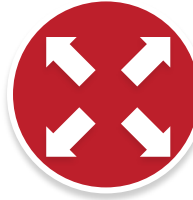


## Expanding Access to HCBS for “Pre-Medicaid” Individuals to Prevent or Delay Nursing Facility Utilization: A Strategy for Strengthening Long-Term Services and Supports

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While a significant proportion of the population will require long-term services and supports (LTSS) at some point, only a small subset actually plan for this eventuality before the need arises. Instead, most people enter the system during a crisis that is often preceded by an acute health care episode. When this happens, those in need of LTSS are often surprised to learn that Medicare and private insurance coverage do not pay for these services. As a result, many people pay out of pocket for LTSS, and at some point they “spend down” their income and assets on services and qualify for Medicaid. Spending down to meet Medicaid eligibility is complicated and expensive, and can create uncertainty for individuals since coverage for home- and community-based services (HCBS) can vary across states.

Reliance on Medicaid for LTSS by a rapidly aging population also increases state and federal Medicaid costs, even beyond the costs of LTSS; once an individual reaches the spend down threshold, that person becomes eligible for full Medicaid benefits. Thus, states pursuing this strategy are seeking to provide supports to likely future Medicaid beneficiaries before they spend-down to Medicaid eligibility, not only to improve beneficiaries’ quality of life, but also to decrease LTSS spending for both beneficiaries and the state.

### ► Strategy Description

To address these issues, a growing number of states, including Washington and Vermont, are expanding access to HCBS for people at-risk of needing nursing facility care who would otherwise not yet qualify for Medicaid-financed LTSS. The goal is to prevent or delay their needing more intensive and more costly LTSS.<sup>1</sup>

Washington is providing a limited set of Medicaid-financed LTSS benefits—including specialized medical equipment, respite care, and assistance with housework, errands, and home-delivered meals—to individuals age 55 and older who are otherwise at-risk of becoming eligible for Medicaid in order to access LTSS. Similarly, Vermont provides limited Medicaid-financed LTSS benefits—including

## More LTSS Reform Strategies

Long-term services and supports (LTSS) enable more than 12 million Americans to meet their personal care needs and live with dignity and independence in a variety of community and institutional settings. With Medicaid LTSS expenditures of more than \$154 billion annually and the aging population projected to grow 18 percent by 2020, the increasing demand for LTSS is putting more pressure on Medicaid.

This LTSS reform strategy is part of a larger toolkit, *Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment*, which provides a menu of LTSS reform strategies adopted by state innovators that may be replicated by other states. It identifies concrete policy strategies, operational steps, and federal and state authorities that states have used to advance their LTSS reforms.



To learn more and view the full toolkit, visit [www.chcs.org/ltss-toolkit](http://www.chcs.org/ltss-toolkit).



case management, homemaker, adult day services, and flexible funding to promote independent living (e.g., personal emergency response systems or home modifications)—to pre-Medicaid eligible adults who are assessed as having “moderate needs” to prevent their decline into a higher need category. States use different risk stratification methods for identifying individuals at-risk of nursing facility care who are eligible for the programs.

## ► Implementation Mechanisms

Washington is using an 1115 waiver—one part of a comprehensive 1115 waiver approved by CMS in early 2017—to expand access to HCBS services for “pre-Medicaid” individuals, funded by Medicaid service dollars. Vermont also uses an 1115 waiver to administer its Choices for Care program, within which it expanded access to LTSS for “moderate need” individuals, leveraging 1115 waiver funding in place of state-only dollars to cover the moderate needs group’s services. Under the Choices for Care Moderate Needs Group program, applicants do not need to be eligible for Medicaid, but must have income no greater than 300 percent of the SSI Federal Benefit Rate (FBR) and meet an asset test.<sup>2</sup>

## ► Results to Date

Vermont partnered with UMass Medical School to annually evaluate the Choices for Care program. The most recent evaluation (published May 2015) found that Choices for Care increased access to HCBS and enabled people to be served in the care setting of their choice.<sup>3</sup> The state has been able to provide services without a waitlist to its “high needs” group, but as of January 2018, there were over 800 individuals on the “moderate needs” waitlist, an area on which the state is continuing to focus its efforts while remaining budget neutral. In 2018, Vermont implemented the first round of its National Core Indicators-Aging and Disabilities (NCI-AD) survey, which will measure consumer perception and alignment with federal HCBS regulations. The first results from the survey will be available in January 2019.<sup>4</sup>

Washington’s waiver was only implemented in September 2017, so outcomes will be evaluated in the future. However, as part of the evaluation protocol that was approved by CMS, the state will track both individual and caregiver outcomes for both the new Medicaid Alternative Care and Tailored Supports for Older Adults benefits, described in the Washington case study below. The state also will evaluate impacts to Medicaid expenditures.

## ► Key Lessons

- **Engage providers, beneficiaries, legislators, and other stakeholders early and often.** In both Washington and Vermont, early and frequent stakeholder engagement was key. Washington began stakeholder events two years prior to its 1115 waiver approval, holding at least seven in-person, public meetings related to the Medicaid Alternative Care and Tailored Supports for Older Adults benefits. Washington also recently initiated a service experience team, in which

beneficiaries and advocates meet to give input on how to improve programs in a collaborative setting focused specifically on understanding beneficiaries' perspectives.<sup>5</sup> In Vermont, the Department of Disabilities, Aging and Independent Living worked diligently to gain community providers' buy-in, assuring them that the existing state funding that it sought to repurpose would be returned in the form of Medicaid covered services. The department also worked closely with its state leadership, who were wary of how the state would manage the transition to more community-based care and how any savings would be spent. To address this, the state defined program savings in its annual budget bill and permitted savings to be reinvested into HCBS if they exceeded more than one percent of state spending on the waiver.

- **Use Medicare and Medicaid data to analyze the nursing facility population and inform program planning.** States can use multiple data sources to identify the target population at-risk for becoming LTSS users and their likely needs. Data on both Medicaid and Medicare beneficiaries should be included, as many of these individuals are over 65 and might be Medicare beneficiaries whose Medicare utilization could indicate worsening health status. Washington's Department of Social and Health Services uses a risk management tool to support resource planning and program design that incorporates Medicaid, Medicare, and other social service data from payment and assessment systems to predict which "pre-Medicaid" individuals will have the greatest expenditures. In designing their programs, both Washington and Vermont identified challenges with how to define their respective "at-risk" and "moderate needs" groups—such as defining population parameters, documenting reporting needs and service use, determining whether individuals had access to similar services in other publicly funded programs, and establishing requirements around spousal impoverishment protections.
- **Educate medical providers about person-centered care to help them understand the impact of HCBS on physical health and well-being.** Vermont noted that while conceptually, medical providers were generally in agreement about the need for expanded HCBS, some felt wary about permitting their patients to engage in what they perceived as "riskier" life choices (i.e., living at home or in a congregate setting versus a more controlled institutional setting). The state found it helpful to educate providers about person-centered, person-directed care and independent living philosophies, encouraging them to allow people to make choices about their care needs and futures.
- **Leverage existing community partners, but expand social networks.** Individuals who are at-risk for becoming Medicaid LTSS users may access social support or other health-related or community-based services for different needs. Community-based organizations or other public entities can be helpful resources for information and service delegation, particularly if individuals already have ties to them. Washington leveraged existing community services to support caregiver activities and delegated some services to Area Agencies on Aging, which has been an important support for program implementation. However, Washington noted difficulties with merging the infrastructure, funding structures, and policies of these entities with Medicaid when their program rules, provider eligibility and payment systems, and other administrative processes did not align with Medicaid requirements or systems.





## ► Case Studies

### Washington Uses 1115 Waiver to Expand Access to Services for Individuals At-Risk of Needing LTSS.

Washington State’s Health Care Authority received CMS approval for its 1115 Waiver, Medicaid Transformation Demonstration, on January 9, 2017. In addition to other systemic reforms that the state advanced through this vehicle, the 1115 waiver created two new LTSS benefit packages and one new eligibility category. Driven by expectations that its population age 65 and over will double in the next 25 years and a desire to create more choices for Washington residents, these LTSS reforms expand access to community-based care and supports for individuals who are at-risk of needing LTSS to prevent further deterioration, higher service utilization, and delay or prevent spending down to impoverishment:

- **Medicaid Alternative Care.** This new benefit package provides supports for unpaid caregivers for individuals who are eligible for Medicaid, but not currently using Medicaid-funded LTSS (as well as meeting the age and financial and functional criteria described below). Washington estimates that more than 830,000 people provide unpaid care to relatives and others at a value of nearly five times the overall Medicaid budget. This initiative aims to protect caregiver health and well-being by providing the supports they need to care for loved ones in the home and avoid use of more intensive, expensive services. Services include training, education, support groups, specialized medical equipment, respite, and assistance with housework, errands, and home-delivered meals.
- **Tailored Supports for Older Adults.** This initiative creates a new eligibility category for people “at-risk” of future Medicaid LTSS use who do not meet Medicaid financial eligibility criteria. To be eligible for the “at-risk” category, individuals must be age 55 or older and meet a set of financial and functional criteria (i.e., Nursing Facility Level of Care as determined through an eligibility assessment). They may also seek presumptive eligibility after completion of a prescreening interview. The new set of limited services and supports available is similar to Medicaid Alternative Care supports and serves both unpaid family caregivers and individuals without caregivers in the community.

The state modeled the Medicaid Alternative Care and Tailored Supports for Older Adults benefits after the successful model of care under the state-funded Family Caregiver Support program. The cost per member varies depending on the level of services an individual is receiving, but the state has calculated an upper threshold of \$550/month.

**Vermont’s Choices for Care Waiver Expands HCBS to People At-Risk of Needing Intensive LTSS.** In October 2005, Vermont’s Department of Disabilities, Aging and Independent Living implemented the Choices for Care program—a statewide initiative for older adults and adults with physical disabilities designed to reduce the use of Medicaid institutional services by managing nursing facility admissions and increasing community-based options—under an 1115 waiver to provide equal access to Medicaid LTSS regardless of care setting, a vision shared by stakeholders. Prior to the demonstration, the state only provided LTSS as an entitlement in nursing facilities and very limited HCBS under 1915(c) waivers. At the waiver’s start, only about 30 percent of all participants were receiving care at home or in an institutional care home

(considered an HCBS setting at that time); today, 56 percent of LTSS is provided outside of a nursing facility in home and residential care settings, and the number of individuals served has grown significantly. To help alleviate budget concerns, Vermont negotiated two categories of nursing facility level of care criteria—“highest need” and “high need”—whereby those assessed as “highest need” would always be entitled to LTSS (approximately 75 percent of the Medicaid LTSS population), whereas those assessed as “high need” could be placed on a waitlist if the state encountered budget challenges, allowing the state to maintain some control over its LTSS budget and utilization of services. After engaging in advocacy for several years, Vermont successfully instituted the requirement that the Choices for Care program maintain a one percent budgetary reserve to prevent a high-need waitlist, and any unspent appropriations above that reserve amount must be reinvested into HCBS at year’s end.<sup>6</sup>

In addition to providing LTSS for those most in need of LTSS, Vermont recognized that providing limited Medicaid services to those with “moderate needs” could prevent people from requiring a higher level of care or becoming impoverished to meet financial eligibility rules to qualify for Medicaid. The Department of Disabilities, Aging and Independent Living worked closely with provider partners to whom the state had been paying small grants for homemaker services and adult day services, and repurposed that funding into Medicaid-covered services with mandatory case management to prevent or delay further decline. Services would be available to individuals with incomes at or below 300 percent of the SSI benefit with assets over \$10,000 factored into the income adjustment, and who scored at a “moderate” risk level on the state’s assessment (i.e., do not meet all the Choices for Care clinical criteria for long-term services but are at-risk of institutionalization). To gain provider buy-in and support for the provision of services for at-risk individuals, the state promised partners that it would reinvest the money the providers had been receiving into the limited benefit package for the moderate needs group and reinvest savings to better support providers and entities that provide services for the moderate needs group. Though some participants are Medicaid-eligible, that is not a requirement for people to get these services, as long as they meet the income and asset tests. In 2014, Vermont increased the funding for individuals with moderate needs and added new “flexible funds” services that allow participants to purchase uncovered essential items or to hire a personal caregiver. However, because the moderate needs option is not an entitlement, the state must carefully budget for the services. It does this by setting the budget and permitting providers to serve as many people as possible, placing people on a waitlist if they run out of funding.

Vermont’s LTSS reform efforts are driven by the value the state places on a person’s right to choose where they receive their services and to make informed decisions about their life. That philosophy has led the state to continually find new ways to fund community-based services, such as Adult Family Care and Flexible Choices, and to encourage people to actively participate and be fully-informed about their care planning process.



## ENDNOTES

<sup>1</sup> M. O'Malley Watts, M. Musumeci, and P. Ubri. "Medicaid Section 1115 Managed Long-Term Services and Supports Waivers: A Survey of Enrollment, Spending, and Program Policies". The Kaiser Family Foundation. January 31, 2017. Available at: <https://www.kff.org/report-section/medicaid-section-1115-managed-long-term-services-and-supports-waivers-key-findings/>.

<sup>2</sup> Case study update from Vermont, September 14, 2018.

<sup>3</sup> L. Long-Bellil, C. Cumings, A. Henry, W. Trafton. "Vermont Choices for Care: Evaluation of Years 1-9." University of Massachusetts Medical School, Commonwealth Medicine, May 2015. Available at: [http://asd.vermont.gov/sites/asd/files/documents/Choices\\_for\\_Care\\_Evaluation\\_Report\\_May2015.pdf](http://asd.vermont.gov/sites/asd/files/documents/Choices_for_Care_Evaluation_Report_May2015.pdf).

<sup>4</sup> Case study update from Vermont.

<sup>5</sup> Interview with Washington, October 4, 2017.

<sup>6</sup> Case study update from Vermont.