculum development, diverse outreach and retention strategies, satisfaction monitoring, family caregiver engagement, and continuing education or specialty training in areas such as trauma-informed care, behavioral health, Alzheimer's and dementia care, chronic disease management, and assistive technology.
- Requires coordination or consultation with State Medicaid agencies, aging agencies, developmental disability offices, workforce boards, curriculum organizations, direct care workforce or family caregiver organizations, Area Agencies on Aging, Centers for Independent Living, State Councils on Developmental Disabilities, Aging and Disability Resource Centers, provider associations, employers, University Centers for Excellence in Developmental Disabilities, protection and advocacy systems, and workforce organizations representing underserved communities, as applicable.

- Requires consultation throughout the project with the workers or caregivers targeted by the project, their representatives, individuals assisted by them, families, and individuals in training.
- Requires outreach to individuals receiving or eligible for TANF-funded assistance and individuals with barriers to employment.
- Directs the Secretary, in selecting grantees, to ensure equitable geographic diversity, including rural and urban areas, and to select entities serving areas where direct care or related occupations are in-demand sectors or occupations.
- Requires grantees to use funds for at least one authorized project, limits administrative costs to 5 percent, requires at least 5 percent of funds to provide direct financial benefits or supportive services to project participants, requires funds to supplement and not supplant existing government funds, and prohibits use of funds for activities subject to certain labor-management reporting requirements.

Section 305. Evaluations and reports; technical assistance.

- Requires grant recipients submit annual reports with relevant data requested by the Secretary.
- Authorizes the Secretary to request data on the number and demographics of individuals served; individuals recruited for, obtaining, or not completing direct care professional employment; family caregivers participating in education or training; completion of work-based learning, on-the-job training, apprenticeship, professional development, or mentoring; other services and supports provided; crude separation and vacancy rates in the geographic area; participant, service recipient, and employer satisfaction; employment, earnings, credential attainment, skill gains, employer satisfaction, and other outcomes.
- Requires the Secretary to submit an annual report to Congress, beginning not later than 2 years after enactment and continuing until all grant projects are completed, on project progress, and activities of the technical assistance center.
- Requires GAO, within 1 year after all grant projects are completed, to report to Congress on how the technical assistance center and grant projects assisted direct care workforce creation, recruitment, training and education, retention, advancement, and family caregiver support, and to recommend legislative or administrative improvements.
- Requires the Secretary, within 6 months after enactment of Title III, to contract with an independent entity to evaluate grant-supported activities and technical assistance center activities.

Section 306. Authorization of appropriations.

- Authorizes $2 million for each of fiscal years 2029 through 2030 for the establishment and activities of the technical assistance center.
- Authorizes $1 billion for fiscal year 2029 for grants under section 303.
- Provides that amounts made available under Title III remain available through September 30, 2038.

TITLE IV. EVALUATION

Section 401. Evaluation of impact on access to HCBS.

- Requires the CMS Administrator, in coordination with the National Academy of Medicine, to conduct or contract for a national survey within 7 years after enactment of States, direct care professionals, family caregivers, providers, and recipients of HCBS.
- Requires the survey to examine the effects of the Act on Medicaid HCBS availability and access nationally and by State; direct service workforce capacity and demographics; direct care worker compensation and working conditions, including scheduling and benefits; economic effects on beneficiaries and families; availability of direct care workers and services for people needing long-term services and supports who are not Medicaid eligible; family caregivers; and recommendations to further expand and enhance HCBS access.

- Requires the CMS Administrator to publish a report with the survey results within 9 years after enactment.
- Requires the Secretary of Commerce, through the Census Bureau, to add a question to the American Community Survey designed to identify the need for long-term services and supports among U.S. residents.
- Authorizes such sums as may be necessary to carry out the section.