LTQA
LONG-TERM QUALITY ALLIANCE

FEBRUARY 2024

A Review of Extended Home- and Community-Based Services (HCBS) in Section 1115 Waiver Programs

REPORT

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Executive Summary

Project Background

Long-Term Quality Alliance (LTQA) worked with O'Leary Marketing Associates and the Minnesota Department of Human Services (DHS) to explore the feasibility of a program that would assist older adults to stay in their homes as their long-term care needs increase. Applying for a Section 1115 Waiver was identified as a possible pathway to pilot such a program.

What is a Section 1115 Waiver?

Section 1115 of the Social Security Act permits the Secretary of Health and Human Services to approve state demonstration or pilot projects that promote the aims of the Medicaid program and "demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations".[1] Several are using Section 1115 waivers to expand access to HCBS to beneficiaries who do not yet meet functional or financial eligibility requirements but are deemed "at risk" of future LTSS use or institutionalization.

Programs Selected for Review

The following 1115 waiver programs extend HCBS to populations who would not otherwise have been eligible based on functional or financial need:

Table 1: Programs Selected for Review

State	Program
Arizona	Arizona Health Care Cost Containment System: Arizona Long Term Care System (ALTCS)
Delaware	Delaware Diamond State Health Plan: DHSP-Plus
Hawaii	Hawaii QUEST Integration
Minnesota	Minnesota Reform 2020: The Alternative Care Program
Rhode Island	Rhode Island Comprehensive Demonstration
Tennessee	TennCare III: CHOICES Program
Vermont	Vermont Global Commitment to Health

[1] Medicaid.gov. About Section 1115 Demonstrations: https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html.

Washington State	Washington Medicaid Transformation Project (MTP): Medicaid Alternative Care (MAC) and Tailored Support for Older Adults (TSOA)

Key Takeaways from the Review

Functional Eligibility:

- Many 1115 programs that extend HCBS do so by expanding functional eligibility to those who do not yet meet a nursing facility level of care (NFLOC) but are determined to be "at risk" of institutionalization by state.

Financial Eligibility:

- Many programs have the same financial eligibility requirements as for NFLOC.
- Unlike other programs examined, programs in Minnesota and Washington State extend financial eligibility for HCBS but to not extend functional eligibility.

Benefits:

- Most programs offer a limited HCBS benefit package to the "at risk" population.

Delivery System:

- Many programs employ a capitated managed care delivery model.

Evaluation:

- While there is limited data on the efficacy of extending HCBS benefits specifically, there is evidence to show that these programs have positive impacts on HCBS rebalancing more generally.

Next Steps for States to Expand HCBS

- Implementing **presumptive eligibility**, as in Washington State's programs, allows beneficiaries to receive services as their eligibility is being determined. An amendment request from this year that would expand presumptive eligibility

indicated a high rate of accuracy in making presumptive eligibility determinations, representing a low risk to the state and federal partners.[2]

- Expanding **functional eligibility**, as programs in Arizona, Delaware, Hawaii, Rhode Island, Tennessee, and Vermont have done, allows beneficiaries to receive HCBS before they reach a NFLOC. Expanding **eligibility based on age** to 55, as in the Washington State programs, would also help achieve this aim.
- Many programs examined employ a **managed care delivery model**. It may be worth exploring contracting with MCOs, such as those that deliver MSHO products, to provide high value, cost efficient care.
- Additional **communications and outreach strategies**, especially for underserved populations, may be needed. Despite presumptive eligibility, enrollment in Washington State's programs was lower than anticipated.[3]

1. Project Background

Long-Term Quality Alliance (LTQA) in partnership with O'Leary Marketing Associates worked with the Minnesota Department of Human Services (DHS) to explore the feasibility of a program that would assist older adults to stay in their homes as their long-term care needs increase. Analysis through the DHS Own Your Future initiative identified that potential program targets should include reduced use of Medical Assistance (Medicaid) to pay for non-medical supports, reduced Medicare hospitalizations, and a more coordinated health and human services infrastructure to serve older adults. Applying for a Section 1115 Waiver was identified by the team as a possible pathway to pilot such a program. This report explores the findings from a review of approved 1115 Waiver programs in other states related to long-term services and supports (LTSS) and home- and community-based services (HCBS) delivery to inform work in Minnesota.

[2] Washington State Medicaid Transformation Project Section 1115 Demonstration Amendment Request. January 2020. Accessed at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medicaid-transformation-pa4.pdf.

[3] Washington State Medicaid Transformation Project Section 1115 Demonstration Amendment Request. January 2020. Accessed at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medicaid-transformation-pa4.pdf.

2. Introduction

Section 1115 of the Social Security Act permits the Secretary of Health and Human Services to approve state demonstration or pilot projects that promote the aims of the Medicaid program and "demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations"[4]. As long-term services and supports (LTSS) are largely not covered by private insurance or Medicare, but are covered by Medicaid, Section 1115 demonstrations in the Medicaid program are an avenue for states to test innovations in LTSS and HCBS delivery. Several are using Section 1115 waivers to expand access to HCBS to beneficiaries who do not yet meet functional or financial eligibility requirements but are deemed "at risk" of future LTSS use or institutionalization. The purpose of this brief is to examine those 1115 waiver programs that expand access to HCBS services, particularly to older adults.

3. Methods

An initial rapid review of approved 1115 waiver programs[5] was conducted of all approved 1115 waivers in areas of interest – managed LTSS (MLTSS), eligibility expansion, and delivery system reform – to eliminate those not relevant to LTSS and HCBS. As of April 16, 2021, there were 63 approved waivers across 45 states[6]. From the initial review, 15 programs were advanced to a second-round review, which sought to identify programs with direct relevance to Minnesota DHS' aim to assist older adults to stay in their homes. Of these programs, 7 were identified for as relevant for inclusion – programs in Arizona, Delaware, Hawaii, Rhode Island, Tennessee, Vermont, and Washington State. Each of these programs extends HCBS to populations who would not otherwise have been eligible based on functional or financial need. In addition to these programs, the Minnesota Reform 2020 program, which also expands eligibility for HCBS, was examined.

[4] Medicaid.gov. About Section 1115 Demonstrations: https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html.
[5] KFF. Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State. Accessed at: https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.
[6] KFF. Section 1115 Waivers Approved as of April 16, 2021. Accessed at: https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Map1.

4. Findings

4.1 Program Aims

The larger aims of each 1115 program were examined to understand how extending HCBS served those aims. Overall program aims included testing the use of a managed care delivery system, expanding access to healthcare for low-income individuals, controlling the growth of health care expenditures, providing cost effective services, and delivering high-quality care. The Rhode Island Comprehensive Demonstration specifically seeks to ensure that beneficiaries "receive the appropriate services in the least restrictive and most appropriate setting." The Vermont Global Commitment to Health has a stated goal to offer beneficiaries a choice of long-term services and supports and HCBS "recognized to be more cost-effective than institutional based supports." *(Refer to the table in Appendix B for more information).*

4.2 Eligibility

Programs that extend HCBS services often do so for individuals who have functional needs but do not meet the functional eligibility requirements for a nursing facility level of care in the state (individuals "at risk" of institutionalization). There are, therefore, different functional eligibility requirements for the extended benefit packages. Financial eligibility requirements are often the same or, in the case of Rhode Island and Vermont, higher, than those required for institutionalization.[7]

While the other six states we looked at extend HCBS to those who do not yet meet a nursing facility level of care, Minnesota and Washington State extend access to HCBS to those who meet a nursing facility level of care but who are not yet eligible for Medicaid. In other words, they extend eligibility to those who do not meet financial eligibility requirements, while the other states we looked at extend eligibility to those who do not yet meet functional eligibility requirements.

[7] KFF. Medicaid Section 1115 Managed Long Term Services and Supports Waivers. Accessed at: https://files.kff.org/attachment/Report-Medicaid-Section-1115-Managed-Long-Term-Services-and-Supports-Waivers#:~:text=Most%20%C2%A7%201115%20MLTSS%20waivers,to%20expedite%20access%20to%20HCBS.

Table 2: Eligibility

State and Program	Functional Eligibility for Extended HCBS	Financial Eligibility for Extended HCBS
Arizona Health Care Cost Containment System	Extended HCBS eligibility (to those without a nursing facility level of need) is limited to working age adults with mental illness or I/DD.[8]	Resources not more than $2,000.[9]
Delaware Diamond State Health Plan	Extended HCBS eligibility to at risk adults and children with disabilities. Nursing facility level of care is defined as needing assistance with 2 ADLs, and those requiring assistance with 1 ADL at risk of institutionalization.	Income up to 250% of the Federal Poverty Level (same as for those who meet NFLOC).[10]
Hawaii QUEST Integration	"The at risk population is defined as Medicaid beneficiaries who do not meet criteria for nursing facility level of care (NFLOC), but who are assessed to be at risk of deteriorating to the institutional level of care."[11]	SSI related using SSI payment standard.[12]
Rhode Island Comprehensive Demonstration	HCBS to adults aged 19-64 with Alzheimer's Disease or a related dementia.	Income up to 250% of the Federal Poverty Level.[13]
Tennessee TennCare III	Long-term care benefits are provided to individuals aged 65 and older and adults aged 21 and older with physical disabilities, who qualify as SSI recipients and who do not meet the nursing facility level of care, but who in the absence of HCBS are "at risk" for institutionalization, as defined by the state: "such that, in the absence of the provision of a moderate level of home and community based services and	Income up to 300% SSI/FBR; resources at or below $2,000.

[8] KFF. Medicaid Section 1115 Managed Long Term Services and Supports Waivers. Accessed at: https://files.kff.org/attachment/Report-Medicaid-Section-1115-Managed-Long-Term-Services-and-Supports-Waivers#:~:text=Most%20%C2%A7%201115%20MLTSS%20waivers,to%20expedite%20access%20to%20HCBS.
[9] Filing an Application for the Arizona Long Term Care Containment System. Accessed at: https://www.azahcccs.gov/Members/Downloads/Publications/DE-828_english.pdf.
[10] KFF. Medicaid Section 1115 Managed Long Term Services and Supports Waivers. Accessed at: https://files.kff.org/attachment/Report-Medicaid-Section-1115-Managed-Long-Term-Services-and-Supports-Waivers#:~:text=Most%20%C2%A7%201115%20MLTSS%20waivers,to%20expedite%20access%20to%20HCBS.
[11] QUEST Integration Medicaid Section 1115 Demonstration. October 2020. Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/hi/hi-quest-expanded-ca.pdf.
[12] QUEST Expanded Medicaid Section 1115 Demonstration Special Terms and Conditions (2013-2018). Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/hi/QUEST-Expanded/hi-quest-expanded-stc-12182012-12312013-amended-032013.pdf.
[13] Rhode Island Comprehensive Section 1115 Demonstration Fact Sheet. February 2020. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-fs.pdf.

State and Program	Functional Eligibility for Extended HCBS	Financial Eligibility for Extended HCBS
	supports, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement"[14]	
Vermont Global Commitment to Health	This group is determined to be at risk of institutionalization as defined by the following clinical criteria. • ADL: Supervision or assistance 3 or more times in 7 days with one ADL or combination of ADL and IADLs. • Physical: Chronic condition that requires monitoring at least monthly. • Behavioral: Impaired judgment or decision-making that requires general supervision on a daily basis.[15]	Not otherwise eligible for Medicaid; income up to 300% of the Federal Benefit Rate (FBR); resources below $10,000.
Washington Medicaid Transformation Project (MTP)	MAC: Age 55 or older; eligible for Categorically Needy (CN) services; meet functional eligibility criteria for HCBS as determined through an eligibility assessment; have not chosen to receive the LTSS Medicaid benefit currently available under optional state plan or HCBS authorities. TSOA: Age 55 or older; meet functional eligibility criteria for HCBS as determined through an eligibility assessment.[16]	MAC: Income at or below 150% of the Federal Poverty Level. TSOA: Not currently eligible for Medicaid but have income up to 300% of the Federal Benefit Rate.

4.3 Extended HCBS Benefit Packages

Benefits offered to the populations for whom HCBS was extended are often more limited the standard HCBS benefit package. Benefits for these populations vary across states, but popular benefits include caregiver support/respite care, home-delivered meals, homemaker services, and adult day care.

[14] TennCare Waiver. Accessed at: https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf.
[15] Vermont Global Commitment to Health Special Terms and Conditions. May 2017. Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/Global-Commitment-to-Health/vt-global-commitment-to-health-spcl-stc-05212017.pdf.
[16] Washington State Medicaid Transformation Project Section 1115 Demonstration Extension Request. January 2021. Accessed at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medicaid-transformation-pa3.pdf.

Table 3: Extended HCBS Benefit Packages

State and Program	Extended HCBS Benefits
Arizona Health Care Cost Containment System	For individuals who qualify based on mental illness or I/DD only. Home health care, homemaker services, personal care, adult day health, hospice, respite care, transportation, attendant care, environmental modification, lifeline alert, and home-delivered meals. Habilitation and day-care services are also covered for the IDD population.[17]
Delaware Diamond State Health Plan	Benefit package is the same as for those who meet NFLOC. In addition to the HCBS provided through the Medicaid state plan institutional and E/D 1915(c) waiver (community based residential alternatives, personal care, respite care, day habilitation, emergency response system, attendant care, IADL (chore), specialized durable medical equipment, minor home modifications, home delivered meals, and case management), expanded services include home modifications, community transition services, and home-delivered meals.[18]
Hawaii QUEST Integration	Limited benefit package, including adult day care, adult day health, home-delivered meals, personal assistance, personal emergency response system, and skilled nursing.[19]
Rhode Island Comprehensive Demonstration	Limited benefit package: “Individuals who do not presently need an institutional level of care will have access to services targeted at preventing admission, re-admissions or reducing lengths of stay in an institution.” Preventative services include homemaker, minor environmental modifications, physical therapy evaluation services, and respite services.[20]
Tennessee TennCare III	Limited in that the cost of HCBS may not exceed $15,000 per calendar year, excluding the cost of minor home modification. Benefits include short-term nursing facility care, community-based residential alternatives, personal care visits, attendant care, home-delivered meals, personal emergency response systems, adult

[17] Arizona Demonstration Fact Sheet. January 2018. Accessed at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/az/az-hccc-fs.pdf.
[18] Delaware Diamond State Health Plan Plus Waiver Amendment Request. July 2011. Accessed at: https://www.dhss.delaware.gov/dhss/dmma/files/dshpplus_waiver.pdf.
[19] Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/hi/hi-quest-expanded-pa2.pdf.
[20] Rhode Island Comprehensive Section 1115 Waiver Special Terms and Conditions. Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/Comprehensive-Demonstration/ri-global-consumer-choice-compact-stc-12232013-12312018.pdf.

State and Program	Extended HCBS Benefits
	day care, in-home respite care, in-patient respite care, and assistive technology.[21]
Vermont Global Commitment to Health	Limited benefit package, including adult day services, case management, and homemaker services.[22]
Washington Medicaid Transformation Project (MTP)	Limited benefit package given that the services are intended for caregivers. Caregiver assistance services, training and education for caregivers, specialized medical equipment and supplies, health maintenance and therapies, and personal assistance services.[23]

4.4 Delivery System

As many states that extend HCBS services through their 1115 programs are testing the cost efficiency of managed care models, it is not surprising that most are using a capitated managed care delivery model or, in the case of Vermont, a "managed care-like" model. *(Refer to the table in Appendix D for more information).*

5. Spotlight on 1115 Programs in Minnesota, Washington State, and Tennessee

5.1 Minnesota Reform 2020: The Alternative Care Program

5.1.1 AIM

The Alternative Care program seeks to divert Minnesota seniors who are assessed to require a NFLOC away from costly nursing home or other residential facilities, offering assistance for those who would like to stay in their homes and communities. Targeted toward those at risk of becoming eligible for Medicaid, known as Medical Assistance (MA) in Minnesota, the program also aims to improve health outcomes for seniors

[21] TennCare Waiver. Accessed at: https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf.

[22] Vermont Global Commitment to Health Special Terms and Conditions. May 2017. Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/Global-Commitment-to-Health/vt-global-commitment-to-health-spcl-stc-05212017.pdf.

[23] Washington State Medicaid Transformation Project Section 1115 Demonstration Extension Request. January 2021. Accessed at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medicaid-transformation-pa3.pdf.

through cost-effective long-term supports and services while delaying or avoiding circumstances where seniors would rapidly spend-down to MA eligibility in nursing home care, which would then continue as an MA cost.

Alternative Care is one element of an array of programs intended to cover HCBS for the senior population. The Elderly Waiver program covers MA-eligible seniors with NFLOC, Alternative Care covers those slightly above the threshold for MA, and Essential Community Supports[24] covers those who meet Alternative Care eligibility but don't require NFLOC.

The goals of the Alternative Care program are to:

1. Provide access to coverage of home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care
2. Provide access to consumer-directed coverage of home and community-based services for individuals with combined adjusted income and assets higher than Medicaid requirements and who require an institutional level of care
3. Provide high-quality and cost-effective home and community-based services that result in improved outcomes for participants measured by less nursing home use over time[25]

5.1.2 ELIGIBILITY

To be eligible for the Alternative Care services, individuals must be 65 years or older, be currently ineligible for Medical Assistance, and must be assessed to require a NFLOC by their county's Long Term Care Consultation screening process. Additionally, while they must exceed the income and asset limits for MA, the individual must have insufficient income and assets to pay for a nursing home stay greater than 135 days (roughly $33,000).[26]

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[24] Essential community supports. Minnesota Department of Human Services. Accessed at: https://mn.gov/dhs/people-we-serve/seniors/services/home-community/programs-and-services/essential-community-supports.jsp.
[25] Reform 2020 Section 1115 Waiver Renewal Request. June 2017. Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mn/mn-reform-2020-pa2.pdf.
[26] How much will care cost? Minnesota Department of Human Services. Accessed at: https://mn.gov/dhs/ownyourfuture/plan/financial/care-cost.jsp.

Individuals must also pay a monthly fee that is determined by their adjusted income after deducting allowable assets and income.[27] At the high end of the scale, for an individual with adjusted income exceeding 200% of FPL and with at least $10,000 in gross assets, they must pay 30% of their average monthly cost of services.

Eligibility, financial and needs, must be annually reassessed by lead agencies (counties and tribal organizations).[28] However, in general, individuals must approach their county lead agency to first enroll in this program and it's likely that many may wait until their need is dire due to the invasive nature of the screening process. The true size of the population that needs and would be eligible for these services in Minnesota, but it is guaranteed to be much larger than the roughly 2,500 monthly enrollees that the program currently sees. There are several potential reasons for this, ranging from: a bias among those who misperceive the program as part of Medical Assistance, or a discomfort with the level of financial information that must be shared with the state for eligibility assessment, to basic lack of awareness of the program. The Elderly Waiver is situated as the primary program and requires significant attention from the same staff administering the Alternative Care program, and DHS and other wraparound services may have greater contacts with those already financially eligible for MA than those above that threshold. Similar to the Elderly Waiver, there is no waiting list for Alternative Care — nor does DHS profess a desire to institute one — but costs for the program might be contained by limited promotion of the program.[29]

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[27] Minnesota 2020 Reform 1115 Demonstration Fact Sheet. February 2020. Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mn/mn-reform-2020-fs.pdf.
[28] Minnesota 2020 System Reform Demonstration. February 2020. Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mn/mn-reform-2020-ca.pdf.
[29] Reform 2020 Quarterly Report (January-March 2020). Accessed at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mn-reform-2020-qtrly-rpt-jan-mar-2020.pdf.

5.1.3 BENEFITS

The benefits of the Alternative Care program[30] closely match those of the Elderly Waiver program[31] with a few exceptions (largely for services related to residential care or medical services). Services include[32]:

- Adult day services
- Case management *(not included in Elderly Waiver when it is conversion from nursing facility)*
- Chore services
- Companion services
- Consumer-directed community supports
- Family caregiver support services, including respite
- Home health aides
- Home-delivered meals
- Homemaker services
- Home and vehicle modifications
- Individual community living supports
- Non-medical transportation
- Personal emergency response systems
- Personal care assistance
- Skilled nursing visits
- Specialized equipment and supplies
- *Nutrition services (not included in Elderly Waiver)*
- *Coaching and counseling*
- *Telehome care in conjunction with in-home visits*
- *Environmental accessibility and adaptations*
- *Discretionary services (not included in Elderly Waiver*

*Italicized services are referenced in statutory language but not consistently on the program page.

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[30] Alternative Care (AC). Minnesota Department of Human Services. Accessed at: https://mn.gov/dhs/people-we-serve/seniors/services/home-community/programs-and-services/alternative-care.jsp.

[31] Elderly Waiver (EW) and Alternative Care (AC) Program. Minnesota Department of Human Services. Accessed at: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_056766.

[32] The state made several changes to the Alternative Care program in 2005, years before it received federal approval through 1115, which eliminated the possibility of estate recovery as well as support for assisted living and adult day care services. One report notes this more than halved the size of the program.

5.1.4 DELIVERY SYSTEM

The Alternative Care program pays service providers fee-for-service with state funds and federal matching funds at the county-level or through tribal organizations.[33] The program is administered by staff at lead agencies jointly with the Elderly Waiver program. Most program services are paid at the state-established rate set by Department of Human Services, although some services — such as cleaning or caregiver education — are paid at market rates. Similar to the Elderly Waiver, providers must be qualified Medicaid providers registered with the state. As part of eligibility, the services required by an individual in the program must not exceed 75% of the cost that MA would pay for a MA-eligible senior with a similar case-mix profile.

Alternative Care acts as the payor of last resort for other private or public programs that could provide these services, and one eligibility requirement is that an individual have no other options to pay for these services.

5.1.5 EVALUATION

Internal DHS evaluation efforts are underway. Additionally, Own Your Future contracted for a survey of the Elderly Waiver spend-down by Peter Spuit, which may yield useful insight into whether a more muscular Alternative Care program could positively impact those who end up on the Elderly Waiver. The survey is ongoing but additional questions might be able to be added.

CMS requires demonstration evaluations as part of the 1115 waiver, including a summative evaluation report posted publicly within a year of the end of the demonstration period (the first period ended in 2018). Due to several extensions, the summative evaluation report (conducted by researchers at the University of Minnesota and Purdue University) has not yet been released. However, an interim evaluation was included with the state's request for renewal.[34]'

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[33] Minnesota 2020 Reform 1115 Demonstration Fact Sheet. February 2020. Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mn/mn-reform-2020-fs.pdf.
[34] Reform 2020 Section 1115 Waiver Renewal Request. June 2017. Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mn/mn-reform-2020-pa2.pdf.

In conversations with the state, it was suggested that that it is possible that the initial support for Alternative Care sprung from the same data that showed the amount saved by the Elderly Waiver program diverting MA-eligible seniors away from nursing home care more than paid for the program itself. During the first three demonstration years, the evaluation estimates Alternative Care saved around $30 million in diversions away from nursing home facilities and the Elderly Waiver.

5.2 Washington Medicare Transformation Project (MTP): Medicaid Alternative Care (MAC) and Tailored Support for Older Adults (TSOA)

5.2.1 AIM

Washington State acknowledges that a significant proportion of its aging population — one in five[35] — will need some form of assistance with Activities of Daily Living (ADLs), with most of their care to be provided by unpaid family caregivers. The aim of MAC and TSOA, created in 2017 and based upon an earlier successful caregiver program, is to provide limited supportive services to unpaid caregivers as an alternative to traditional LTSS services. Both programs were initially designed for caregiver-recipient dyads, although TSOA also opened to individual seniors (who consistently make up two-thirds of the program population).

An important caveat on TSOA is that its benefits are intended for the caregiver rather than the care recipient. Yet, as most in TSOA are without any caregiver, the reality of the program appears to be at odds with how it was initially conceived.

5.2.2 ELIGIBILITY

Both MAC and TSOA have age, financial, and functional eligibility requirements. Care recipients must be at least 55 years old and require a Nursing Facility Level of Care. Additionally, while TSOA participants do not require a caregiver, all caregivers must be informal and at least 18 years old (though they are not required to be a family member). Unlike MAC, which serves those already eligible for Medicaid, TSOA care recipients may not be eligible for Medicaid (except under Medically Needy or other select categories).

[35] Medicaid Transformation Project Evaluation Interim Report. December 2020. Accessed at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medicaid-transf-cms-approved-interim-evaluation-report.pdf.

TSOA participants are still expected to fall under specified resource and income limits as the program is intended for those at risk of impoverishment due to their LTSS needs. Currently, the resource standard for a single applicant is $53,100 while married applicants may also have the state spousal resource standard.[36] The income threshold, calculated with adjustments for disregarded income, must be equal to or less than 300% of the federal benefit rate.[37]

A notable element of Washington's programs is a presumptive eligibility process. For TSOA, individuals or caregiver dyads only need to complete high-level prescreening questions about functionality and finances before they can begin receiving benefits. Presumptive eligibility lasts for about 60 days, although it will continue until the application is processed and receives a final determination if the applicant's full financial information has been filed. Presumptive eligibility screening can even take place over the phone. In general, program eligibility is reassessed every six months.[38]

There are no penalties for transfer of assets like in traditional Medicaid. The state estimated that there are likely 250,000 seniors who may be functionally eligible for these programs but are not served by the state (not accounting for financial eligibility).

5.2.4 BENEFITS

The benefits for MAC and TSOA are nearly identical. However, since TSOA includes individuals without a caregiver, that program also offers personal care-type services in lieu of caregiver respite. Benefits are somewhat a la carte, given the program's focus on choice, but they include: PERS; caregiver training, education, consultation; housework; home-delivered meals; specialized supplies or DME; and potentially some environmental modifications.

[36] Health care services and supports. Washington State Health Care Authority. Accessed at: https://www.hca.wa.gov/health-care-services-supports/program-administration/wac-182-513-1640-tailored-supports-older.
[37] Health care services and supports. Washington State Health Care Authority. Accessed at: https://www.hca.wa.gov/health-care-services-supports/program-administration/wac-182-513-1640-tailored-supports-older.
[38] TSOA Presumptive Eligibility. Accessed at: https://www.hca.wa.gov/health-care-services-and-supports/program-administration/tailored-supports-older-adults-tsoa.

Program participants work with specialist staff to design an individual care plan[39] that assesses the care recipient and caregiver's needs, preferences, and choice of services. During PE, an individual can receive Step 1 benefits after designing their care plan, which are limited to a one- time $250. After completing the GetCare screening (or TCare for caregivers), individuals are eligible for $500 in services annually (minus any funds spent in Step 1).[40] If the screening indicates they need a full GetCare assessment, the individual will receive Step 3 services — $736 a month for individuals, or an average of $736 a month for dyads (not to exceed $4,416 in a six- month period).

There is no cost-sharing responsibility and no threat of estate recovery in either MAC or TSOA. While the interim evaluation submitted to CMS (as discussed below) describes high satisfaction with the two programs, the state call informed us that caregivers consistently wish that the program offered more benefits.

5.2.3 DELIVERY SYSTEM

MAC and TSOA are delivered by Area Agencies on Aging (AAAs). Individuals and dyads can approach local Home and Community Services offices or AAA agency offices to enroll in TSOA. A case manager authorizes plan services every month through state-contracted providers.

5.2.5 EVALUATION

Washington State submitted its interim evaluation report for its 1115 waiver in December 2020, covering a period between 2017 and 2019. The primary takeaways include:

- Enrollment for MAC and TSOA fell short of expectations. While the state aimed for 7,500 enrolled combined by year three, by the end of 2019 only 3,364 people were enrolled in the programs. The state believes that few individuals eligible for Medicaid felt incentivized to enroll in MAC when a broader menu of LTSS were available at no cost through in-home services. Additionally, far more individuals enrolled in TSOA than had been predicted. In conversations with DSHS, they

[39] Questions and Answers on the MAC and TSOA Programs. Accessed at: https://www.washingtonlawhelp.org/files/C9D2EA3F-0350-D9AF-ACAE-BF37E9BC9FFA/attachments/D3890080-0C98-4D8D-8E53-D5D13B85FD2F/5171en_questions-and-answers-on-tsoa-and-mac-programs.pdf.
[40] GetCare Screening. Accessed at: https://apps.leg.wa.gov/wac/default.aspx?cite=388-106-1933&pdf=true.

explained that they believe that there was a more dire need for the program than expected given that those in TSOA aren't eligible for alternative programs and face waiting lists. With further outreach, the state hopes to bring the individual/dyad numbers to parity, but they admit that they underestimated the need among individual seniors.

- Both programs had extremely high satisfaction rates among individuals and caregivers, and for the most part care recipients felt the program would rescue them from moving to residential or nursing facility care. However, despite satisfaction with the program, only 30% of MAC caregivers thought the program would keep the individual they cared for out of a nursing home.
- Using in-home care recipients as a proxy, the evaluation found that ED visits, hospitalizations, and readmissions tended to decrease six months in. Only small percentages of program participants moved on to use more intensive LTSS or nursing home care within six months.
- More than 50% of TSOA participants enrolled under presumptive eligibility, and TSOA participants tended to be enrolled in services for about 14 months.
- About one-third of TSOA went on to enroll in Medicaid due to spenddown after six months, though a smaller percentage did with caregivers compared to those alone.[41]

5.3 TennCare: CHOICES in Long-Term Services and Supports

5.3.1 AIM

The overall aims of TennCare are to provide services to Medicaid state plan and demonstration enrollees using a managed care approach that does not exceed the costs of fee-for-service Medicaid, to ensure access to quality care, to improve health care, to ensure participating health plans are sustainable and viable, and to provide cost-effective HCBS that will "improve the quality of life for persons who qualify for Nursing Facility care, as well as for persons who do not qualify for Nursing Facility care

[41] Medicaid Transformation Project Evaluation Interim Report. December 2020. Accessed at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medicaid-transf-cms-approved-interim-evaluation-report.pdf.

but are “at risk” of institutional placement and that will help to rebalance long-term services and supports expenditures.”[42]

The aims of the CHOICES Program, launched in 2010, are expanding access to HCBS, rebalancing LTSS expenditures, and delivering HCBS as an alternative to institutionalization in cost effective way. This is intended to delay or prevent the need for institutional care.

5.3.2 ELIGIBILITY

CHOICES 3 is intended for older adults aged 65 and older and working-age adults aged 21 and older with physical disabilities who do not meet nursing facility level of care but require some services in order to delay or prevent institutionalization.[43] To qualify, individuals must be SSI recipients who do not meet the nursing facility level of care, but who in the absence of HCBS are “at risk” for institutionalization, as defined by the state: “such that, in the absence of the provision of a moderate level of home and community based services and supports, the individual’s condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement.”[44]

5.3.3 BENEFITS

The total cost of HCBS may not exceed $15,000 per calendar year, excluding the cost of minor home modification. Otherwise, the benefit package is the same as for those that meet nursing facility level of care. Benefits include short-term nursing facility care, community-based residential alternatives, personal care visits, attendant care, home-delivered meals, personal emergency response systems, adult day care, in-home

[42] TennCare II Special Terms and Conditions (July 2013-June 2016). Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/TennCare-II/tn-tenncare-ii-stc-07012013-06302016-4.pdf.
[43] CHOICES. Tennessee Division of TennCare. Accessed at: https://www.tn.gov/tenncare/long-term-services-supports/choices.html.
[44] TennCare Waiver. Accessed at: https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf.

respite care, in-patient respite care, and assistive technology.[45] The cost of home care may not exceed the cost of nursing home care.[46]

5.3.4 DELIVERY SYSTEM

At-risk MCOs coordinate physical health, behavioral health, and LTSS for members eligible for the program.

5.3.5 EVALUATION

A special study report of the CHOICES Program from 2015 investigates the impact of the program on Tennessee's long-term services and supports system from 2011-2013. In particular, the study examined the impact of CHOICES on rebalancing nursing facility and HCBS participants and expenditures, the cost efficiency of HCBS as compared to nursing facility services, and transitions between HCBS and nursing facility services.

The study found that member months for nursing facility residents as a percentage of all CHOICES member months decreased 15.76% while member months for HCBS members increased 41.23%. The percentage of total long-term care expenditures accounted for by nursing facility services decreased from 87.67% in 2011 to 78.23% in 2015, reflecting a 10.77% shift in expenditures from nursing facility care to HCBS. The study found a decrease in the average amount spent per CHOICES member per month of $119.97 (4.14%) over two years – while the average monthly cost of nursing facility members increased over the two years, the average monthly cost of HCBS members decreased. HCBS was found to be more cost effective than nursing facility care, and transitions of nursing facility members to HCBS were found to increase over the course of the study. Overall, the CHOICES Program was found to have the expected result of shifting utilization and expenditures from nursing facility care to HCBS.

6. Conclusion

This review has revealed trends in eligibility requirements, HCBS benefit offerings, and delivery models used by states in 1115 programs that extend HCBS benefits. Many

[45] TennCare Waiver. Accessed at: https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf.
[46] CHOICES. Tennessee Division of TennCare. Accessed at: https://www.tn.gov/tenncare/long-term-services-supports/choices.html.

1115 programs that extend HCBS do so by expanding functional eligibility to those who do not yet meet a NFLOC but are determined to be "at risk" of institutionalization by the state. Of these programs, many have the same financial eligibility requirements as for a NFLOC. Unlike the other programs examined, the Alternative Care program in Minnesota and MAC and TSOA in Washington State extend financial eligibility for HCBS but to not extend functional eligibility. As for benefits, most programs that extend HCBS offer a more limited HCBS benefit package to the "at risk" population. Many programs examined are testing the efficacy of a managed care delivery model. While there is limited data on the efficacy of extending HCBS benefits specifically, there is evidence to show that these programs have positive impacts on HCBS rebalancing more generally.

6.1 Next Steps for States to Expand HCBS

- Implementing **presumptive eligibility**, as in Washington State's programs, allows beneficiaries to receive services as their eligibility is being determined. An amendment request from this year that would expand presumptive eligibility indicated a high rate of accuracy in making presumptive eligibility determinations, representing a low risk to the state and federal partners.[47]
- Expanding **functional eligibility**, as programs in Arizona, Delaware, Hawaii, Rhode Island, Tennessee, and Vermont have done, allows beneficiaries to receive HCBS before they reach a NFLOC. Expanding **eligibility based on age** to 55, as in the Washington State programs, would also help achieve this aim.
- Many programs examined employ a **managed care delivery model**. It may be worth exploring contracting with MCOs, such as those that deliver MSHO products, to provide high value, cost efficient care.
- Additional **communications and outreach strategies**, especially for underserved populations, may be needed. Despite presumptive eligibility, enrollment in Washington State's programs was lower than anticipated.[48]

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[47] Washington State Medicaid Transformation Project Section 1115 Demonstration Amendment Request. January 2020. Accessed at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medicaid-transformation-pa4.pdf.

[48] Washington State Medicaid Transformation Project Section 1115 Demonstration Amendment Request. January 2020. Accessed at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medicaid-transformation-pa4.pdf.

Appendix A: Key Terms

Area Agency on Aging (AAA): A nonprofit agency "designated by a state to address the needs and concerns of all older persons at the regional and local levels."[49]

Activities of Daily Living (ADLs): Basic daily activities that are necessary for independent living (i.e. maintaining personal hygiene, eating, dressing, toileting, etc.)

Centers for Medicare and Medicaid Services (CMS): The federal agency responsible for administering Medicare and working with States to administer Medicaid. Part of the Department for Health and Human Services (HHS).

Federal Benefit Rate (FBR): The maximum amount that someone who qualifies for Supplemental Security Income (SSI) may receive each month, determined by the Social Security Administration (SSA). In 2021, the FBR is $794 for an individual and $1,191 for a couple.[50]

Federal Poverty Level (FPL): An income measure determined each year by the Department of Health and Human Services (HHS). In 2021, the FPL is $12,880 for an individual, $17,420 for a family of 2, and $26,500 for a family of 4.[51]

Home- and Community-Based Services (HCBS): HCBS allows Medicaid beneficiaries to receive services in their home or a community setting rather than an institutional setting.

Long-Term Services and Supports (LTSS): Services, such as personal care, that individuals may require to perform activities of daily living, such as bathing and dressing.

Managed Care Organizations (MCOs): Organizations that practice the principles of managed care, "to manage cost, utilization, and quality."[52]

Nursing Facility Level of Care (NFLOC)/Nursing Home Level of Care (NHLOC): A level of care designation used to determine eligibility for a nursing facility in the Medicaid program. Determinations differ from state to state.

[49] https://acl.gov/programs/aging-and-disability-networks/area-agencies-aging.
[50] https://www.ssa.gov/ssi/text-benefits-ussi.htm.
[51] https://www.healthcare.gov/glossary/federal-poverty-level-fpl/#:~:text=A%20measure%20of%20income%20issued,and%20Medicaid%20and%20CHIP%20coverage.
[52] https://www.medicaid.gov/medicaid/managed-care/index.html.

Appendix B: Program Aims

Table 4: Program Aims

State and Program	Program Start	Overall Program Aims
Arizona Health Care Cost Containment System	October 2011	"The demonstration will **test the use of managed care entities to provide cost effective care coordination.** In addition, the demonstration will provide for payments to IHS and tribal 638 facilities to address the fiscal burden of services provided in or by such facilities. This authority will enable the state to ensure the continued availability of a robust health care delivery network for current and future Medicaid beneficiaries."[53]
Delaware Diamond State Health Plan	January 1996	"The original goal of the demonstration was to **improve the health status of low-income Delawareans by expanding access to healthcare to more individuals throughout the State; creating and maintaining a managed care delivery system with an emphasis on primary care; and controlling the growth of healthcare expenditures for the Medicaid population.** The DSHP 1115 Demonstration was designed to mandatorily enroll eligible Medicaid recipients into managed care organizations (MCOs) and create cost efficiencies in the Medicaid program that could be used to expand coverage."[54]
Hawaii QUEST Integration	August 1994	"[Hawaii's] QUEST program was designed to **increase access to health care and control the rate of annual increases in health care expenditures.** The demonstration also allowed the State to expand coverage beyond its Medicaid State plan."[55]
Rhode Island Comprehensive Demonstration	July 2009	"Rhode Island's Comprehensive demonstration establishes a new State-Federal compact that provides the State with substantially greater flexibility than is available under existing program guidelines. Rhode Island will use the additional flexibility afforded by the waiver to redesign the State's Medicaid program to **provide cost-effective services that will ensure that beneficiaries receive the appropriate services in the least restrictive and most appropriate setting**."[56]
Tennessee TennCare III	May 2002 (TennCare II)	"The goal of the TennCare Demonstration is to **show that careful use of a managed care approach can enable the State to deliver quality care to all enrollees without spending more**

[53] Arizona Demonstration Fact Sheet. January 2018. Accessed at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/az/az-hccc-fs.pdf.
[54] Diamond State Health Plan Section 1115 CY 2020 1st Quarterly Report. May 2020. Accessed at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/de-dshp-qtrly-rpt-jan-mar-2020.
[55] Hawaii QUEST Expanded 1115 Demonstration: Fact Sheet. October 2015. Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/hi/hi-quest-expanded-fs.pdf.
[56] Quarterly Operations Report Rhode Island Comprehensive 1115 Waiver Demonstration. November 2020. Accessed at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ri-global-consumer-choice-compact-qtrly-rpt-jan-mar-2020.pdf.

State and Program	Program Start	Overall Program Aims
		than would have been spent had the State continued its Medicaid program."[57]
Vermont Global Commitment to Health	October 2005	"The State's goal in implementing the Demonstration is to improve the health status of all Vermonters by: • Promoting delivery system reform through value based payment models and alignment across public payers; • Increasing access to affordable and high-quality health care by assisting lower income individuals who can qualify for private insurance through the Marketplace; • Improving access to primary care; • Improving the health care delivery for individuals with chronic care needs; and Allowing beneficiaries a choice in long-term services and supports and providing an array of home and community-based (HCBS) alternatives recognized to be more cost-effective than institutional based supports."[58]
Washington Medicaid Transformation Project (MTP)	January 2017	"The activities of [Washington State's Medicaid Transformation Project] aim to: • Improve the health care delivery system's capacity to address local health priorities. • Deliver high-quality, cost-effective, and whole-person care. Create a sustainable link between clinical and community-based services."[59]

[57] TennCare II Section 1115 Quarterly Report. May 2019. Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/TennCare-II/tn-tenncare-qrt-rpt-jan-mar-2019.pdf.
[58] Global Commitment to Health Section 1115 Medicaid Demonstration Evaluation Design. August 2017. Accessed at: https://dvha.vermont.gov/sites/dvha/files/documents/Administration/vt-gc-evaluation-plan-final-8.31.17-final-cms-submission.pdf.
[59] Washington State Medicaid Transformation Project Section 1115 Demonstration Extension Request. January 2021. Accessed at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medicaid-transformation-pa3.pdf.

Appendix C: Relevant Components of 1115 Programs

HCBS, and extended HCBS to a population who would not have otherwise been eligible, are often just one component of larger 1115 waiver programs in each state. Instances in which the component of the 1115 program that provides HCBS or extended HCBS has a different name than the overall program are outlined below (Hawaii and Rhode Island's programs do not have a separate name).

Table 5: Relevant Components of 1115 Programs

State and Program	Component of Program that Extends HCBS	Summary
Arizona Health Care Cost Containment System	Arizona Long Term Care System (ALTCS)	"The ALTCS program is for individuals who are age 65 and over, blind, disabled, or who need ongoing services at a nursing facility or ICF/MR level of care. ALTCS enrollees do not have to reside in a nursing home and may live in their own homes or an alternative residential setting and receive needed in-home services. The ALTCS package also includes all medical care covered under AACP inclusive of doctor's office visits, hospitalization, prescriptions, lab work, behavioral health services, and rehabilitative services. Rehabilitative services may only be eligible for FFP if these services reduce disability or restore the program enrollee to the best possible level of functionality."[60]
Delaware Diamond State Health Plan	Delaware Diamond State Health Plan Plus (DHSP-Plus)	Aims include improving access to health care for the Medicaid population, rebalancing in favor of HCBS; promoting early intervention for individuals with LTSS need or individuals at risk of LTSS need, increasing coordination and choice; improving quality of services, creating incentives for resources to shift from institutions to HCBS, improving integration for full dual eligible beneficiaries, and expanding managed care coverage to low-income Delawareans.[61]
Hawaii QUEST Integration	Hawaii Medicaid combined QUEST (for families and children) and QUEST Expanded Access (for aged, blind and	

[60] Special Terms and Conditions, Arizona Health Care Cost Containment System. 2014. Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-stc-10012011-09302016-amended-122014.pdf.
[61] Delaware Diamond State Health Plan Plus Waiver Amendment Request. July 2011. Accessed at: https://www.dhss.delaware.gov/dhss/dmma/files/dshpplus_waiver.pdf.

State and Program	Component of Program that Extends HCBS	Summary
	disabled) as QUEST Integration in 2015	
Rhode Island Comprehensive Demonstration	Expanded HCBS in 2013 renewal	"Individuals eligible as aged, blind or disabled (ABD) under the Medicaid state plan will receive benefits for institutional and home and community-based long term care services including an option for self-direction."[62]
Tennessee TennCare III	CHOICES Program (CHOICES 3)	Provides LTSS and HCBS to individuals 65+ and 21+ with disabilities. Eligibility extends to SSI-eligible individuals 65+ or 21+ with disabilities, who do not have need for nursing facility services, but "have a lesser number/level of functional deficits in activities of daily living as defined by the state…such that, in the absence of the provision of a moderate level of home and community based services and supports, the individual's condition and/or ability to continue living in the community will likely deteriorate, resulting in the need for more expensive institutional placement"[63]
Vermont Global Commitment to Health	Demonstration Population 6: Moderate Needs Group (Expansion Group)	One of 8 population groups eligible under the demonstration, Population 6 is described as "individuals who have incomes below 300 percent of the SSI Federal Benefit rate and would be described in Populations 4 or 5 except that they meet the clinical criteria for the moderate needs group and are at risk of institutionalization."[64]
Washington Medicaid Transformation Project (MTP)	Medicaid Alternative Care	MAC: "a benefit package for individuals who are eligible for Medicaid but not currently accessing Medicaid funded LTSS. This benefit package will provide services to unpaid caregivers, which is designed to assist them in getting supports necessary to continue to provide high-quality care and focus on their own health and well-being." TSOA: "a new eligibility category and benefit package for individuals "at risk" of future Medicaid LTSS use who currently do not meet Medicaid financial eligibility criteria. This is designed to help individuals avoid or delay impoverishment and the need for Medicaid-funded services. The TSOA benefit package provides services and supports to unpaid family caregivers as well as services and supports to individuals without unpaid caregivers."[65]

[62] Rhode Island Comprehensive Section 1115 Waiver Special Terms and Conditions. Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/Comprehensive-Demonstration/ri-global-consumer-choice-compact-stc-12232013-12312018.pdf.
[63] TennCare Waiver. Accessed at: https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf.
[64] Vermont Global Commitment to Health Special Terms and Conditions. May 2017. Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/Global-Commitment-to-Health/vt-global-commitment-to-health-spcl-stc-05212017.pdf.
[65] Medicaid Transformation Demonstration. Accessed at: https://www.dshs.wa.gov/altsa/stakeholders/medicaid-transformation-demonstration.

Appendix D: Delivery System

Table 6: Delivery System

State and Program	Delivery System
Arizona Health Care Cost Containment System	Pre-paid, capitated, managed care delivery model
Delaware Diamond State Health Plan	Medicaid state plan benefits and LTSS provided through a mandatory managed care delivery system with some services paid for by the state (fee-for-service)
Hawaii QUEST Integration	Capitated managed care
Rhode Island Comprehensive Demonstration	Pre-paid, fully capitated, managed care delivery model
Tennessee TennCare III	State contracts with full or partial risk managed care organizations
Vermont Global Commitment to Health	Capitated contracts and a "managed care-like model applying utilization controls and care management"
Washington Medicaid Transformation Project (MTP)	Managed care organizations incentivized to implement value-based payment; MAC and TSOA are run by AAAs

Long-Term Quality Alliance

Long-Term Quality Alliance (LTQA) is a 501(c)3 membership organization aimed at improving outcomes and quality of life for people who need long-term services and supports (LTSS), and their families. LTQA advances person- and family-centered, integrated LTSS through research, education, and advocacy. For more information, visit **ltqa.org.**

Acknowledgements

This report was prepared for the State of Minnesota Department of Human Services (DHS) and is shared with the permission of the State of Minnesota.

Thank you to Drew Gerber for his contributions to this report.