

**Joint Task Force on Affordable, Accessible Health Care
December 15, 2021**

Policy Option: Extending Moderate Needs Supports



Description

This policy option includes:

- Advanced analytic tools
- Limited package of home and community-based services, including support for family caregivers

The use of **advanced analytic tools**, which would enable program administrators to more effectively target the provision of Moderate Needs Supports services to individuals who are predicted to need more intensive long-term services and supports (LTSS) in the future. This feature is closely aligned with both the Cost Growth Benchmark Option and Blueprint for Health Expansion Option, in that it harnesses the power of emerging technologies to identify the Vermonters who are most in need of services.

A limited package of home and community-based services to address nutrition, dehydration, falls prevention, social isolation, medication management, and other needs typically not covered by standard insurance plans. These additional services will improve quality of life, promote health and wellbeing, and stave off the need for more intensive long-term services and supports (LTSS).

Support for family caregivers, who help keep their loved ones healthy and at home. Nationally, two out of three (66%) older people with disabilities who receive long term services and supports (LTSS) at home get all their care exclusively from a family caregiver, mostly wives and daughters. Another quarter (26%) receives some combination of family care and paid help; only 9% receive paid help alone¹. With higher income, households can provide more unpaid family caregiver time, therefore additional support is especially needed for low- and moderate-income households. Support for these caregivers is particularly

¹ <https://www.caregiver.org/resource/selected-long-term-care-statistics/>

important given the current healthcare workforce shortage. HST recommends adding caregiver support to this Extending Moderate Needs Supports option.

Vermont would need to consider alternatives and develop the best approach for the state. Many states are beginning to offer services and payments to family caregivers, as summarized in the table below and described in the ‘What have other states done?’ section.

<i>State</i>	<i>Program Name</i>	<i>Caregiver Support</i>	<i>Maximum Annual benefit</i>
<i>Oregon</i>	Family Caregiver Assistance Program	Personal care services Adult day services Respite services Emergency response systems Special medical equipment and supplies Supports for consumer direction Assistive technology Home modifications Home delivered meals Transportation Counseling / Support Groups Family Caregiver Hotline Education and training for unpaid caregivers.	\$6000
<i>Washington</i>	Tailored Supports for Older Adults	Adult Day Care Caregiver Training and Education Counseling / Support Groups Home Modifications Housekeeping / Errands / Yard Work Information Regarding Caregiving Meal Delivery Personal Emergency Response Systems Respite Care Specialized Medical Equipment / Supplies Therapies (massage and acupuncture) Transportation	\$7500
<i>Arizona</i>	Family Caregiver Grant Program	Information and referral Training Support groups Respite Home modifications	\$1,000
<i>Hawaii</i>	Kupuna Caregivers	Cash to pay for things like Adult Day Care Personal Care Meal Preparation Transportation	\$25000

The September 2021 Administration for Community Living², outlined the following recommended 5 priority areas:

- Increased awareness of family caregiving.
- Increased emphasis on integrating the caregiver into processes and systems from which they have been traditionally excluded.
- Increased access to services and supports to assist family caregivers.
- Increased financial and workplace protections for caregivers.
- Better and more consistent research and data collection.

Who will this affect?

Vermonters with any or no health insurance, who are identified as needing home and community-based services (HCBS) by their health care providers via provider referrals and by data-driven risk stratification tools, and who are found clinically and financially eligible for the program. (Please see the attached Appendix for HST’s MNG cohort analysis and extrapolation to the broader Vermont population.)

Population Group	Estimated Number of Vermonters	Estimated Annual Cost ³
<i>Vermonters who meet Moderate Needs Group (MNG) clinical criteria with incomes below 300% SSI FBR and are currently on the MNG wait list</i>	500 -- 700 ⁴	\$1.7 -- \$2.4 million ⁵
<i>Medicare Members who meet MNG clinical criteria with incomes above the MNG cut off (\$2,523 per month per individual)⁶</i>	11,587 -- 14,715 ⁷	\$20 -- \$25 million ⁸
<i>Commercially insured who meet MNG clinical criteria with incomes above the MNG cut off (\$2,523 per month per individual)⁹</i>	2,589 -- 3,371 ¹⁰	\$4.5 -- \$5.9 million ¹¹

² https://acl.gov/sites/default/files/RAISE-Initial%20Report%20To%20Congress%202021_Final.pdf

³ Please see the attached Appendix for HST’s MNG cohort analysis and extrapolation to the broader Vermont population

⁴ DAIL is currently working to update the wait list

⁵ The MNG average benefit for individuals receiving services between 7-1-2020 and 6-30-2021 was \$3,476.21. Multiplying by 500 and 700 provides the total cost range.

⁶ <https://www.ssa.gov/OACT/COLA/SSI.html>

⁷ HST started with a cohort of Vermonters identified in VHCURES as receiving the MNG benefit and ran multiple simulations accounting for demographic medical utilization information. The result is an estimate of the maximum number of individuals that would potentially access a new limited MNG benefit.

⁸ Using a benefit figure of 50% of the MNG average, \$1,738.10, and multiplying it by the 11,587 and 14,715 figures provides the cost range. HST believes this range is the high end of the estimate and the actual eligible population in any given single year is likely to be far lower. Further research and analysis is warranted.

⁹ <https://www.ssa.gov/OACT/COLA/SSI.html>

¹⁰ See footnote 5

¹¹ See footnote 8

Why?

The lifetime probability of becoming disabled in at least two activities of daily living or of being cognitively impaired is 68% for people age 65 and older¹². Individuals who have significant needs to support their activities of daily living often need supports not covered by traditional insurance and these uncovered costs can be expensive and debilitating to family finances. A federal government study estimated that out of pocket HCBS costs from age 65 to death are approximately \$140,000 (in 2015 dollars)¹³.

Access to a limited benefit of HCBS for those people who need them but are not yet financially and clinically eligible for full Medicaid LTSS may provide the necessary supports to stave off the need for more intensive services later.

Expansion of the Moderate Needs Group is intended to reduce the total number of and extend the timeline for individuals who could ultimately become “Medically Needy” for Medicaid which, for individuals with income too high to qualify for Medicaid, requires them to “spenddown”, reducing their assets, in order to become eligible for long term services and supports¹⁴.

What has Vermont done?

As part of the Choices for Care program administered by the Department of Disabilities, Aging and Independent Living (DAIL), Vermont offers a limited HCBS benefit to adults with “Moderate Needs” whose income is at or below 300% of the SSI payment standard after deducting recurring monthly medical expenses and who are without available resources that are easily converted to cash. Clinical eligibility requires a functional limitation resulting from a physical condition (including stroke, dementia, traumatic brain injury, and similar conditions) or associated with aging. This program is limited by available funding and serves about 1,000 Vermonters at any one time.¹⁵

Eligibility for Choices for Care Highest and High needs groups, which pays for full HCBS or Nursing Facility care as well full Medicaid coverage, requires applicants to meet the clinical criteria for nursing home level of care and financial criteria with specific income and asset limitations.

Current MNG services include:

1. Case Management – up to 12 hrs per calendar year via the local AAA or Home Health Agency.
2. Homemaker – up to 6 hrs per week via the local Certified Home Health Agency
3. Adult Day – up to 50 hrs/week.
4. Flexible Funds – Small amount of flexible spending funds through the chosen case management agency.

¹² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8040099/>

¹³ <https://aspe.hhs.gov/reports/long-term-services-supports-older-americans-risks-financing-research-brief-0>

¹⁴ <https://aspe.hhs.gov/reports/analysis-pathways-dual-eligible-status-final-report-0>

¹⁵ [Moderate Needs Services | Adult Services Division \(vermont.gov\)](#)

What have other states done?

HCBS services for individuals not financially eligible for Medicaid or that don't quite meet nursing home level of care:

- **Oregon** submitted a request to CMS on November 1, 2021 for an 1115 Demonstration Waiver that creates a federally matched program; Oregon Project Independence (OPI) and a new Family Caregiver Assistance Program (FCAP) for older adults and adults with physical disabilities who are not currently accessing Medicaid programs. These programs provide limited services and supports to individuals at risk of entering the Medicaid long-term services and supports system, with the intent to assist individuals to either avoid or delay entering the Medicaid system. Adults with incomes up to 400% of the Federal Poverty Level (FPL) who pass a resource test and meet certain clinical eligibility criteria would be eligible, with a projected enrollment of up to 4,500 individuals in OPI and up to 1,800 individuals and their caregivers in the FCAP. The member per month (PMPM) cost is projected to be \$289 for OPI and \$500 for FCAP, and the state is projecting a small savings to the Medicaid program at the end of a 5 year demonstration period¹⁶.
- The Kupuna Care program (KC) is a **State of Hawaii**-funded program that provides community-based long-term care services. It is intended to provide in-home services to impaired elders, starting at age 60, who fall into the "gap group." These are elders who do not qualify for other government programs and do not have private assistance to help. This normally includes those with financial resources not high enough to afford the high cost of private-pay services, but not low enough to qualify for regular Medicaid or have levels of care not high enough to qualify for long term care Medicaid¹⁷. Approximately \$9M was budgeted in 2020 and varying numbers of individuals were served, depending on the service, from approximately 700 for personal care services to 3,900 for case management and home delivered meals¹⁸.
- In September 2021 **California** released its list of "In Lieu of Services" for their Medicaid program, Medi-Cal¹⁹. These include services available to Medi-Cal beneficiaries that are intended to address social determinants of health, which would otherwise not be available but are offered as a less expensive and potentially more effective 'upstream' alternative to an existing state plan service. Included are services that would align with the Vermont Moderate Needs Expansion Option:
 - Respite Services
 - Day Habilitation Programs
 - Personal Care and Homemaker Services
 - Environmental Accessibility Adaptations (Home Modifications)
 - Medically Supportive Food/Meals/Medically Tailored Meals
- As part of their 1115 demonstration waiver, **North Carolina** is in the process of standing up 'Health Opportunities Pilots'²⁰ which will test the effectiveness of providing new services to Medicaid beneficiaries that address certain social determinants of health, including housing modifications, access to healthy foods, and interpersonal violence.

¹⁶ <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-1115s-projectindependence-application-pa.pdf>

¹⁷ https://www.elderlyaffairs.com/site/454/services_faqs.aspx

¹⁸ https://health.hawaii.gov/opppd/files/2020/12/EOA_LEG-REPORT-2020-w_attachment-12.21.20.pdf

¹⁹ <https://www.dhcs.ca.gov/Documents/MCQMD/ILOS-Policy-Guide-September-2021.pdf>

²⁰ <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots>

Additional Support for Caregivers:

- **Washington State’s** Tailored Supports for Older Adults (TSOA) is a program authorized under their 1115 waiver that provides services to support unpaid caregivers and provides a small personal care benefit to people who don’t have an unpaid family caregiver to help them. It creates a new eligibility category and benefit package for people age 55 or older who are at risk of needing long-term services and supports in the future who don’t currently meet Medicaid financial eligibility criteria²¹. Quarter 2 of 2021 enrollment was 3,544 dyads and 6,631 individuals, at a cost of \$5.5M.²²
- **Arizona’s** Family Caregiver Grant Program²³ supports friends and family caring for Arizonans with incomes up to \$75,000 for a single person or \$150,000 for a married couple with information and referral, training, support groups, respite, and home modifications. Grants are capped at \$1,000 and the administration has requested \$325K in their 2023 budget²⁴
- **Hawaii’s** Kupuna Caregivers program helps family caregivers who work at least 30 hours/week outside the home by providing up to \$70/day benefit in services that make caring for aging family members who are 60 and over more affordable and accessible. It can help pay for things like adult day care costs, home health care workers, extra help preparing meals, and transportation²⁵. In 2019 the state budgeted \$1.5M and 114 individuals were served. A study conducted showed a reduction in caregiver burden after receiving program services, and the state has since developed a plan to maximize the number of caregivers served²⁶

Health Equity Impact

The United States Centers for Disease Control and Prevention (CDC) describes Health Equity as “...action to ensure all population groups living within an area have access to the resources that promote and protect health”²⁷. This option will reduce disparities and promote access by making important HCBS available to more Vermonters, regardless of insurer or income level, facilitated with the use of population health data analytics to tailor services to peoples’ specific needs, reduce gaps in care, and avoid duplication of services. Further, providing needed support to family caregivers will enable more families to care for their loved ones in culturally familiar ways²⁸. Support for family caregivers will also help alleviate workforce pressures by encouraging families to care for loved ones rather than to seek out external caregivers.

Alignment with other Proposed Options

A statewide identification and stratification system can help identify Vermonters that are appropriate for limited HCBS and Caregiver Supports offered in this Moderate Needs Expansion option, as well as services provided by the Blueprint for Health and other payer and provider care coordination and care management programs. Additionally, as part of Vermont’s overarching Cost Growth Target and Affordability Index, the ROI experienced via the Moderate Needs expansion can be ‘booked’ as savings,

²¹ <https://www.hca.wa.gov/health-care-services-supports/program-administration/tailored-supports-older-adults-tsoa-0>

²² <https://www.hca.wa.gov/assets/program/quarterly-progress-report-dy5q2.pdf>

²³ <https://legiscan.com/AZ/text/SB1172/2019>

²⁴ <https://des.az.gov/about-des/budget-information>

²⁵ <http://www.careforourkupuna.com/#introducing>

²⁶ <https://health.hawaii.gov/opppd/files/2019/12/EOA-Annual-Legislative-Report-2019.pdf>

²⁷ https://www.cdc.gov/minorityhealth/publications/health_equity/index.html

²⁸ https://acl.gov/sites/default/files/RAISE-Initial%20Report%20To%20Congress%202021_Final.pdf

along with other proven cost saving technologies and interventions, and formally used by the Green Mountain Care Board to regulate commercial health insurance premiums as well as positively impact budgets for publicly funded care.

Federal Support

1. Sections 30711-30713 of the Build Back Better Act would create the HCBS Improvement Program, which would provide a permanent 6 percentage point increase in federal Medicaid matching funds for HCBS. To qualify for the enhanced funds, states would have to maintain existing HCBS eligibility, benefits, and payment rates and have an approved plan to expand HCBS access, strengthen the direct care workforce, and monitor HCBS quality²⁹.
2. HST believes that a detailed financial model analysis would show the potential for future savings to both the state and federal government. With that in hand, Vermont could negotiate with CMS for federal support for this option. The vehicle for that could be an amendment to Vermont's current 1115 Global Commitment for Health waiver, a separate demonstration project, or some combination of the two. Other state examples above should be reviewed in detail as part of Vermont's modeling.

Further Research

People need varying levels of MNG services, depending on their preferences, clinical condition, and other informal supports available to them. A deep dive into Vermont specific data will provide needed insight into the level of need and projected costs. A detailed analysis of Medicaid claims data specific to CFC MNG individuals and a further analysis of the Commercial and Medicare insured individuals as well as some analysis of ERISA lives would help to further define the level of need for the services suggested in this options document. There is also information available from the Washington State program which can also inform the detailed analysis of an expanded Vermont option.

²⁹ [Potential Costs and Impact of Health Provisions in the Build Back Better Act | KFF](#)

APPENDIX

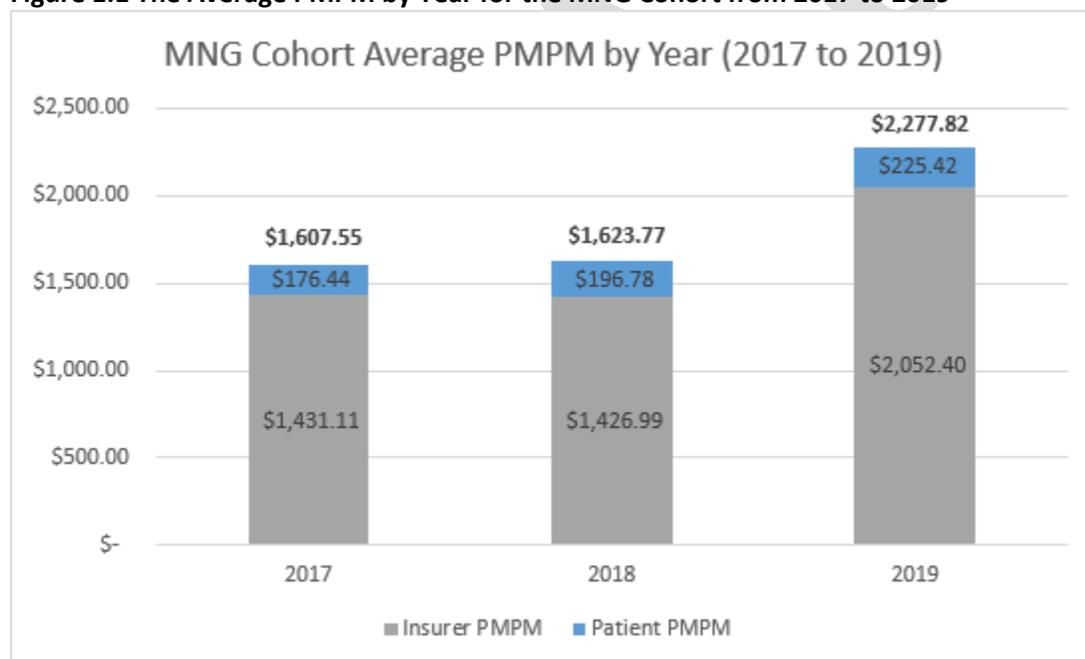
Moderate Needs Group (MNG) Cohort Data Analysis³⁰

Introduction to the Methodology for the MNG Cohort

- HST reviewed available data in the VHCURES dataset to identify individuals that were in the MNG during calendar year 2019 and then looked backwards to calendar years 2017, 2018, 2019.
- There are 328 individuals that have a WM code in their claims data in 2019. HST understands that those with a WM code in the Aid category field are a subset of the total Moderate Needs Group (MNG) population.
- Of the 328 individuals with a WM code in 2019, 306 individuals have age, insurance, and location data available.

MNG Cohort Figures and Analysis

Figure 1.1 The Average PMPM by Year for the MNG Cohort from 2017 to 2019



³⁰ In conducting this analysis HST relied upon the “WM” AID category code in the VHCURES database to identify a subset of approximately one third of the individuals in MNG during the study time period. It is not known if or how this subset of the MNG population may differ from the MNG population in total.

Figure 1.2 The Average PMPM for the MNG Cohort from 2017 to 2019

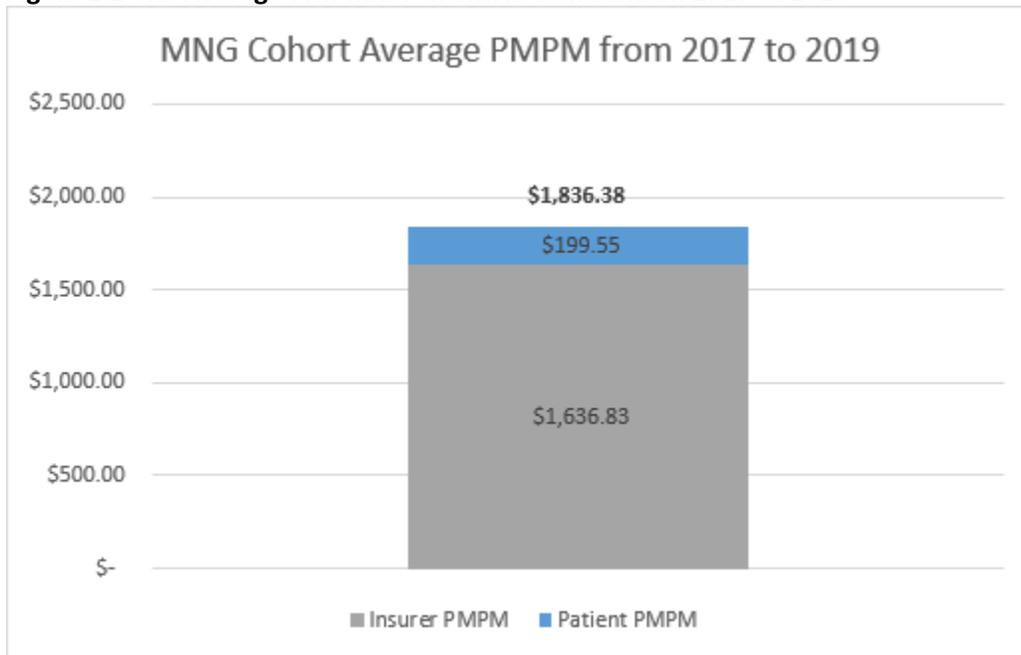
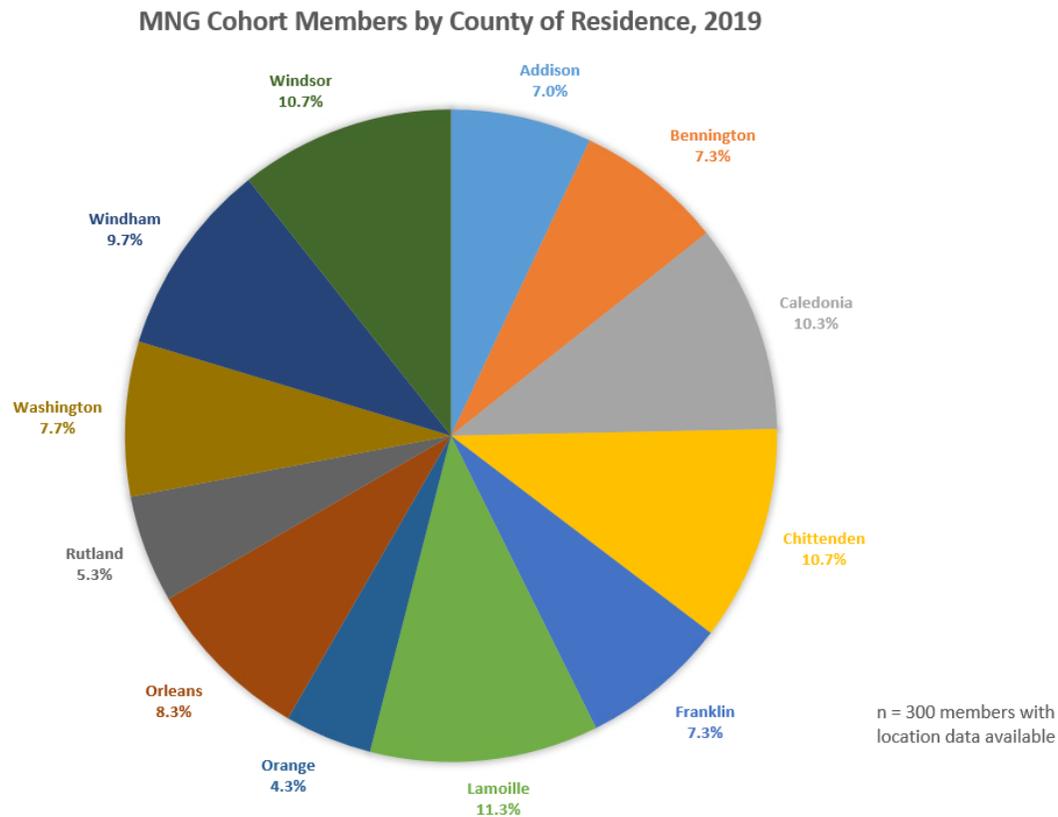
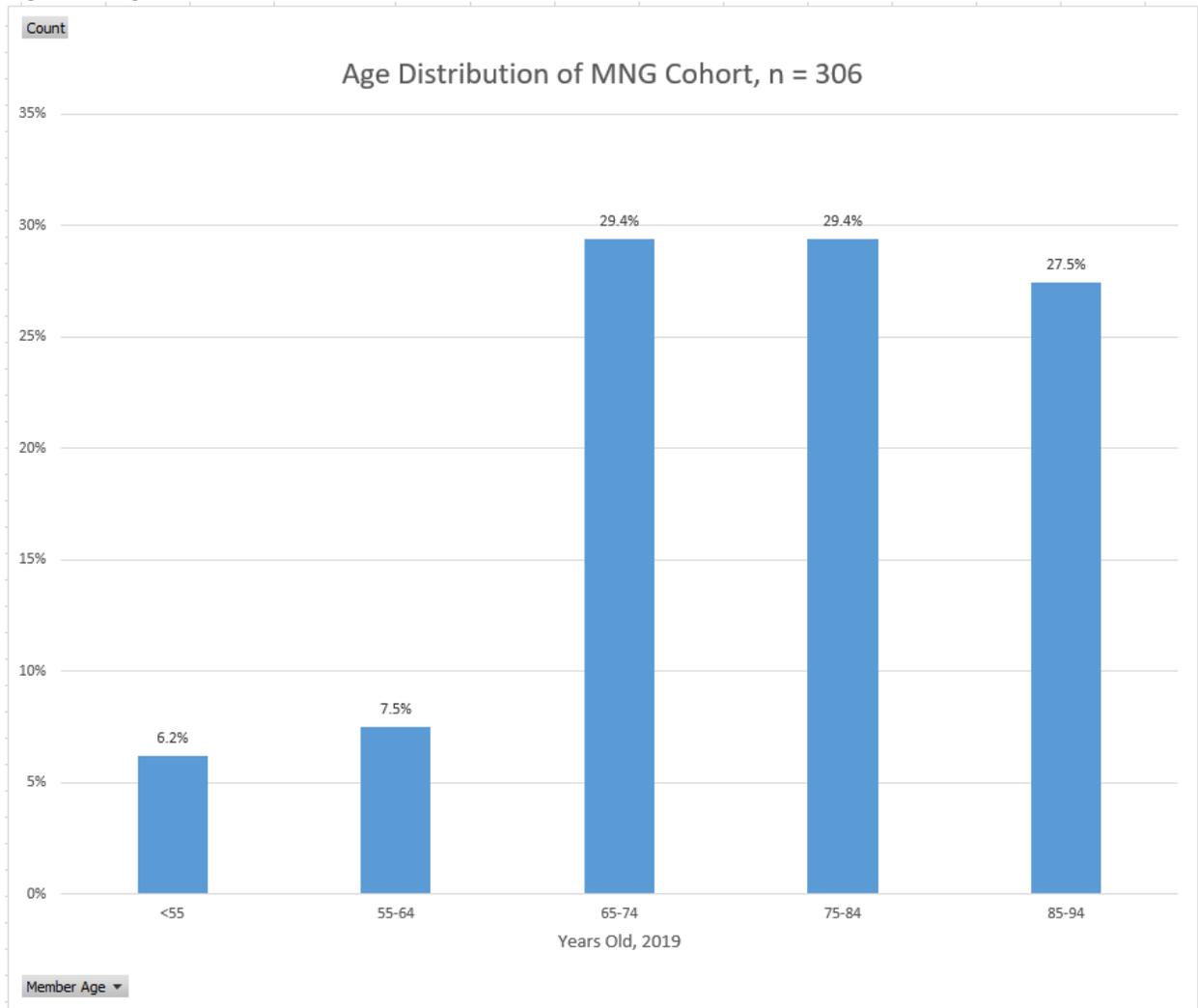


Figure 2. Breakdown of MNG Cohort Members by County



Cohort consists of 328 individuals with claim history; only 300 individuals have location data.
 Note: Grand Isle and Essex counties are excluded due to small cell sizes.

Figure 3. Age distribution of MNG Cohort



Note: Age data exists for 306 individuals of the 328 individuals MNG Cohort.

Figure 4. Top Hospital Diagnoses for MNG Cohort

HST reviewed the top 37 hospital diagnoses from the MNG Cohort and selected the Ambulatory Care Sensitive Conditions (ACSC) and Mental Status Conditions that have a high likelihood of identifying potential individuals with clinical needs similar to those in the MNG cohort in the total VHCURES population (as of December 2019). The list of the top conditions is included below:

Row Labels	Distinct Count of id
ESSENTIAL PRIMARY HYPERTENSION	89
SHORTNESS OF BREATH	84
ENCOUNTER FOR IMMUNIZATION	81
UNSPECIFIED ESSENTIAL HYPERTENSION	80
OTHER LONG TERM CURRENT DRUG THERAPY	76
OTHER AND UNSPECIFIED HYPERLIPIDEMIA	75
COUGH	75
HYPERLIPIDEMIA UNSPECIFIED	73
OTHER MALAISE AND FATIGUE	71
WEAKNESS	70
CHEST PAIN UNSPECIFIED	70
NEED PROPHYLACTIC VACCINATION&INOCULATION FLU	67
PAIN IN SOFT TISSUES OF LIMB	65
DIZZINESS AND GIDDINESS	65
PERSONAL HISTORY OF OTHER SPECIFIED CONDITIONS	63
LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS	61
URINARY TRACT INFECTION SITE NOT SPECIFIED	60
OTHER NONSPECIFIC ABNORMAL FINDING OF LUNG FIELD	59
PURE HYPERCHOLESTEROLEMIA	59
HEADACHE	58
DIAB W/O COMP TYPE II/UNS NOT STATED UNCNTL	57
LOW BACK PAIN	57
TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS	56
MAJOR DEPRESSIVE DISORDER SINGLE EPISODE UNS	56
ANEMIA UNSPECIFIED	55
PERSONAL HISTORY OF NICOTINE DEPENDENCE	54
PERSONAL HISTORY OF OTHER SPECIFIED DISEASES	54
LOCALIZED EDEMA	54
ASHD NATIVE CORONARY ARTERY W/O ANGINA PECTORIS	54
ESSENTIAL HYPERTENSION, BENIGN	54
UNSPECIFIED ANEMIA	51
LUMBAGO	51
UNSPECIFIED ABDOMINAL PAIN	50
OTHER FATIGUE	50
UNSPECIFIED BACKACHE	50
ALTERED MENTAL STATUS UNSPECIFIED	49
LONG TERM CURRENT USE OF ASPIRIN	49

Potential MNG Population Data and Analysis

Introduction on the Methodology for the Potential MNG Population³¹

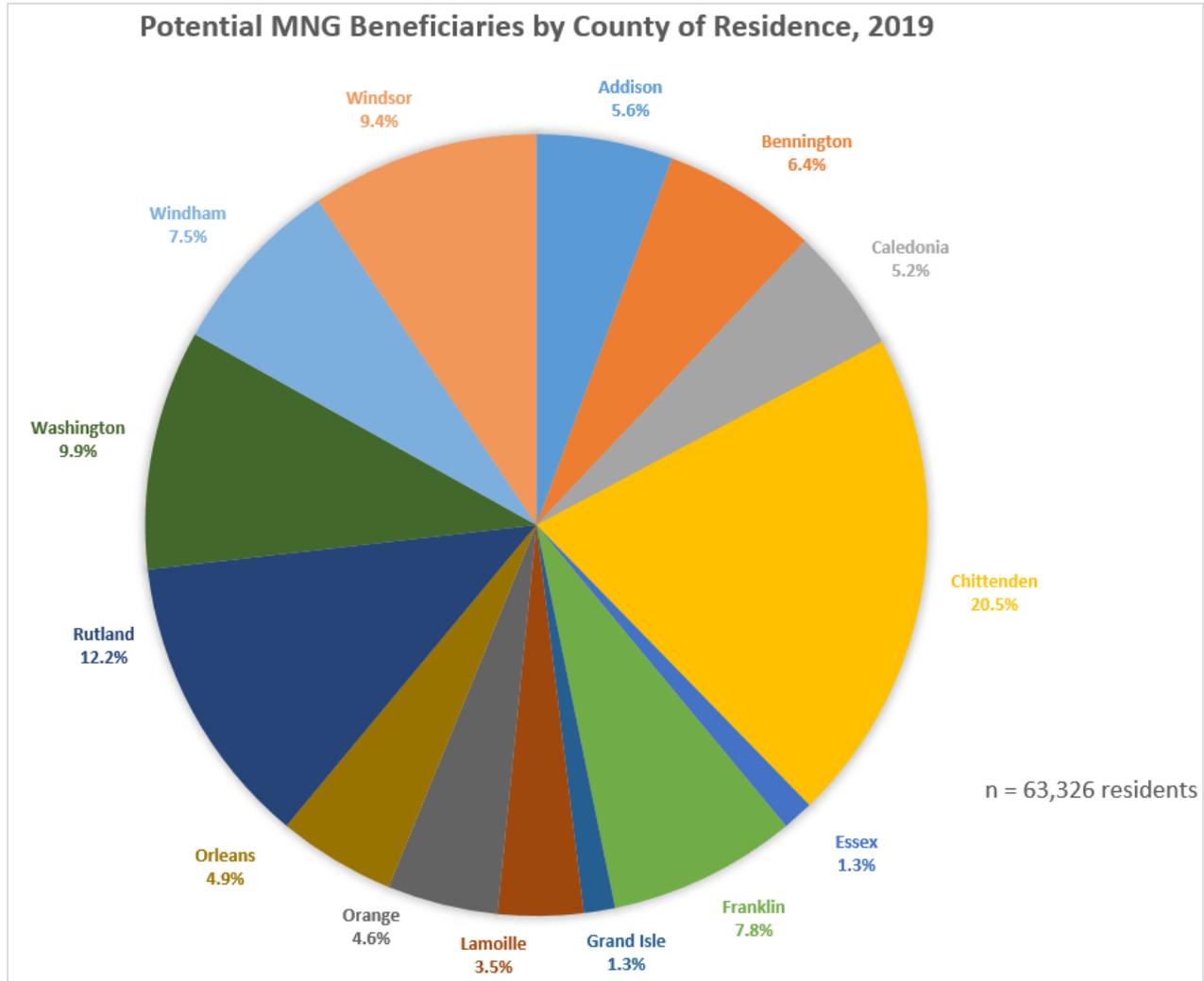
- Using the Top MNG Cohort ACSCs and Mental Status Conditions, HST determined that:
 - 63,422 individuals 45 and older had at least one of those conditions.
 - Of the 63,422 individuals 45 and older, 96 individuals do not have location, age, or insurance data, lowering the number to 63,326.
- HST further filtered down those numbers to identify those that were within the middle 80% range (between \$3,330.35 and \$67,667.36) and middle 90% range (between \$2,002.04 & \$90,035.28) of each member of the MNG Cohort's Annual Spend.
 - Of the 63,326 individuals 45 and older with insurance data:
 - Those with annual spends falling within the middle 80% range = 14,176
 - Those with Commercial insurance = 2,589
 - Those with Medicare = 11,587
 - Those with annual spends falling within the 90% range = 18,086
 - Those with Commercial insurance = 3,371
 - Those with Medicare = 14,715
- Individuals 45 and older represent 96.7% of the total MNG Cohort.

³¹ This analysis does not include those individuals covered by ERISA plans.

MNG Cohort Figures and Analysis

Figure 5.1 Breakdown of Potential MNG Beneficiary Members by County (45+ Breakdown)

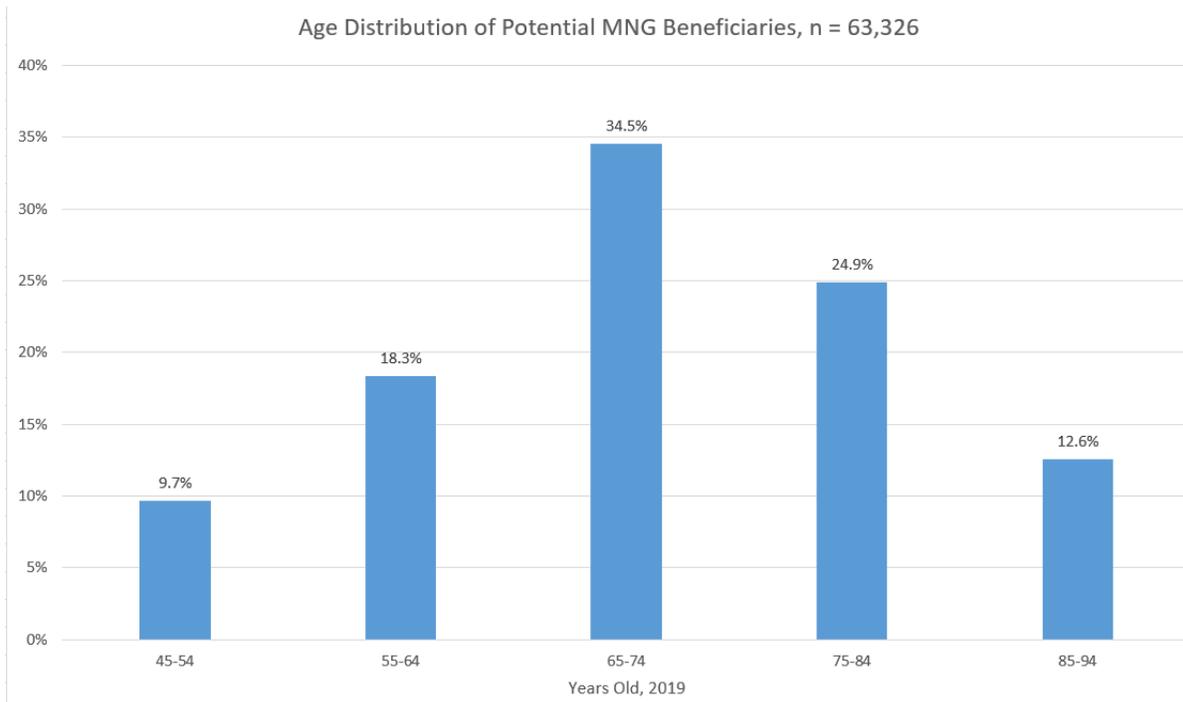
The following is the county breakdown for 45 and up.



Of the 63,422 individuals 45 and older, 96 individuals do not have location data.

Figure 6.1. Age distribution of MNG Cohort (45+ Distribution)

The following is the age distribution for the 45+ Potential MNG group.



Of the 63,422 individuals 45 and older, 96 individuals do not have age data.

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