IMPROVING THE HEALTH AND WELL-BEING OF THE NATION'S AGING POPULATION

Considerations for Governors

NGA
NATIONAL GOVERNORS ASSOCIATION

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EXECUTIVE SUMMARY

The U.S. population is aging rapidly, with 10,000 adults turning 65 every day. As individuals age and live longer than ever before, the need for long-term services and supports (LTSS) will continue to grow. LTSS assists people who have functional or other limitations with activities such as bathing, eating and medication management through a variety of medical and personal care services delivered in the home, community, or residential facilities such as nursing homes. Some studies estimate that as many as two-thirds of adults over 65 years of age will need LTSS at some point in their older years.[1] In addition to older adults, many younger people with physical, intellectual or developmental disabilities also require LTSS to maintain their health and well-being.

Addressing the needs of these populations relies heavily on state Medicaid programs, which together are the largest payer of LTSS in the United States. The onus on Medicaid to ensure access to LTSS for a growing population comes at a time when states are managing tight budgets, of which Medicaid spending is already a significant portion. To meet this challenge, it is critical that states learn from one another about innovative and sustainable strategies that work to effectively manage the health, well-being and costs of their growing LTSS populations.

On June 27, 2018, the National Governors Association Center for Best Practices (NGA Center) Health Division hosted an expert roundtable in Washington, D.C. on state strategies for improving the health and well-being of aging and disabled populations. Several dozen state and national LTSS experts representing health plans, providers, consumers and research institutions discussed key challenges and opportunities for states to better serve individuals with LTSS needs while reducing the cost to individuals, families and public programs. States participating in the roundtable included **Arizona**, **Delaware**, **Michigan**, **Pennsylvania**, **Vermont**, **Washington** and **Wyoming**. This report summarizes the key takeaways and considerations that emerged during the roundtable and subsequent discussions.

Key Considerations for Governors

Governors can play a key role in building more efficient, high-quality systems of care for older adults and individuals with disabilities who have LTSS needs. As the largest payer of LTSS in the United States, Medicaid is critical to ensuring the health and well-being of some of the nation's most vulnerable populations. Given this role, it is important for governors to take an active role in preparing their state to meet the growing LTSS needs of older adults and people with disabilities.

The considerations that follow offer insights for governors and other state leaders as they design and implement strategies to best meet the needs of their state's LTSS populations. The report provides greater detail on each consideration as well as state examples raised during an NGA Center roundtable in June 2018. These considerations reflect important insights that states and other experts shared, but they do not represent the full scope of issues or opportunities governors can consider when charting a path forward.

Coordinating Long-Term Services and Supports with Medical Care

Governors seeking to optimize care by better coordinating LTSS with medical care may consider:

- The implementation timeline, existing provider networks and state capacity to effectively manage health plan contracting if pursuing a managed LTSS program.
- Effective provider-led models as opportunities to coordinate and improve care for older adults and individuals with disabilities.

Integrating Care for the Dual-Eligible Population

Governors seeking to better align care and reduce administrative barriers for individuals dually eligible for Medicare and Medicaid may consider:

- Lessons learned from state and federal demonstrations to align financing, benefits and administration.
- Leveraging contracts with Medicare Advantage Dual Eligible Special Needs Plans.
- Engaging federal partners and other stakeholders to develop approaches that may require new authorities.

Supporting At-Risk Populations and Limiting Medicaid "Spend Down"

Governors seeking to support at-risk populations and limit the need for individuals to spend down their assets to qualify for Medicaid LTSS coverage may consider:

- Providing targeted services and supports for individuals with LTSS needs and their caregivers, including those who do not qualify for Medicaid.
- Innovative strategies to advance affordable long-term care insurance options as an alternative to Medicaid.

Addressing Barriers to Home and Community-Based Services

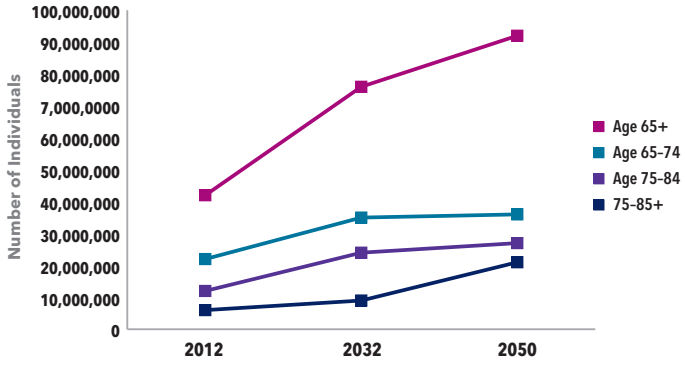
Governors seeking to ensure access to home and community-based services may consider:

- Strategies to address home and community-based services workforce shortages, such as new training programs, a career ladder for direct care workers and support for family caregivers.
- Partnerships to ensure that individuals have access to timely and accessible transportation, such as ride-sharing services.
- Expansion of housing transition and tenancy-sustaining services to help individuals remain in the community.

BACKGROUND

The U.S. population is aging rapidly. According to the U.S. Census Bureau, the number of adults over 65 years of age will nearly double to 84 million between 2012 and 2050.[2] The number of individuals 85 years of age and older is projected to rise at an even faster rate – from 6 million in 2014 to nearly 15 million by 2040.[3] The growing population of older adults and longer average life spans are expected to drive an increase in total and per-capita public spending on health care services.[4]

The 65 and Over Population Will More Than Double and the 85 and Over Population Will More Than Triple by 2050[5]

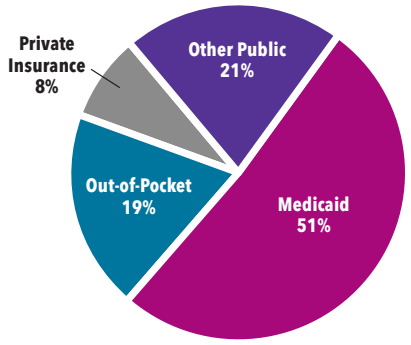


In the United States, Medicaid is the primary payer of long-term services and supports (LTSS), representing more than 50 percent of all LTSS spending. Many associate spending on care for older adults with Medicare, but Medicare's coverage of LTSS is limited, including only brief stays in long-term care (LTC) hospitals; short-term stays in skilled nursing facilities (SNFs); limited, short-duration home health; and some durable medical equipment.

Medicaid LTSS spending far surpasses that of Medicare, other public programs and private insurance. In 2016, Medicaid spent $167 billion on LTSS – approximately 30 percent of Medicaid budgets on average.[6,7] Individuals with LTSS needs also pay for a significant portion of those needs out of pocket, representing approximately 20 percent of all LTSS costs in 2013. However, other analyses suggest that the lifetime costs for individuals 65 and older with LTSS needs equal 53 percent of all LTSS expenditures.[8] Many experts believe that estimates of the financial burden on individuals are conservative and not necessarily representative of direct and indirect costs they and their caregivers incur, such as unpaid labor.[9]

LTSS are primarily delivered in two settings: institutions, such as nursing facilities, and in the home or community. For decades, states and the federal government have worked to increase access to home and community-based services (HCBS), which

Medicaid is the Primary Payer for Long-Term Services and Supports, 2013[10]



Total National LTSS Spending = $310 billion

What are Long-Term Services and Supports?

Many older adults and younger people with physical, intellectual or developmental disabilities have functional limitations and illnesses that require long-term services and supports (LTSS), including nursing or assisted living facility care, home health aide services, personal care services and caregiver supports. LTSS offers medical and personal services to assist individuals with activities of daily living (ADL), including dressing and bathing, as well as instrumental ADL such as preparing meals or medication management.

can be more cost-effective than institutional care and represent the setting of choice for a vast majority of individuals.[11] The transition to delivering more services in homes and in the community has seen significant success. In 2016, HCBS made up 57 percent of total Medicaid LTSS expenditures, up from 1 percent in 1981.[12] Although the delivery of LTSS through HCBS can be more cost-effective, rising demand and increases in the volume of services delivered have placed growing financial pressure on states. The continuing escalation of costs raises concerns about long-term sustainability and potential impacts on quality of care.

In addition to transitioning to HCBS, another more recent trend across states has been the significant growth in managed LTSS (MLTSS). MLTSS involves state Medicaid agencies contracting with managed care organizations (MCOs) for the delivery of LTSS benefits. The number of states with MLTSS has grown from eight in 2004 to 24 in 2019.[13] Managed care is not the only mechanism by which states are seeking to improve care delivery and control costs for individuals with LTSS needs, however. States are implementing an array of approaches, including accountable care organizations (ACOs), medical and health homes and other provider-led models geared toward specific populations, such as individuals who are dually eligible for Medicare and Medicaid and have some of the most complex and costly care needs.

The Critical Role of Gubernatorial Leadership in Connecticut's Long-Term Services and Supports Reform

Governors can play a key role in setting a vision and pathway for long-term services and supports (LTSS) reforms, guided by state agencies and stakeholders. In fact, several governors are leading the way. In Connecticut, data on quality of life and the state's fiscal outlook made a compelling case for a statewide effort to address LTSS quality and the growing demand for services, particularly home and community-based services (HCBS). After tasking state agencies to work with stakeholders and develop a plan, former Governor Dannel Malloy unveiled Connecticut's Strategic Plan to Rebalance Long-Term Services and Supports in 2013, with new investments to support implementation.[14] According to state leaders, the governor's request was key to breaking down silos across state agencies and creating a smoother path to meaningful reform. Fiscal analysis from the University of Connecticut also helped build the case for change and offered an important third-party voice in discussions with legislators and other stakeholders.

KEY ELEMENTS OF CONNECTICUT'S LTSS REBALANCING PLAN INCLUDE:

- **Expanding HCBS options.**
- **Building the capacity of the HCBS workforce by establishing career ladders for direct care workers.**
- **Addressing housing and transportation supports.**
- **Assisting nursing facilities in adapting to the shift to HCBS.**

A stakeholder workgroup made up of advocates, consumers, providers and others that meets regularly has been key to the state's success in developing and implementing the plan, now in its third iteration. To participate in the workgroup, stakeholders must agree on a set of values or core principles, which serve as a baseline for discussions. Providers can participate in workgroups and observe proceedings but are not part of the decision-making steering committee because of concerns about conflicts of interest.

As a result of these efforts, Connecticut has made significant progress in improving quality of life for individuals with LTSS needs. The percentage of individuals receiving HCBS versus institutional care has increased from 52 percent in 2007 to 64 percent in 2018. The state has also seen an increase in the percentage of individuals reporting high levels of well-being and a decrease in unmet personal care needs.[15]

COORDINATING LONG-TERM SERVICES AND SUPPORTS WITH MEDICAL CARE

For decades, states have contracted with MCOs to coordinate and manage primary and acute services for nonelderly, nondisabled adults and children. More recently, several states have begun to shift to managed care for populations that have more complex care needs, such as those requiring LTSS and behavioral health services. Some states see managed care, including MLTSS, as an avenue to improving integration, coordinating services and establishing budget predictability. However, though MLTSS is growing across several states, many other states are employing different models and approaches to enhance care coordination, such as regional or provider-led organizations. In some cases, a combination of methods is used. Ultimately, regardless of which approach a state chooses, fostering seamless coordination across medical services and LTSS is a key aspect of state efforts to improve the quality of care beneficiaries receive and build needed efficiencies into the system.

Considerations for Governors

Governors may consider the implementation timeline, the role of existing provider networks and state capacity to effectively manage health plan contracting if pursuing MLTSS.

In 2019, 24 states operated MLTSS programs, including the nation's four most populous states: **California**, **Florida**, **New York** and **Texas**. Some states have comprehensive managed care plans that provide the full continuum of services – acute, primary, LTSS and behavioral health – while others have established stand-alone, limited-benefit MLTSS plans. Further, variation exists in the populations served through MLTSS. In 2017, an estimated 1.8 million individuals were enrolled in MLTSS across the country, up from 800,000 in 2012.[16] The most frequently served populations under MLTSS are older adults and individuals with physical disabilities.[17] Individuals with intellectual and developmental disabilities have typically been carved out, but this tendency has started to shift as states and MCOs gain additional experience serving special-needs populations.[18]

POPULATIONS INCLUDED IN MLTSS IN 2017[19]

	Older Adults	Physical Disabilities	Intellectual/ Developmental Disabilities	Children with Disabilities
Number of States	22	20	19*	11

*In 2017, 19 states covered individuals intellectual/developmental disabilities (I/DD), although only a handful had both home and community-based services as well as intermediate-care facility for individuals with I/DD services carved in for this population

States pursue MLTSS for a variety of reasons that reflect their economic, demographic and health system dynamics. Some believe that making one entity responsible for the management of LTSS can help achieve key objectives, such as shifting care from institutions that have higher per capita costs to HCBS and reducing wait lists. For certain states, a transition to MLTSS can help overcome challenges related to limited state capacity, particularly with respect to data and information technology infrastructure, because MCOs often have sophisticated systems and significant staff capacity. During the National Governors Association Center for Best Practices (NGA Center) roundtable, participants from **Delaware** noted that, in their state, transitioning to MLTSS was the "only way to make progress" in shifting to a more HCBS-focused delivery system.

Regardless of the factors and rationale for moving to MLTSS, the shift represents significant change for state leaders, and implementation has not been without challenges. Effective change management, sufficient state resources and robust stakeholder engagement are critical to a successful transition. In weighing this approach, governors and state leaders may consider their capacity to manage change and invest the time needed to build relationships with stakeholders.

During the NGA Center roundtable discussion, state and national experts noted that states interested in pursuing MLTSS may want to consider the following points as they design and implement programs:

- ***Successful implementation of MLTSS takes time.*** It is important that states set realistic timeframes for implementing MLTSS, factoring in the time needed to engage key stakeholders, ensure plan and provider readiness, and build reliable management and oversight functions. Participants at the NGA Center roundtable noted that a minimum of 24 months for full implementation is "ideal." States that have experience using managed care for acute services may have a leg up in making the transition to MLTSS. Roundtable participants noted the "cultural shift" required of state agencies in moving to this new delivery system, however. Two states that recently transitioned to MLTSS – **Pennsylvania** and **Virginia** – took a regional, phased-in approach to implementation. Pennsylvania's MLTSS rollout will be completed over three years, with staggered timelines for implementation in different state regions.[20]

- ***Existing provider networks can be leveraged.*** States may consider encouraging or requiring MCOs to take advantage of established HCBS providers, such as Area Agencies on Aging (AAAs).[21] For example, **Ohio** requires that MCOs participating in its demonstration program for dual-eligible beneficiaries partner with AAAs. These and other aging- and disability-focused community-based organizations have critical links to the community and understand the populations they serve. AAAs are also required to serve specific geographic areas, giving them a population health perspective that can help MLTSS providers address supportive services availability in the community. States should be intentional about understanding what provider networks exist and how they can be effectively used in transitioning to a managed care environment. They should also assess billing and other administrative challenges that may exist for community providers who are new to working with Medicaid and private health plans. Coordination and collaboration across state agencies, such as Medicaid and state agencies on aging and disability, can help facilitate this coordination.

- ***Contracts should be carefully structured, with emphasis on monitoring, oversight and evaluation.*** Participants at the NGA Center roundtable agreed that for states to see the greatest success in improving care delivery and quality in a transition to MLTSS, they must effectively use their contracts with MCOs to drive desired outcomes and make course corrections as needed. For example, in Arizona, MCOs receive a blended HCBS/nursing facility capitation rate, creating a financial incentive to serve beneficiaries in lower cost home or community settings. States should be clear about their goals and consider whether additional staff or contractor resources are needed for monitoring, oversight and evaluation. Such capabilities can help ensure that MCOs are meeting established benchmarks and quality targets and that overall program goals are being achieved.

Governors may consider effective provider-led models as opportunities to coordinate and improve care for older adults and individuals with disabilities.

Although many states have transitioned to MLTSS in recent years, not all rely on MCOs to manage care for their LTSS populations. For instance, states are exploring a variety of additional models, such as health homes, Accountable Care Organizations (ACOs), and the Program of All-Inclusive Care for the Elderly (PACE). **Washington** is an example of a non-MLTSS state that has operated managed care for its physical health benefits since 1987 but currently carves out LTSS. The state has been one of the most successful in shifting care away from institutional settings, serving approximately 85 percent of its LTSS population in HCBS settings[22] – far above the median.

Participants at the NGA Center roundtable noted other options for enhancing integration of LTSS and medical care beyond MLTSS. One approach that 31 states currently use at varying levels is PACE, which began in the 1970s as a demonstration program and was later authorized under federal law as a state plan option in 1997. PACE was one of the first programs to coordinate services for individuals dually eligible for Medicare and Medicaid, which today account for about 90 percent of PACE enrollment.[23] To be eligible for PACE, individuals must be 55 or older, require nursing facility-level care and live in an area that a PACE program serves. PACE provides all medical services and LTSS for seniors with chronic health care needs and uses interdisciplinary teams.[24]

The program has good satisfaction rates among those enrolled, and evidence exists that enrollees experience fewer hospital admissions compared with the general dual-eligible

population.[25] On other important metrics, however, results are mixed or data are incomplete. Despite some success, PACE has faced challenges concerning sustainability and scalability. States looking to PACE or similar models as an avenue for fostering integration and coordination of care for LTSS populations should consider common barriers to implementation, which include difficulty generating upfront capital and investor interest, limits on the number of members served because of program design and insufficient enrollment. Nationally, only 45,000 individuals are enrolled in PACE – smaller than a single state's MLTSS program in most cases.

Participants at the NGA Center roundtable also discussed the evolving role of Medicaid ACOs in coordinating LTSS with medical care. ACOs have been implemented widely for medical care across the country in the past decade, but integration of LTSS into those models is a relatively new consideration for state Medicaid programs. At the roundtable, **Vermont** representatives noted that the state is considering a path forward for integration of LTSS in its existing all-payer ACO. **Massachusetts** is pioneering a multifaceted approach to integrating LTSS, physical health and behavioral health through Medicaid ACOs. Through its Section 1115 waiver, the state is establishing Medicaid ACOs that offer a comprehensive array of physical and behavioral health services and a limited number of LTSS, such as short-term nursing facility services and home health. All other LTSS will be integrated in years three and four of the demonstration.[26]

INTEGRATING CARE FOR THE DUAL-ELIGIBLE POPULATION

Dual-eligible individuals are those jointly eligible for the Medicare and Medicaid programs. Of the nearly 11 million dual-eligible people in the United States, roughly 8 million are eligible for full Medicare and Medicaid benefits, while approximately 3 million receive financial assistance from Medicaid to cover Medicare premiums and cost sharing.[27] Dual-eligible individuals are generally some of the most vulnerable and costly individuals Medicaid and Medicare serve, and they often have complex care needs and substantial functional limitations.[28] Serving this population through two separate and complex health care programs creates barriers to care coordination, which in turn can result in higher costs and poor health outcomes. Although dual-eligible people constitute only 15 percent of individuals enrolled in Medicaid, they represent 33 percent of total Medicaid spending.[29]

To help mitigate these challenges, the Centers for Medicare & Medicaid Services (CMS) launched the Financial Alignment Initiative (FAI) in 2011. Under the initiative, CMS' Medicare-Medicaid Coordination Office granted select states waiver authority to pursue a capitated or managed fee-for-service (FFS) model to align financing and administrative functions across programs, such as enrollment, marketing and reporting. In total, 10 states implemented a capitated program, two states selected a managed FFS model and one state pursued an alternative administrative alignment initiative.*

In addition to the FAI, states are pursuing other approaches to improving care and alignment for dual-eligible individuals. Several states are leveraging contracts with Dual Eligible Special Needs Plans (D-SNPs), a type of Medicare Advantage (MA) plan designed to meet the needs of dual-eligible individuals, which must adhere to certain unique requirements. Participants at the NGA Center roundtable discussed this approach as well as other, yet-to-be-tested ideas to better support the needs of this high-cost, high-need population.

*Thirteen states that have or previously operated FAI demonstrations: California, Colorado, Illinois, Massachusetts, Michigan, Minnesota, New York, Ohio, Rhode Island, South Carolina, Texas, Virginia and Washington.

Considerations for Governors

Governors may consider lessons learned from state and federal demonstrations to inform new and innovative state-led efforts.

The FAI demonstrations offered an important opportunity for states and CMS to work together in testing new ways to align financing and integrate service delivery for dual-eligible populations. Participants at the NGA Center roundtable discussed successes and challenges related to the demonstrations and explored interest in new opportunities to partner with CMS in refining or developing new approaches.

Some participants noted that although aligning enrollment, benefits and data across two large, complex programs has been challenging, those efforts have fostered greater collaboration across state agencies and strengthened the partnership between states and CMS. State experience and initial evaluations of the FAI demonstrations point to effective care coordination as the cornerstone of success in some demonstrations.[30] Evaluations of the managed FFS demonstration in Washington, for example, show that targeted case management supported by robust data analytics has yielded promising results in terms of enrollee health outcomes and Medicare savings, which are being shared with the state.[31]

NGA Center roundtable participants also discussed implementation challenges related to state operations and partnering with Medicare, health plans and providers. Enrollment in FAI demonstrations proved to be one of the most difficult challenges, with several states enrolling relatively small percentages of eligible populations. One notable exception is **Ohio**'s demonstration, which outperformed others in enrolling more than 70 percent of those eligible.[32] An analysis of FAI enrollment points to several key factors associated with increased enrollment, including aligning demonstrations with broader state MLTSS programs, beneficiary relationships with care coordinators and passive enrollment processes, which automatically enroll beneficiaries unless they opt out. Limited health plan engagement and lack of support among LTSS providers were associated with lower enrollment.[33]

With the expiration of the FAI demonstrations, states are looking for ways to improve and expand on existing efforts. For example, **Massachusetts** is seeking a Medicaid 1115 waiver to combine the state's two dual-eligible programs – One Care (for dual-eligible individuals under 65 years of age) and Senior Care Options (for dual-eligible individuals over 65 years of age) – with the goal of increasing enrollment, streamlining the member experience and strengthening financial stability and accountability. Notably, the state is also pursuing a more advanced shared savings model with CMS, similar to the one Washington uses, wherein it would receive a retrospective payment for Medicare savings that result from improvements in care coordination and quality. A concept paper has been submitted to CMS and posted for comment.[34]

New Evaluations Highlight Impact of Financial Alignment Initiative Demonstrations

On Nov. 29, 2018, the Medicare-Medicaid Coordination Office released highly anticipated evaluations of five Financial Alignment Initiative demonstrations. The reports include the first evaluations of demonstrations in California, Illinois and Ohio and the second evaluations of demonstrations in Minnesota and Washington. While the evaluations examine limited periods within each demonstration, they highlight some encouraging early trends in utilization, beneficiary experience and Medicare costs as well as areas for improvement. For example, the three evaluations that looked at changes in service utilization (Illinois, Ohio and Washington) showed significant decreases in inpatient hospital use and skilled nursing facility admissions. Demonstrations in Washington and Ohio produced declines in long-stay nursing facility use, while the Illinois evaluation showed a 3 percent increase. With respect to Medicare savings, evaluations in Illinois, Ohio and Washington showed significant reductions in Medicare spending for at least one demonstration period, while the California demonstration yielded no significant savings.[35]

Governors may consider leveraging contracts with Medicare Advantage Dual Eligible Special Needs Plans.

Promoting or requiring alignment between D-SNPs and Medicaid MLTSS is one mechanism states can use to enhance coordination for dual-eligible populations. States can pursue a variety of approaches to foster enrollment in aligned plans. For example, in 2016, **Arizona**'s Medicaid program implemented what is known as "default enrollment" and successfully enrolled 7,000 new dual-eligible individuals in D-SNPs with companion Medicaid MLTSS plans. The state has also sanctioned health plans that have failed to maintain a D-SNP, which is a requirement for Medicaid MCOs. **Arizona** has seen significant benefits to aligning care for dual-eligible individuals, including a 31 percent decrease in hospitalizations, a 43 percent lower rate of days spent in the hospital and a 21 percent lower readmission rate than the Medicare FFS population, according to one study.[36]

As states consider taking steps to enhance alignment between MLTSS and D-SNP plans, it is important to be aware of new flexibilities in the Bipartisan Budget Act of 2018 that may support those efforts.[37] The law permanently authorized D-SNPs and opens the door for MA plans, including D-SNPs, to pay for certain LTSS as optional supplemental benefits, such as adult day health, in-home support and respite care.[38] The extent to which MA plans will provide such benefits remains unclear, but this new flexibility may help foster alignment for dual-eligible populations and potentially offset some LTSS costs for states. In September 2018, CMS announced that approximately 270 of the 3,700 MA plans that will be operational in 2019 will provide supplemental benefits.[39]

Governors may consider engaging federal partners and other key stakeholders to develop innovative approaches that may require new authorities.

Although some avenues currently exist to improve the effectiveness and efficiency of care for dual-eligible individuals, states and other stakeholders are contemplating bold new approaches to further those efforts. Participants at the NGA Center roundtable discussed two ideas that could help empower states to improve care for their dual-eligible populations:

- ***Engage with federal partners to develop arrangements that allow state Medicaid programs to share in Medicare savings.*** Because of the nature of services that Medicare and Medicaid provide, savings on acute medical and LTSS, respectively, that are achieved through better coordination and integration of these services typically accrue to Medicare and not to Medicaid. Consequently, states do not typically benefit from savings that accrue from their investment in alignment and integration. Engaging with federal partners on new ways to align savings with investment under new or existing models could help spur greater action at the state level to drive coordination and improved care for the dual-eligible population.
- ***Engage with federal partners to examine options for states interested in fully integrating financing and care at the state level.*** Participants at the NGA Center roundtable noted that some states may be interested in managing all financing and services for dual-eligible populations, referred to as the "state as integrator model." Under such a voluntary demonstration, states would receive the full financial allotment for their dual-eligible population and assume responsibility for the continuum of services, enabling them to take a more coordinated, whole-person approach to service delivery. Participants noted that CMS has not historically been receptive to this idea.

SUPPORTING AT-RISK POPULATIONS AND LIMITING MEDICAID "SPEND DOWN"

As states continue to grapple with the increasing costs of a growing LTSS population, the importance of upstream solutions is emerging. By implementing strategies that provide needed support to at-risk populations, such as those at risk of significant declines in health or of Medicaid "spend down," states can avoid more costly care down the road. Medicaid "spend down" refers to a pathway to Medicaid eligibility for individuals whose income or assets exceed the Medicaid threshold but who may become eligible over time because of high medical or LTSS expenses. For older adults, the spend down process is commonly precipitated by a hospitalization followed by rehabilitation in an SNF. Individuals frequently stay in the SNF for the 100-day period that Medicare covers, and then they require longer term support. To access LTSS, individuals must either purchase private coverage, which is often unaffordable, or rely heavily on family caregivers and out-of-pocket spending, depleting their personal assets until they reach the Medicaid eligibility threshold. NGA Center roundtable participants discussed strategies some states are adopting to meet individuals further "upstream," limit spend down of assets and delay declines in health status as well as the need for full Medicaid benefits. Participants also discussed bold ideas for enhancing affordable public and private coverage options for LTSS as an alternative to Medicaid.

Considerations for Governors

Governors may consider providing targeted services and supports for individuals with LTSS needs and their caregivers, including those who do not qualify for Medicaid.

Nationwide, there is increasing recognition of the critical role family caregivers play in delivering LTSS for older adults and individuals with disabilities. Family caregivers are essential to slowing declines in health status and the need for individuals to spend down to become eligible for Medicaid. Participants at the NGA Center roundtable highlighted how states are looking for ways to support family caregivers as a critical component of the workforce serving Medicaid enrollees and others with LTSS needs who may become eligible for Medicaid.

Several states, including **Delaware**, **Minnesota**, **Vermont** and **Washington**, have pursued targeted Medicaid benefits for individuals with LTSS needs and their caregivers.[40] The programs vary in whether they serve individuals who are eligible for Medicaid or those who do not yet qualify for Medicaid. At the NGA Center roundtable, Washington officials detailed the new benefits offered to both populations under its 1115 waiver:

- ***Medicaid Alternative Care (MAC).*** MAC is an alternative limited LTSS benefit package available to Medicaid-eligible individuals over 55 years of age who also meet the criteria for nursing facility level of care. MAC is designed to help unpaid caregivers provide quality care and delay the need for more intensive services. Beneficiaries who select this benefit package forgo traditional Medicaid LTSS benefits but can switch out of the more limited package at any time.
- ***Tailored Supports for Older Adults (TSOA).*** TSOA is a limited benefit package, similar to MAC, available to a new eligibility group of individuals over 55 years of age who meet the criteria for nursing facility level of care but are not financially eligible for Medicaid. Individuals who qualify for TSOA can have assets up to approximately $53,000 for an individual or $108,000 for a couple. In addition to caregiver supports, TSOA offers a small personal care benefit for individuals who do not have an unpaid family caregiver to assist them.

States are also looking beyond Medicaid at innovative approaches that can support individuals and their families and help avoid the need to spend down assets to qualify for Medicaid LTSS. In 2017, the **Hawaii** legislature passed a bill establishing the Kupuna Caregivers Program, with $600,000 for implementation. To be eligible, caregivers must work 30 hours or more for individuals 60 years of age or older who do not reside in an LTC facility and have some combination of impaired activities of daily living (ADL), instrumental ADL or cognition. Qualified caregivers can receive up to $70 a day in benefits, pending the availability of funds, to offset health care costs and

pay for meals, transportation and other services.[41] While $70 per day is insufficient to cover intensive LTSS, such as assisted living, the benefit is an important step in enhancing support for family caregivers – one that can help reduce financial burden and limit spend down to Medicaid.

As states look to implement new and innovative programs to serve a growing number of older adults and individuals with disabilities who need LTSS, calculating a return on investment from services delivered and having good data matter more than ever. Establishing new benefit packages – and particularly new eligibility categories – may be difficult to propose given budget constraints and competing funding priorities. The ability to show that new programs can reduce costs or slow cost increases over time may help address those concerns. For example, Washington estimated that MAC and TSOA would result in significant annual savings by their fourth year of operation. As states develop new programs to support caregivers, it is also important that they design adequate mechanisms for oversight.

Governors may consider innovative strategies to advance affordable long-term care insurance options as an alternative to Medicaid.

The lack of adequate and affordable private coverage options for individuals who wish to purchase protection against a possible need for LTSS in the future is a core challenge that leads many to rely on family caregivers or spend down their assets to become eligible for Medicaid. Previous efforts at the national level have focused on trying to establish a dedicated social insurance program for LTSS, but those efforts have been unsuccessful. Difficulties reaching agreement on how to finance such a program have plagued several efforts, including the Community Living Assistance Services and Supports Act, which was repealed in January 2013.[42]

Meanwhile, the high and rising costs of LTSS in nursing homes, where costs average $80,000 a year, and even part-time home care services, which average $25,000 annually, mean that most middle-class individuals with LTSS needs are unable to self-finance their LTSS for any extended period. Significant premium hikes have put traditional private LTC insurance out of reach for most middle-income consumers, and many carriers have exited the market over the past decade, resulting in less competition and fewer viable product options.

To address this challenge, NGA Center roundtable participants noted novel arrangements that states can consider with insurance companies to create supplemental packages of LTSS benefits. For example, **Minnesota** has embarked on an initiative to analyze how to price and launch more affordable private LTSS products for households making $50,000 to $125,000 per year. The state is now considering an enhanced home care benefit that would be embedded in MA and supplemental plans to help seniors remain longer in their homes. This new package of nonmedical services and support would be financed through a small increase in premiums or savings that result from the benefits, lowering overall costs. Another option being considered in Minnesota is a term life insurance product that converts into an LTC insurance policy when the policyholder retires. It is a life-stage protection product that covers family members during working years, but then converts to offer protection against LTC costs as individuals age.

Other states are exploring state-funded public insurance options for LTSS. The political viability of this approach will vary across states because it would require dedicated state funds with new taxpayer revenue. In **Washington**'s Legislature, bipartisan support exists for a new public LTSS insurance program financed through a payroll tax. A bill was considered in 2018 and reintroduced in the state's 2019 legislative session with significant revisions based on extensive stakeholder engagement, according to state officials. In **Maine**, a more targeted "universal home care program" was put forward in 2018 to provide long-term health and social services in home to older adults with physical or mental disabilities. The ballot initiative failed to pass during the 2018 midterm elections held in November 2018. Other states, including **Michigan** and **Maryland**, are embarking on comprehensive LTSS studies to explore similar public-private options.

National experts are also looking at combinations of front-end private coverage and back-end publicly financed LTSS programs. As exploration of these approaches continues, it will be important for states to weigh in as they continue to seek opportunities that can limit the fiscal burden on Medicaid and sustainably address the growing LTSS needs of their residents.

ADDRESSING BARRIERS TO HOME AND COMMUNITY-BASED SERVICES

As states continue to prioritize and pay for the delivery of LTSS in homes and communities, several challenges can limit their ability to ensure seamless access to those services, including workforce, transportation, and affordable and accessible housing. For example, a national evaluation of the Money Follows the Person (MFP) program – a major federal effort to help states transition older adults and people with disabilities from nursing facilities into HCBS settings – identified insufficient accessible housing as the number one barrier to program success.[43] Overcoming these and other challenges is critical to the success of continued state efforts to serve more individuals in HCBS settings and improve the quality of their care.

Considerations for Governors

Governors may consider strategies to address home and community-based services workforce shortages, such as bolstering support for family caregivers and building new training programs and a career ladder for the direct care workforce.

Serving an expanding population of older adults and individuals with disabilities in their home and community requires an adequate workforce to deliver services in those settings. Direct care workers (DCWs), such as personal care assistants or home health aides, are critical to the HCBS workforce.[44] Meeting the demand for HCBS requires a sufficient number of DCWs who are adequately trained to provide high-quality care. NGA Center roundtable participants discussed issues that states face in recruiting, training and retaining an adequate DCW workforce and some of the approaches they are taking or considering to overcome them.

A growing older adult population necessitates an increase in workers who are already in scarce supply and often have less demanding employment alternatives. Further, some states have noted that it is even more challenging to recruit critical workers, such as DCWs, during periods of extended economic growth, which the United States is currently experiencing. Moreover, as states expand HCBS options, they lose out on the economies of scale of serving multiple individuals in one setting, meaning that greater staff capacity is required. Health care workforce shortages hit rural areas particularly hard.

NGA Center roundtable participants noted several strategies that states are exploring to address HCBS workforce shortages, including initiatives to improve health insurance coverage and offer more flexible work schedules. To improve career mobility, **Washington** is implementing "advanced care aide" training that enables aides to earn higher wages and serve clients with a higher level of need among other areas of growth. The state is partnering with Service Employees International Union 775 and the Training Partnership to test the new advanced skills training.[45] **Arizona** is requiring that MCOs employ a workforce development administrator to develop and implement a workforce development plan, including initiatives aimed at ensuring the capacity of the LTSS workforce. States also discussed using telemedicine and considering other staff extenders as potential solutions that were not explored in depth during the roundtable. The **Wisconsin** Legislature recently appropriated $60.8 million aimed at funding increases for the direct care portion of MLTSS capitation rates.[46]

As noted in the previous section, states are increasingly recognizing the important role of unpaid family caregivers as a critical element of the workforce serving those with LTSS needs. In 2013, unpaid family caregivers in the United States provided an estimated 37 billion hours of care, with an economic value of $470 billion.[47] As more and more individuals age, caregivers will become even more important as a supplement to DCWs. Family caregivers, however, often lack the support and resources they need while facing numerous challenges, such as stress and burnout, increasingly complex medical tasks, inflexible work schedules that can lead to reduced pay or loss of employment, and their own health and social issues.

In response, many states are enhancing support to help family caregivers overcome challenges and continue to provide care. Common services that Medicaid and other programs offer, such as those that the Older Americans Act of 1965 support, include respite care, education and training, and support groups. Some states, such as **Connecticut**, **Massachusetts**, **Rhode Island**, **Ohio**, **Indiana** and **Washington**, also offer a direct payment or stipend to family caregivers who support Medicaid beneficiaries. One way that states provide payment for services that family caregivers provide is through consumer-

directed models, which give eligible Medicaid members the choice of hiring their friends or family as paid caregivers in lieu of receiving services from a home care agency.[48]

Governors may consider unique partnerships to ensure that individuals have access to timely and accessible transportation, such as ride-sharing services.

Accessible, affordable transportation is important to the well-being and daily functioning of older adults and individuals with disabilities; it is also an area where states face key hurdles related to HCBS. Transportation challenges exist both for delivering services to individuals at their home and ensuring that beneficiaries have access to transportation for medical and nonemergency medical transportation (NEMT) to ensure well-being and community engagement.

State representatives participating in the NGA Center roundtable discussed opportunities and challenges related to the rise of ride-sharing services such as Uber and Lyft. In some areas, the competition has led to a decline in the availability of traditional taxi companies and an increase in wait times for older adults and individuals with disabilities. At the same time, states and experts highlighted the potential for ride-sharing to greatly increase transportation options for individuals who require LTSS. To work, states and ride-sharing companies must develop new payment arrangements, training requirements and service delivery models. For example, NEMT providers receive cardiopulmonary resuscitation, first aid and privacy training and typically offer "door-to-door" service. Currently, ride-sharing companies only offer "curb-to-curb" service, which is not workable for most individuals using a wheelchair or facing other mobility challenges. Participants discussed other community-based solutions, such as using school buses in rural areas when they are not being used to transport students or using nontraditional providers, such as emergency medical technicians, to conduct home visits and limit the need for transportation.

States seeking opportunities to address transportation and other social determinants may be interested in **North Carolina**'s recently approved Medicaid Section 1115 demonstration waiver. Under the waiver, the state will launch "Healthy Opportunity Pilots" in several geographic areas to test evidence-based interventions designed to reduce costs and improve health by addressing housing instability, transportation gaps, food insecurity, interpersonal violence and toxic stress for eligible Medicaid enrollees. Through the pilots, Medicaid will pay for NEMT, help enrollees access and pay for public transportation, and provide account credits for cost-effective private forms of transportation such as taxis or ride-sharing services.[49]

Governors may consider expansion of housing transition and tenancy-sustaining services to help individuals remain in their community.

Expanding the availability of affordable housing and supportive housing services is critical to the delivery of HCBS for individuals with LTSS needs, and this need is increasingly front and center for states in their broader efforts to address the social factors that affect an individual's health. Under federal law, Medicaid cannot directly pay for rent, but more than half of states report that they are implementing other supports such as housing transition services (for example, assistance with housing searches and application processes) and tenancy-sustaining services (for example, advocacy to prevent eviction). For example, in **Pennsylvania**, managed care plans are required to have a housing coordinator, and the state's Community HealthChoices program pays for pest eradication. In **Vermont**, the Medicaid program has a "shared living" model for beneficiaries with developmental disabilities, dementia or psychiatric conditions. Under this innovative model, the state recruits and trains home providers who agree to furnish room, board and other types of assistance, as outlined in a negotiated support plan, in return for a monthly stipend.

Innovative housing supports are on the rise in states, but the supply of accessible, affordable housing for older adults and individuals with disabilities remains an acute challenge. To address the significant housing-related challenges states face, there was broad agreement among roundtable attendees on the importance of extending the federal MFP program, which has enabled states to transition more than 75,000 individuals with chronic conditions and disabilities out of institutions and into the community.[50] MFP expired in 2016; in January 2019, the U.S. Congress passed a short-term extension, enabling states to continue spending any remaining funds.[51] Roundtable participants also expressed interest in other approaches to providing supportive housing services, such as those being implemented through Medicaid waivers in **California**, **Louisiana**, **Massachusetts** and **Washington**.[52]

CONCLUSION

As governors continue to pursue health system reforms to enhance the quality of care and sustainability of public programs, a focus on LTSS is critical. In the absence of bold reforms at the federal level, states will continue to be the primary payer of services for their large and growing populations with LTSS needs. This situation presents states with the significant challenge of controlling LTSS costs while also meeting fast-growing need. State and national leadership is essential to ensuring that the nation's most vulnerable residents have access to services and the highest quality of life as they age.

As with most transformative efforts, improving the financing and delivery of LTSS requires innovative ideas, new ways of doing business and significant investment of time and resources. The success of these efforts also relies on partnerships with the federal government, state lawmakers, consumers, health plans, providers and other stakeholders. Foundational elements such as data infrastructure and state oversight capacity are part and parcel of this work and often present significant challenges for states. Despite the barriers to change, many states have already demonstrated pathways to meaningful LTSS reforms, making significant strides in rebalancing care from institutional to home and community-based settings, improving integration and coordination of services, supporting family caregivers and addressing other barriers to HCBS. Looking ahead, opportunities for cross-state learning and the dissemination of effective strategies will continue to drive further state innovation and inform national efforts to meet the growing need for LTSS.

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