Promising Practices and an Emerging Innovation

Home- and Community-Based Services Beyond Medicaid: How State-Funded Programs Help Low-Income Adults with Care Needs Live at Home

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About This Paper

People with low incomes who need home- and community-based services (HCBS) may not receive assistance from Medicaid because of a state's clinical and financial eligibility criteria. However, adults with significant needs for assistance can find themselves on a path to Medicaid, especially when family caregivers are unable to provide all of the assistance required, or when paying for services drains the financial resources of the person needing support. Roughly 6 out of 10 (62 percent) nursing home residents rely on Medicaid, often because they have spent their funds paying for care.*

Many states have sought to lower these risks by establishing one or more general revenue–funded programs designed to provide modest assistance to low-income people who are not enrolled in Medicaid, to address unmet needs, prevent adverse events, and improve well-being. These programs also are intended to help adults use their resources effectively to maintain their community residence, and delay or prevent out-of-home placement and spend down to Medicaid.**

This paper is part of a series on promising practices and emerging innovations from the *2017 Long-Term Services and Supports State Scorecard*.*** The Scorecard includes state-funded HCBS programs as an indicator of a high-performing long-term services and supports (LTSS) system because these programs can be used to reach the *near poor*—who may not yet qualify for Medicaid—to prevent impoverishment and more expensive nursing home care. The Scorecard found that most states provide some non-Medicaid state funding for HCBS. While some states have made significant investments, funding is typically very small and limited compared with Medicaid.

We interviewed state administrators and reviewed program documents to provide a profile of programs in nine states: Connecticut, Illinois, Massachusetts, Nebraska, New Jersey, North Dakota, Oregon, Pennsylvania, and Washington. The programs—which rely on state general fund revenues and *sometimes* additional sources of funding, such as lottery revenues and federal Social Services Block Grants—are designed to support low-income older adults and adults with physical disabilities at home. Most programs were started decades ago, when Medicaid was still a relatively young program that emphasized nursing home care. In addition, the paper highlights Washington state's emerging innovation: the Medicaid Transformation demonstration, which tailors support for near poor older adults and family caregivers. The design, operation, and outcomes of these programs can provide useful insights for federal and state policy makers.

Note: This paper focuses on state-funded programs for older adults and adults with physical disabilities, not other populations that require LTSS, such as individuals with behavioral health needs or intellectual/developmental disabilities. We are grateful to the state administrators who provided program insights as well as enrollment and spending data.

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* Ari Houser, Wendy Fox-Grage, and Kathleen Ujvari, *Across the States, Profiles of Long-Term Services and Supports, 2018* (Washington, DC: AARP Public Policy Institute, August 2018), http://www.aarp.org/acrossthestates.

** To varying degrees, states help connect older adults and family caregivers to community services, such as assistance with meals, transportation, family caregiver respite services, and care management, often delivered by Area Agencies on Aging with Older Americans Act funding.

*** Susan C. Reinhard, et al., *Picking Up the Pace of Change. A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* (Washington, DC: AARP Public Policy Institute, June 2017), http://www.longtermscorecard.org.

Purpose

This *Promising Practices* paper highlights examples of how state-funded HCBS programs are supporting low-income older adults and/or people with physical disabilities and their family caregivers to live with maximum independence at home (exhibit 1). See the appendix for more detailed information. This paper aims to help administrators, policy makers, and advocates learn from each other and implement programs that will reach people who do not qualify for Medicaid or who are waiting to receive Medicaid services.

EXHIBIT 1
Brief Descriptions of HCBS Programs

STATE	PROGRAM AND STARTING YEAR	DESCRIPTION
Connecticut	Connecticut Home Care Program for Elders, 1987	Provides a wide range of services (11 types) to adults ages 65+ to live at home, in an adult foster care home, or in some assisted living facilities and avoid nursing home placement. Enrollees must have low assets. There is income-related cost sharing but no income limit for eligibility.
Illinois	Community Care Program, 1979	Provides a range of services, including adult day services, emergency home response services, and in-home services, to delay or prevent nursing home placement for adults ages 60+ who need or at risk of needing this level of care. Enrollees must have low assets and participate in cost sharing according to income.
Massachusetts	Home Care Program, 1973	Also called the basic program, to distinguish it from the enhanced program, it provides a wide range of services (25 types) to adults ages 60+ (or younger adults with a diagnosis of Alzheimer's disease or a related disorder) to maintain maximum independence in their home environment. Eligible adults who are low income must pay income-related monthly copayments. Adults who are *over income* may qualify for home care and respite care services and have additional cost-sharing requirements.
	Enhanced Community Options Program, 1993	Provides enhanced home care services to people with a higher level of need (i.e., who meet nursing home level of care), who do not qualify for standard Medicaid. Financial eligibility is the same as for the Home Care Program. This program is not available to adults determined over income who are found eligible for the home care and respite over income programs.
Nebraska	Care Management, 2008	Provides information, referral, and care management for adults ages 60+.
	Lifespan Respite, 2002	Provides or funds respite care for family caregivers of individuals who are not eligible for any other government-funded respite care.
	Social Services for Aged and Disabled Adults, 1973	Provides a range of HCBS to older adults or adults with disabilities who need lower levels of care at home to live in the community than those in the Medicaid Personal Assistance Services program.
New Jersey	Jersey Assistance for Community Caregiving, 2000	Provides 14 types of HCBS to adults ages 60+ who meet nursing home level of care. Clients may reside at home or in the home of a relative or friend. Income and asset limits apply, and income-related copayments are required. Monthly cost caps apply.

STATE	PROGRAM AND STARTING YEAR	DESCRIPTION
North Dakota	Service Payment for the Elderly and Disabled (SPED), 1983	Provides 13 types of HCBS for people who are older or physically disabled and who have difficulty completing tasks that enable them to live independently at home. An asset limit applies, and income determines a recipient's cost share based on sliding fee schedules.
	Expanded Service Payment for the Elderly and Disabled, 1994	Similar to SPED, but it is targeted to low-income older individuals who may require some assistance with activities of daily living but whose primary need is for help with instrumental activities of daily living or supervision at home or in a structured environment (e.g., adult foster care).
	Dementia Care Services, 2010	Provides care, consultation, and training to family caregivers to address individual needs that arise during dementia.
Oregon	Oregon Project Independence, 1975	Provides individuals ages 60+ or younger adults with Alzheimer's disease (and younger adults with disabilities in a 2005 pilot) with in-home services to promote self-determination and aging in place. Services include personal care, homemaker, adult day care, care management, and home-delivered meals. There are no income or asset limits for eligibility. Clients with income above 150% of the federal poverty level (FPL) pay income-related cost sharing (100% of costs are paid by clients with income > 400% of FPL).
Pennsylvania	OPTIONS, 1990	Provides consumers ages 60+ with a range of HCBS to assist them in maintaining independence with the highest level of functioning in the community and to delay the need for more costly services. Area Agencies on Aging operate the program. Local agencies must offer four required services and may offer additional optional services. Enrollees with income between 133% and 300% of FPL pay income-related cost sharing.
	Caregiver Support Program, 1990	Provides financial assistance to primarily qualified caregivers who assist dependent low-income older adults.
Washington*	Medicaid Alternative Care (MAC), 2017	Supports unpaid family caregivers caring for adults ages 55+, who are eligible for Medicaid, and who meet nursing home level of care. Provides caregiver assistance services such as housework, transportation, respite, and home-delivered meals; caregiver training; adult day health; and personal emergency response.
	Tailored Supports for Older Adults (TSOA), 2017	Provides seven types of HCBS to individuals ages 55+ and their family caregivers with low income and limited assets, who currently do not meet Medicaid financial eligibility criteria but have been deemed at risk of becoming Medicaid eligible. Person-centered care planning is used to identify participants' and unpaid caregivers' needs.
	Family Caregiver Support Program, 1989	Provides services to unpaid caregivers who provide supports to adults, using evidence-based TCARE® to assess the burdens, stresses, and uplifts that caregivers experience and to guide the choice of interventions, such as training/education, counseling, respite, equipment/supplies, and wellness therapies.
	Senior Citizens' Services Act, 1977	Provides older individuals, regardless of income, with in-home HCBS to help them stay in their own homes, to promote self-determination and aging in place. Limited state funding is used to overmatch Older Americans Act funding. Service offering is designed at the local level.

* Unlike the other programs in this paper, the Washington MAC and TSOA programs are provided under an 1115 Medicaid demonstration waiver and use 100 percent federal funds. They are included in this paper because these programs serve near poor older adults and family caregivers who are not in the traditional Medicaid program. We consider this waiver demonstration to be an emerging innovation.

Findings

The design of state-funded HCBS programs varies across states, but most provide care management and direct services to people who need assistance to remain independent in the community. Programs share features such as standardized needs assessment, care management, cost sharing, spending caps, and substantial discretion for care managers to decide how to spend available resources. Across states, programs vary widely in size because of differences in the population to be served and the amount services provided (exhibit 2).

EXHIBIT 2
Size of HCBS Programs That Serve Low-Income Adults with Care Needs

STATE	PROGRAM	ENROLLEES (MOST RECENT ENROLLMENT DATA AS OF 2017)	AVERAGE MONTHLY EXPENDITURE (OR CAP)
Connecticut	Connecticut Home Care Program for Elders	2,750	$715
Illinois*	Community Care Program (CCP)	About 54,000	$983
Massachusetts	Home Care Program	31,504	NA
	Enhanced Community Options Program	9,843	NA
	Home Care Over Income	About 500	NA
	Respite Care Over Income	5,731	NA
Nebraska	Care Management	4,151	NA
	Lifespan Respite	949	Capped at $125/month; $1,000/year for exceptional need
	Social Services for Aged and Disabled Adults	4,049	Congregate meals: $54 Adult day: $228 Home chores: $140 Transportation: $127
New Jersey	Jersey Assistance for Community Caregiving	2,153	Capped at $600/month
North Dakota	Service Payment for the Elderly and Disabled (SPED)	1,025	$494
	Expanded SPED	140	$408
	Dementia Care Services	1,838	NA
Oregon	Oregon Project Independence	2,099	$332
Pennsylvania	OPTIONS	67,463	$765
	Caregiver Support Program	5,256	$200
Washington**	Medicaid Alternative Care (MAC)	63 dyads	About $350 (capped at $3,438 for 6 months)
	Tailored Supports for Older Adults (TSOA)	675 dyads 1,735 individuals without a caregiver	About $350 (capped at $573/month)
	Family Caregiver Support Program	5,460 dyads	$358
	Senior Citizens' Services Act	About 6,000	NA

NA = Not Available

* As of September 2018, total aging participants were 107,908 (30,733 with a Medicaid managed care organization, 39,251 on CCP and Medicaid, and 37,924 on CCP and non-Medicaid). Roughly half of the total clients are non-Medicaid. Source: Email communication with Jose Jimenez, Illinois Department of Aging, December 10, 2018.

** Given Washington's new MAC and TSOA programs, the numbers representing the first year of enrollment do not reflect what the cost per person will be over the lifetime of the waiver. Some individuals access the program for one-time services while others receive services on a monthly basis. Enrollment is increasing by 40–100 clients per month. Source: Email and phone interview communications with Washington Aging and Long-Term Support Administration, October 2018.

MISSION

State-funded HCBS programs provide services and supports to help low-income, older adults and people with physical disabilities live at home. Services may be provided to both the care recipient and their family caregivers, with the goals of improving quality of life for those who need assistance, reducing burdens on family caregivers, and decreasing nursing home utilization and spending down to Medicaid eligibility. These services can be provided much quicker than in the traditional Medicaid programs because the Medicaid eligibility process often takes several months.

Adults with physical and cognitive impairments may need assistance with self-care activities (e.g., eating, showering, getting to the toilet, dressing); with household activities (e.g., doing laundry, shopping for groceries, preparing meals, keeping track of medication); with mobility (e.g., getting out of bed, getting around inside the home, getting outside the home); and with complex medical/nursing tasks. Some may receive all the assistance they need from family members and friends. Others may receive some assistance but not all the assistance they need when family caregivers, for example, are unavailable because of work and other demands. Older adults and adults with physical disabilities with unmet needs for assistance are at risk of adverse health consequences, diminished quality of life, and out-of-home placement.

These state-funded HCBS programs typically serve adults ages 60 and older and/or younger adults ages 19–59 with disabilities (and their family caregivers) who have assessed needs for assistance. They are part of a strategy to decrease reliance on nursing homes and support community living through the cost-effective use of public and private resources. For example, in **Nebraska**, citizens who are ages 60+ or between the ages of 19 and 59 with a disability can receive a limited range of HCBS—such as meals, home services, adult day service, personal care, and transportation—in its Social Services for Aged and Disabled Adults program. This program offers two basic types of supportive services: those targeted to individuals who need care and to their primary family caregivers. **North Dakota'**s Expanded Service Payment for the Elderly and Disabled program pays for in-home and community-based services for older adults ages 60+ or adults ages 19–59 with disabilities who would otherwise receive care in a licensed basic care facility. These individuals usually require assistance with tasks such as meal preparation, housework, laundry, or medication management.

Because the goal of these programs is to support adults at home, people living in an assisted living facility or another residential care setting typically are not eligible for assistance. In **Oregon**, any individual who resides in a nursing facility, assisted living facility, residential care facility, or adult foster home setting is not eligible for Oregon Project Independence services.

Clinical eligibility varies across states. Some states target adults with significant disabilities who are eligible for nursing home care under Medicaid. For example, **Illinois** and **New Jersey** offer services to older adults who meet the clinical eligibility guidelines for Medicaid nursing home care in the state.[1] Other state programs offer services more broadly, including adults with lower levels of functional impairment and more modest needs for assistance. Because the goal is to reduce nursing home placement, states use various strategies to target the population most at risk of a nursing home placement.

In **Massachusetts**, the state-funded Enhanced Community Options program provides assistance to people who are clinically eligible for nursing home care (requiring at least one skilled nursing or therapy visit daily or requiring

1 The level of care requirements for Medicaid nursing home care vary widely across states. States use comprehensive assessments of functional needs, medical conditions, cognitive impairment, and social support needs to determine eligibility. At the most general level, individuals who are unable to care for themselves for a sustained period of time and who would be at risk of harm without substantial assistance may meet the clinical eligibility criteria for nursing home admission under Medicaid.

a nursing service at least three times per week plus two other services for activities of daily living [ADLs]). In addition, the state's basic Home Care Program provides services on a less frequent basis to older adults who need some assistance with daily activities but who do not meet the clinical eligibility threshold for nursing home care. To qualify for any of the home care programs, older adults must require assistance with at least one ADL and have a critical unmet need for assistance (unmet need for assistance with any ADL, meal preparation, food shopping, home health services, medication management, respite care, or transportation for medical treatments).[2]

In **Connecticut**, people who meet a nursing home level of care (three or more critical needs) are eligible for a higher level of service than those who are at risk of nursing home placement but with lower needs (one to two critical needs).

NEEDS ASSESSMENT

States use a needs assessment for eligibility determination and care planning. Services are targeted to adults who require assistance to live at home and who have critical unmet needs.

In all states, community-based agencies are essential to effective service delivery. Programs typically are administered at the state level by the Aging Division within the state's Department of Human Services and managed at the sub-state level by Area Agencies on Aging (AAAs) or other nonprofit social service agencies that are contracted to provide assessment, eligibility determination, and care management. For example, in **Massachusetts**, the Home Care Program is operated by 26 Aging Services Access Points (ASAPs). ASAPs are private, nonprofit agencies with governing boards (appointed by local Councils on Aging) that are made up of at least 51 percent representation of people ages 60 and older. ASAPs provide information and referral, interdisciplinary case management (intake, assessment, development, and implementation of service plans), service plan monitoring and needs reassessment, and protective services (investigations of abuse, neglect, and self-neglect of elders).

Similarly, in **Illinois**, the state contracts with 48 Care Coordination Units (CCUs), independent nonprofit organizations that serve as central access points for older adults with LTSS needs. CCUs are typically not-for-profit agencies or a governmental entity, such as a local public health department. These units cannot deliver services in the same areas in which they provide assessment and case management services. CCU care managers evaluate the need for LTSS using a standardized needs assessment instrument—the Determination of Need. In addition to initial intake and assessment responsibilities, care managers write plans of care, arrange for the implementation of services, perform needs reassessments (at least annually), and provide ongoing care management to program beneficiaries.

In **North Dakota**, by contrast, the program is operated by local governments through county offices of social services. In many states, the assessment and care planning for people seeking assistance from Medicaid is conducted by the entity responsible for enrollees in the general revenue–funded program.

Care managers use a standardized assessment to evaluate an individual's assistance needs, the assistance they currently receive from family caregivers, and their unmet needs. In general, state-funded HCBS programs seek to deliver services to (a) people who lack family support or those whose family caregivers need assistance, and (b) people who have limited financial resources. States use a variety of strategies to use

2 Critical unmet needs are distinguished from noncritical unmet needs, which include one or more of the following: laundry, housework, shopping other than food shopping, transportation other than transportation for medical treatment, socialization, and telephone use. See Massachusetts Home Care Program regulations, 651 CMR 3.00: Home Care Program, https://www.mass.gov/files/documents/2017/10/19/651cmr3.pdf.

needs assessments to target limited resources in state-funded HCBS programs (exhibit 3).

The need for assistance with ADLs is the criterion used most commonly to assess functional eligibility for HCBS. Other assessment criteria include the need for assistance with instrumental activities of daily living (IADLs); the presence of medical conditions; cognitive impairment; the need for a minimum number of hours of assistance; and unmet needs for assistance with critical supports such as medical needs, cognitive or memory issues, behavioral issues, and functional needs. The assessment (and eligibility thresholds) may be the same as those used for nursing facility screening in the state.

For example, in the **Massachusetts** Home Care Program, an interdisciplinary team of care managers and nurses from ASAPs conducts a Long-Term Care Assessment in the person's home to determine eligibility for the programs. The assessment measures the degree of functional impairment experienced by an applicant or consumer as evidenced by an inability to complete ADLs and IADLs. This assessment is used to determine eligibility for services and care planning and is completed periodically thereafter to assess a consumer's needs for Home Care Program services.

FINANCIAL ELIGIBILITY AND COST SHARING

Programs target low-income people at risk of nursing home admission and of spending down to Medicaid. With the exception of people living in or near poverty, enrollees usually are required to contribute to care plan costs.

State-funded programs are targeted to very low-income people with limited financial resources (savings or other liquid assets). Programs generally pay for services only when there are no other available sources of support (e.g., Medicare-funded home health care, private long-term care insurance, informal supports). Many states require individuals who appear to be eligible for Medicaid to apply for Medicaid, to reduce the burden on state spending. Some states also apply Medicaid's estate recovery rules for services received under a state-funded HCBS program.

In **Illinois**, older adults are eligible to receive Community Care Program (CCP) services if they are at least 60 years of age, have no more than $17,500 in nonexempt assets, and are determined in need of LTSS. CCP clients can be Medicaid or non-Medicaid eligible. Non-Medicaid clients may have a copayment for services received depending on their income level. Medicaid enrollees do not have a copayment.

EXHIBIT 3

Oregon Project Independence's Strategy for Managing Limited Resources

The goal of the Oregon Project Independence program is to serve those who are the most functionally impaired and who have no (or inadequate) alternative service resources. Priority is given to frail and vulnerable older adults who lack sufficient access to other LTSS and who are the most at risk for out-of-home placement. Almost half of those who are screened for the program need help with at least two ADLs, such as bathing, dressing, or walking. More than 65 percent intend to remain at home and do not wish to move to a higher level of care.

Program administrators seek to manage limited resources to enable the greatest number of people to receive needed services. Oregon's model uses service priority levels, which are categories that indicate a person's need for assistance when receiving state- and federal-funded services. Levels range from Level 1, which reflects the most impaired, to Level 18, which reflects the least impaired. The current average service priority level for program enrollees is 12.

Massachusetts's Home Care Program assesses a flat, income-related copayment of $10 to $141 (for an individual in 2017). In the over income programs, enrollees pay income-related cost sharing of 50–100 percent of costs. Copayment adjustments may be considered owing to high consumer expenses related to medical care or traumatic events, such as weather-related events. **New Jersey** also has flat monthly copayments.

Fees for **Oregon** Project Independence in-home services are charged based on a sliding fee schedule determined by the AAA. Individuals with net incomes below 150 percent of the Federal Poverty Level (FPL) have a one-time fee; those between 150 and 400 percent of FPL are expected to pay a fee (of 5–90 percent of their service costs) toward their service. Clients with net incomes above 400 percent of FPL pay the full hourly rate for the service provided.

In **Connecticut**, the state-funded program has no income limit. People with more assets than the Medicaid limit, but not unlimited assets, can qualify for state-funded home care. The asset limit for an individual is 150 percent of the minimum amount that a community spouse could have under Medicaid ($35,766 in January 2016). Clients pay a 9 percent cost share each month based on paid claims data for that month.

In **Pennsylvania**'s OPTIONS program, clients pay on a sliding fee scale, with clients above 300 percent of FPL paying the full cost. Clients are required to apply for Medicaid if they are close to financial eligibility.

BENEFITS AND CARE PLANNING

HCBS programs include a wide range of services, with care management as a core service. Care planners typically have wide discretion to authorize whatever services can cost-effectively support adults with care needs in the manner they prefer.

A wide range of services may be authorized, including services to provide assistance with self-care, household activities, and mobility. Commonly provided services include care coordination, homemaker, chore, personal emergency response, adult day health, home-delivered meals, and respite services. In most programs, care managers meet with older adults, adults with physical disabilities, and family caregivers before developing a care plan, to assess their needs, their current sources of support, and their unmet needs for assistance.

In **Illinois**, for example, the CCP provides older adults with case management services to help them determine what their specific needs are and what services are available to meet those needs. Service plans can include home services—such as assistance with cleaning, doing laundry, shopping, running errands, and preparing and planning meals, and assistance with personal care tasks such as dressing, bathing, and grooming—as well as adult day services.

In **Massachusetts**, care managers can authorize adult day health care, Alzheimer's/dementia coaching, behavioral health services, chore services, companion services, food shopping, home health aides, homemaker services including laundry, meal delivery, meal planning and preparation, medication assistance, minor home repair and yard work, nutritional counseling, personal care services, personal emergency response services, respite care, and transportation assistance.

Benefits are more limited in some state programs. In the **Nebraska** Care Management program, for example, care management is the primary benefit offered to assist individuals ages 60+ with coordinating in-home and community-based care.

In establishing a care plan, care managers must arrange for services that can be paid for within a monthly cap on program expenditure per client. In many states, benefit maximums are the same for all enrollees regardless of need. In **Washington's** Tailored Supports for Older Adults, service costs are capped at $573 per month. In the **Nebraska** Lifespan Respite program, family caregiver support is capped at $125 per month and $1,000 per year for exceptional needs. Because of the limited dollar amounts, families can bank the respite subsidies for months and then use them for adult day services or camps.

In some programs, however, per-enrollee budgets vary by level of need, with higher budgets authorized for people with greater needs. For example, in **Illinois**, budgets (*service cost maximums*) rise with level of need as measured by the state's Determination of Need assessment.[3] In **Connecticut**, care plan service cost limits are set as a percentage of average nursing home costs, with higher caps for enrollees with greater needs. Category 1 clients are eligible for limited home care plans that cost less than 25 percent of nursing home costs (i.e., a cap of $1,445 per month). Category 2 clients for frail older adults with some assets above Medicaid limits have a care plan cost cap of 50 percent of nursing home costs ($2,889 per month).

Several programs allow care managers to authorize expenditures that exceed the monthly budget caps when necessary (e.g., for home modifications to enable aging in place). In **Illinois**, the state expanded CCP services to include emergency home response as a core service and funding to allow for home modifications, such as wheelchair ramps, grab bars, and other home improvements, to further prevent aging older adults from turning to premature nursing home entry because of gaps in community-based LTSS.[4] Some programs allow for additional expenditures when needs rise, such as when needs for assistance are greater after a hospitalization.

FAMILY CAREGIVERS

The preservation of family caregiving is an important component of these state-funded programs.

Several state departments on aging administer state-funded family caregiver programs that are funded outside the federal National Family Caregiver Support Program. Many of the departments began these programs before the inception of the National Family Caregiver Support Program in the Older Americans Act,[5] which was established in 2000 to provide grants to states and territories to help family caregivers care for their family members at home. These state-funded family caregiver support programs also can provide services to younger clients who would not qualify under the Older Americans Act.

In many state-funded HCBS programs, care planning includes an explicit assessment of the support and assistance provided by family caregivers and other informal supports. Their roles and contributions are assessed and included in the care plan, so that services preserve and support family caregiving, rather than reduce family caregivers' contributions. This assessment of the family caregiver is part of the strategy pursued by most states to target resources based on needs.

Oregon, for example, identifies *natural supports*, meaning resources and supports (e.g., relatives, friends, significant others, neighbors, roommates, the community) who are willing to voluntarily provide services to an individual without the expectation of compensation. Natural supports are identified in collaboration with the individual and the potential natural support. The natural support is required to have the skills, knowledge, and ability to provide the needed services and supports.

In **Massachusetts**, care managers assess consumers' needs and provide service plans that meet their needs, by incorporating family caregiver supports and other available resources and utilizing the home care–funded benefits as part of the service plan.

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3 Some concerns have been raised about whether the level of resources available to people with the highest level of need are adequate to meet their needs for assistance in the community.

4 Finance Workgroup of the Illinois Older Adult Services Advisory Committee, *How Long-Term Care Services for Seniors Are Currently Financed in Illinois* (Springfield, IL: Illinois Department on Aging, June 2007), https://www2.illinois.gov/aging/CommunityServices/Documents/finance.pdf.

5 Lewin Group, *Process Evaluation of the Older Americans Act Title III-E National Family Caregiver Support Program: Final Report*, prepared for the Administration for Community Living, (Falls Church, VA: Lewin Group, March 2016), https://acl.gov/sites/default/files/programs/2017-02/NFCSP_Final_Report-update.pdf.

Providing support to family caregivers, especially in rural areas, is important for some of these state-funded programs. In sparsely populated places, people in need of care face a lack of nearby providers, grocery stores, and pharmacies, which is particularly hard for people who do not drive and their family caregivers.

The **Nebraska** Lifespan Respite Program serves individuals of any age with a special need who live with an unpaid family caregiver in a noninstitutional setting; it also provides limited respite care to give these caregivers a break from the ongoing demands.

In **North Dakota**, both the Service Payment for the Elderly and Disabled and the Expanded Service Payment for the Elderly and Disabled programs cover a wide range of services and may pay family caregivers, including a spouse. Under its Family Home Care benefit, the program may reimburse a family caregiver who meets the relationship requirements defined by state law and who resides in a client's home 24 hours per day. The state's Dementia Care Services program provides care consultation and training to family caregivers who are caring for someone with dementia.

Pennsylvania's Caregiver Support program provides financial assistance to qualified caregivers who assist dependent low-income older adults. The program also supports individuals ages 55 and older who care for related children.

FINANCING

Because general revenue–funded HCBS programs compete with other state needs and priorities, they are often at risk when policy makers want to or must reduce program spending, shift resources to other priorities, or close budget gaps. Alternative financing strategies—such as dedicated revenues (e.g., from tobacco taxes, lottery revenues, taxes on casinos) and federal Medicaid matching payments—can help ensure adequate funding.

The level of state funding—and its stability over time—determines how many adults can receive services and the level of assistance they can receive. State HCBS programs are general revenue–funded and operate with fixed budgets. Because HCBS programs compete with other state needs and priorities, they are often at risk of budget cuts. State legislatures make annual (or biennial) appropriations for services and administrative operating costs of the programs, often informed by recommendations from the administrative agency as well as public hearings and comments.

Oregon Project Independence recently has been subject to substantial budget uncertainty. Although it ultimately was funded, the threat of defunding undermined program operations and may have deterred families from seeking assistance, causing enrollments to decline. Several years ago, enrollments also declined (from 2,166 in 2010 to 1,583 in 2011) and wait lists expanded (to 406 individuals) when program funding was reduced.[6]

Many of these programs are small and are underfunded relative to needs. In **Connecticut**, the Home Care Program for the Elderly is closed to new enrollees who are moderately frail and at risk of hospitalization or short-term nursing home placement (e.g., Category 1). In **New Jersey**, the Jersey Assistance for Community Caregiving program budget has not changed since its inception—with funding of $10 million per year and about 500 people on the waiting list.

By contrast, **Illinois** has no arbitrary cap on program spending; the CCP operates as an entitlement without a waiting list.[7] Funds are authorized to meet projected program needs, and supplemental funds can be sought to ensure

6 Legislative Committee Services, "Seniors, People with Disabilities, and Long-Term Care Services," Background Brief, (Salem, OR: Legislative Committee Services, September 2012), https://www.oregonlegislature.gov/lpro/Publications/SeniorsDDLongTermCare.pdf.

7 The entitlement resulted from a court case that was brought against the state to eliminate waiting lists for services. In 1982, the Department on Aging received an order from the US District Court in *Benson vs. Blaser*. The class action suit focused on the lengthening waiting list for community-based services for older adults. The court ruled that people on the waiting list were as entitled to timely determination of eligibility and receipt of services as beneficiaries who applied earlier, when no waiting list existed.

that all eligible applicants can be served. The CCP provides services to both Medicaid HCBS waiver enrollees and non-Medicaid enrolled adults. Services for enrollees without Medicaid are funded from general revenues.

Program funding also is relatively secure in **Pennsylvania** because lottery revenues are earmarked for programs for older adults, including HCBS programs. In a few programs, Medicaid also has become a source of funding for historically state-funded-only programs.

Washington recently secured a Medicaid waiver for vulnerable family caregivers and older adults who do not receive Medicaid (exhibit 4). This program is an emerging innovation because it combines the federal budget assistance of Medicaid with some of the state flexibilities, expanded eligibility, and speed of enrollment of a state-funded program.

EXHIBIT 4

Washington State's Emerging Innovation: Medicaid Transformation Demonstration to Tailor Supports for *Near Poor* Older Adults and Family Caregivers

Effective September 2017, Washington's Medicaid 1115 waiver allows the state to provide services to support unpaid family caregivers, and to provide a small benefit to near poor individuals who do not have an unpaid family caregiver to help them. Services that can be purchased include personal care, home-delivered meals, adult day services, and other supports designed to assist individuals to live in their own home.

The Medicaid Alternative Care (MAC) program supports unpaid caregivers to avoid or delay the need for more intensive Medicaid-funded services. The caregivers must be caring for an older Medicaid-eligible person who meets nursing home level of care. People who choose these services must decide between receiving them or traditional LTSS services such as those in the Medicaid HCBS waiver or Community First Choice.

This waiver also creates a new eligibility category and benefit package for people ages 55+ who are at risk of future Medicaid-funded LTSS but who do not currently meet Medicaid financial eligibility criteria. The Tailored Supports for Older Adults (TSOA) program offers up to $573 per month in assistance and may include the following benefits: adult day services, family caregiver training, counseling/support groups, home modifications, housekeeping, information, meal delivery, personal emergency response systems, respite care, specialized medical equipment and supplies, and transportation. Individuals who do not have an unpaid caregiver may receive personal care.

People who participate in this demonstration are not subject to Medicaid estate recovery or cost sharing. They also can begin HCBS under a presumptive eligibility determination, which is much quicker than in the traditional Medicaid program because they do not have to wait for the Medicaid eligibility process, which can take up to 45 days.

The cost of this demonstration is roughly $400 a month for each member, compared with roughly $2,000 in the traditional Medicaid personal care program. During the first year, 2,222 clients participated in the demonstration (57 clients in MAC; 616 TSOA family caregivers/clients; and 1,549 TSOA individuals). However, enrollment is increasing by 40–100 clients each month. An independent evaluation on the demonstration's impact on delivery systems, care, health outcomes, and costs will be conducted; for more information, go to https://www.hca.wa.gov/assets/program/mtd-design-for-eval.pdf.

OUTCOMES

Few states have the capacity to measure HCBS program outcomes over time, but administrative data help demonstrate their value. Program administrators and state policy makers have championed these programs.

State-funded HCBS programs help fill a pressing need. State-funded services help support family caregivers and prevent the negative consequences of unmet needs for adults who require assistance to remain in the community. Many of these programs have been in existence for decades, having demonstrated success in meeting the needs of adults and improving quality of life. Program administrators, advocates, families, and policy makers have advocated strongly for these programs and the need to improve the infrastructure for HCBS.

Few states have the capacity to formally evaluate program outcomes (e.g., enrollee and caregiver satisfaction, quality of life, care plan adequacy, reduced transitions to Medicaid, nursing home diversion, cost savings to the state), but some insights can be gleaned from administrative data.

Oregon Project Independence is linked to the state's efforts to improve health outcomes. The program empowers individuals to direct their own services and make choices to enhance their quality of life and live as independently as possible. In addition, the program is credited with reducing the number of older adults who access Medicaid-funded LTSS. In 2009, nearly two-thirds (64 percent) of clients had income below FPL, 33 percent had income between 100 and 200 percent of FPL, and 3 percent had income above 200 percent of FPL. Less than 10 percent of clients transitioned to Medicaid-funded services.[8]

In **New Jersey**, program administrators also note that relatively few clients transition to Medicaid. Most clients (roughly 50 percent) who leave the program died; about 25 percent disenrolled owing to spend down and enrolling in the state's Medicaid managed LTSS program.

8 Oregon Project Independence often has a waiting list. AAAs maintain a list of individuals who are eligible to be served by Oregon Project Independence but are unable to be served because of funding limitations. To assess the value of the program, the unable to serve lists of individuals are evaluated to determine how many of these individuals accessed Medicaid-funded services while waiting to be served by Oregon Project Independence. See Oregon Department of Human Services, "2017–19 Agency Budget Request," (Salem, OR: Department of Human Services, pages 4–5), http://www.o4ad.org/uploads/5/9/2/2/59228911/dhs_apd_arb_17-19_0916.pdf.

Conclusion: Strengthening HCBS Programs

Some states—but not most—have made significant investments outside the Medicaid program to provide services and supports to low-income people who need assistance to remain in home and community settings. These state-funded programs help families understand services and use resources wisely; they also provide modest financial assistance with the cost of an overall care plan. Although program expenditures are relatively low for most adults who receive assistance, care plan services help improve quality of life for adults who require assistance, reduce the adverse consequences of unmet needs, and delay or prevent nursing home residence.

The state-funded programs profiled in this paper provide examples of promising practices in delivering flexible and cost-effective services and supports, blending private and public resources, leveraging other sources of funding, and reinforcing family caregiving. Additional funding, such as that received by some states through Medicaid waivers, can help alleviate the financial burden on state governments and allow states to extend services to people who, today, have income or resources above Medicaid's eligibility thresholds. With additional funding, these programs could be expanded to improve services, especially for those with the highest level of need and their family caregivers.

Appendix. HCBS Programs in Nine States: Program Elements

PROGRAM NAME	PROGRAM START DATE, ADMINISTERING AGENCY	PURPOSE	ELIGIBILITY		SERVICES, BENEFIT DESIGN, COST CONTAINMENT STRATEGIES (SERVICE LIMITATIONS, COST CAPS)	CASELOAD, WAIT LIST	FUNDING, EXPENDITURES	COST PER PERSON SERVED
			AGE, CLINICAL ELIGIBILITY/CARE NEEDS, ASSESSMENT PROCESS	FINANCIAL ELIGIBILITY AND COST SHARING				
Connecticut Home Care Program for Elders (CHCPE)	1987 Administered by the Department of Social Services (DSS) DSS contracts with access agencies to assess the care needs of program participants and coordinate and manage the services provided	CHCPE helps eligible clients live at home and avoid nursing home placement Each applicant's needs reviewed to determine if they may remain at home with the help of home care services	• Age 65+ • Connecticut resident • At risk of nursing home placement (applicant needs assistance with critical needs such as bathing, dressing, eating, taking medications, and toileting; one to two critical needs [eligible for Category 1 services]) • Or clinically eligible for nursing home care (very frail, in need of short-term or long-term nursing home care; three critical needs [eligible for Category 2 services])	• State-funded portions of CHCPE (Categories 1 and 2) have no income limit • Asset limit = $35,766 for an individual; $47,688 for a couple • Cost sharing: Participants in the state-funded program pay 9% of care costs • Participants with income above 200% of the FPL; (currently $22,340 for one person) must contribute based on their *applied income* (Participants residing in affordable housing under the state's assisted living demonstration project pay only the applied income above 200% of FPL.) • CHCPE supplements and does not supplant existing help (All available third-party payments, such as Medicare, must be exhausted.)	Care plan limits: Category 1: Limited home care for moderately frail elders, at risk of hospitalization or short-term nursing home placement; care plan limit = 25% of nursing home costs ($1,445 monthly) Category 2: Intermediate home care for very frail elders with some assets above the Medicaid limits; care plan limit = 50% of nursing home costs ($2,889 monthly) • Adult day health services • Adult family living • Care management • Chore services • Companion services • Homemaker services • Home-delivered meals • Home health services • Laundry services • Mental health counseling • Respite care • Personal emergency response system • Transportation	2,750 = monthly average number of clients in the state-funded portion of CHCPE Category 1 closed to new enrollees Monthly average in state-funded and waiver portions = 16,337 Monthly average in Medicaid waiver portion = 12,224	State and federal funds (Medicaid and Social Services Block Grant) $44,502,082 = state funded Total $189,726,358	$715 = average monthly client cost in state-funded portion of CHCPE

PROGRAM NAME	PROGRAM START DATE, ADMINISTERING AGENCY	PURPOSE	ELIGIBILITY: AGE, CLINICAL ELIGIBILITY/CARE NEEDS, ASSESSMENT PROCESS	ELIGIBILITY: FINANCIAL ELIGIBILITY AND COST SHARING	SERVICES, BENEFIT DESIGN, COST CONTAINMENT STRATEGIES (SERVICE LIMITATIONS, COST CAPS)	CASELOAD, WAIT LIST	FUNDING, EXPENDITURES	COST PER PERSON SERVED
Illinois Community Care Program (CCP)	1979 (Public Act 81-202) Administered by the Department on Aging (DOA) DOA contracts with CCUs for local administration of CCP CCUs serve as central access points for older adults who have intensive long-term care needs	To provide a cost-effective and accessible system of home- and community-based services that provides alternatives to delay or prevent nursing home placement DOA has Division of Long-Term Care that administers CCP, which combines a state-funded entitlement and a Medicaid section 1915(c) waiver to provide HCBS to people ages 60 and older	Have an assessed need for long-term care (to be at risk for nursing facility placement as measured by the Determination of Need [DON] assessment) DON defines the factors that help determine a person's functional capacity and his or her unmet need for assistance in dealing with these impairments Individuals eligible for CCP services if they receive minimum score of 29 points on DON	• No income limit; asset limit: nonexempt assets of $17,500 or less; exempt assets include home, car, and personal furnishings • Although no income limit, an income level is established to determine participant's ability to contribute to cost of care • Client agrees to pay portion of all income that exceeds FPL to the provider as cost sharing for the monthly cost of care	CCU care coordinator assesses needs and determines eligibility for various programs, develops plan of care, and arranges for services Services include in-home care (homemaker, chore), adult day care, emergency home response, automated medication dispenser, information and referral, and comprehensive care coordination DON used to determine program eligibility and allocate service dollars according to a Service Cost Maximum schedule	As of September 2018, total aging participants = 107,908 (30,733 with a Medicaid managed care organization, 39,251 on CCP and on Medicaid, and 37,924 on CCP and non-Medicaid) Roughly half of the clients are non-Medicaid No wait list; all applicants who meet eligibility receive services	State funds cover non-Medicaid enrollees in CCP $800 million total appropriated state funds for FY 2019, which includes about 50 percent for Medicaid. The funds used for the CCP are general funds and later, after services are paid, reimbursement for Medicaid clients is requested.	For FY 2019, projection of an average monthly cost of care for CCP participants = $983.34 (This includes services and case management.)

PROGRAM NAME	PROGRAM START DATE, ADMINISTERING AGENCY	PURPOSE	ELIGIBILITY: AGE, CLINICAL ELIGIBILITY/CARE NEEDS, ASSESSMENT PROCESS	ELIGIBILITY: FINANCIAL ELIGIBILITY AND COST SHARING	SERVICES, BENEFIT DESIGN, COST CONTAINMENT STRATEGIES (SERVICE LIMITATIONS, COST CAPS)	CASELOAD, WAIT LIST	FUNDING, EXPENDITURES	COST PER PERSON SERVED
Massachusetts Home Care Program	1973 Executive Office of Elder Affairs Locally administered by 26 ASAPs	Assists elders to secure and maintain maximum independence in their home environment	• Eligibility based on age, residence, income, and ability to carry out daily tasks such as bathing, dressing, and preparing meals • Must be a Massachusetts resident • Must be age 60 or older, or younger than 60 years with a physician's documented diagnosis of Alzheimer's disease, a related disorder, or other dementia • Must live at home or in the home of a caregiver (cannot reside in an adult foster home, assisted living residence, or skilled nursing facility) • Must require assistance with at least one ADL and have a critical unmet need (any ADL, meal preparation, food shopping, home health services, medication management, respite care, transportation for medical treatments) • Applicants assessed using a comprehensive tool and assigned a functional impairment level/priority	• Eligible individuals may have monthly copayment for services based on income amount • Copayments in the form of a fixed monthly amount or a percentage of a service rendered for which the consumer is responsible • Income eligibility thresholds adjusted annually by cost of living • Income-related cost sharing required (monthly copayment of $10 to $141 for an individual in 2017) • Cost sharing may be waived in case of hardship, but individuals may be disenrolled for nonpayment • Voluntary copayment • Annual redetermination of eligibility • Financial Eligibility Guidelines adjusted annually by a cost-of-living index	• Interdisciplinary team of care managers and nurses from ASAPs conducts an assessment in the person's home to determine eligibility for the programs • Final services determined on a case-by-case basis and are written up in a care management plan. They may include any of the following: – Adult day health care – Alzheimer's/dementia care – Companion services – Chore services – Food shopping – Home health aides – Home health services – Homemaker services, including laundry – Meal delivery – Meal planning and preparation – Medication assistance – Minor home repair and yard work – Nutrition counseling – Personal care services – Personal emergency response services – Respite care – Skilled nursing care – Transportation assistance	47,000 low-income older adults through its Home Care Program, including the Basic Home Care Program (with 31,504 enrollees) and three related programs: Enhanced Community Options (9,843); Respite Over Income (5,731), which began as a respite program in 1985; and Home Care Over Income (199), which began in 2017	NA	NA

PROGRAM NAME	PROGRAM START DATE, ADMINISTERING AGENCY	PURPOSE	ELIGIBILITY		SERVICES, BENEFIT DESIGN, COST CONTAINMENT STRATEGIES (SERVICE LIMITATIONS, COST CAPS)	CASELOAD, WAIT LIST	FUNDING, EXPENDITURES	COST PER PERSON SERVED
			AGE, CLINICAL ELIGIBILITY/CARE NEEDS, ASSESSMENT PROCESS	FINANCIAL ELIGIBILITY AND COST SHARING				
Massachusetts Enhanced Community Options Program (ECOP)	1993 Executive Office of Elder Affairs Locally administered by 26 ASAPs	Enhanced Community Options Program designed to address the needs of nursing home-eligible elders who do not qualify for Mass Health standard and who require additional supports and services to remain safely and independently at home	Participants must be assessed and determined to require the level of care provided in a skilled nursing facility (or nursing home) Care manager/nurse team from Elder Services conducts needs assessment to determine eligibility. This team will work with the older adult and his or her family members to determine a plan of care and offer ongoing case management support. *Eligibility requirements:* • Meet the eligibility guidelines for the state Home Care Program • Meet clinical eligibility requirements for nursing facility placement • Require home care services greater than two times those available through the general state Home Care Program	Enhanced Community Options Program has same financial eligibility requirements as Home Care Program As of 2017, for financial assistance for home care services, single adult must have annual income of less than $26,561; for a couple, less than $37,581	Same services as basic Home Care Program (see above) Consumers on ECOP receive home visits more frequently and have higher monthly dollar amount available to them to design a service plan to meet their specific needs	9,843	NA	NA
Nebraska Care Management	2008	To assist older individuals in coordinating in-home and community-based care, provided by the AAAs	Individuals ages 60+	All individuals ages 60+ eligible, but there is a sliding fee scale based on income No cost sharing for under 149% of FPL; 100% cost sharing for 300% of FPL	Information and referral and case management	4,151 in 2017 49,446 hours in 2017	$2.3 million in 2018	NA

PROGRAM NAME	PROGRAM START DATE, ADMINISTERING AGENCY	PURPOSE	ELIGIBILITY		SERVICES, BENEFIT DESIGN, COST CONTAINMENT STRATEGIES (SERVICE LIMITATIONS, COST CAPS)	CASELOAD, WAIT LIST	FUNDING, EXPENDITURES	COST PER PERSON SERVED
			AGE, CLINICAL ELIGIBILITY/CARE NEEDS, ASSESSMENT PROCESS	FINANCIAL ELIGIBILITY AND COST SHARING				
Nebraska Lifespan Respite	2002	To give caregivers a break from the demands of providing ongoing care for an individual with special needs regardless of the individual's disability and/or chronic illness diagnosis, special needs, or family circumstances To coordinate community respite services and to provide funding for caregivers to purchase respite services	Individuals of any age with a special need who live with an unpaid caregiver in a noninstitutional setting and meet financial criteria. Special needs include, but are not limited to, developmental disabilities; physical disabilities; chronic illness; physical, mental, or emotional conditions; special health care needs; cognitive impairments that require ongoing supervision; or situations in which there is a high risk of abuse or neglect for the individual with special needs. For individuals who are ineligible for other government-funded respite services	Client's income minus allowable disregards must be at or below 312% of FPL to qualify	$125 per month and up to $1,000 per year for exceptional needs Families can bank respite subsidies for months and then use them for camps or adult day health	340 on any given day in 2017 OR 949 total for 2016	$810,000 for direct services + $404,643 for infrastructure in 2017	NA

PROGRAM NAME	PROGRAM START DATE, ADMINISTERING AGENCY	PURPOSE	ELIGIBILITY		SERVICES, BENEFIT DESIGN, COST CONTAINMENT STRATEGIES (SERVICE LIMITATIONS, COST CAPS)	CASELOAD, WAIT LIST	FUNDING, EXPENDITURES	COST PER PERSON SERVED
			AGE, CLINICAL ELIGIBILITY/CARE NEEDS, ASSESSMENT PROCESS	FINANCIAL ELIGIBILITY AND COST SHARING				
Nebraska Social Services for Aged and Disabled (SSAD) Adults program	1973 Administered by Nebraska Department of Health and Human Services	To offer two types of support services to Nebraska residents: support targeted at the individual in need of care and support targeted at his or her primary caregiver. SSAD's goal is to help frail seniors continue to live as independently as possible, and as such, services are provided to beneficiaries in their homes and in the community, but not to people residing in skilled nursing residences. The exception to this is when nursing home residency is temporary and the individual will be returning to live in his or her home at some point in the near future.	Targeted to individuals who need lower levels of care at home than those in the Medicaid Personal Assistance Services program To qualify for services, one must be the following: • A legal resident of the state of Nebraska • 60 years of age, or blind and between the ages of 19 and 59, or determined disabled by a medical professional • Physically or mentally impaired such that assistance is required for ADLs • Living at home or temporarily residing in rehabilitation and intending to return home Service needs assessment can be conducted over phone	Income guidelines change each year with cost-of-living adjustments. In 2018, the approximate limit for an individual was $1,149 per month and for a married couple was $1,288 per month. Or, in annual terms, under $13,776 for an individual and under $15,459 for a married couple/two-person household. However, individuals with incomes over these thresholds may still qualify, as there are many exceptions to what is considered *countable* income. Currently, there are no asset limits. No cost sharing Some recipients are on Medicaid but do NOT qualify for personal assistance services because of a lower level of functional need Great flexibility regarding resources and exceptions	• Adult day care • Chore services • Food preparation • Grocery shopping • Group meals (in senior centers) • Homemaker services • Housecleaning • Laundry • Meal delivery • Personal care (limited) • Transportation assistance Service limits: • Chores limited to 15 hours per week • Transportation for shopping is one trip a week • Transportation for legal and financial services limited to twice a month • One meal a day limit • Adult day limited to three days a week but allows for exceptions Unpaid caregivers (but not spouses or someone legally responsible) can get paid, but they need to complete training and background check	Currently 4,049 individuals receive SSAD services. No wait list	$8,243,567 ($941,420 from federal Social Services Block Grant; $7,302,147 from state general funds)	Average cost a year per person: Congregate meals: $651; adult day services: $2,735; home-based services chore: $1,683; transportation: $1,529

PROGRAM NAME	PROGRAM START DATE, ADMINISTERING AGENCY	PURPOSE	ELIGIBILITY		SERVICES, BENEFIT DESIGN, COST CONTAINMENT STRATEGIES (SERVICE LIMITATIONS, COST CAPS)	CASELOAD, WAIT LIST	FUNDING, EXPENDITURES	COST PER PERSON SERVED
			AGE, CLINICAL ELIGIBILITY/CARE NEEDS, ASSESSMENT PROCESS	FINANCIAL ELIGIBILITY AND COST SHARING				
New Jersey Jersey Assistance for Community Caregiving (JACC)	Established in 2000 Overseen by New Jersey Department of Human Services, Division of Aging Services; administered by local AAAs (Aging and Disability Resource Connection)	Provides a broad array of in-home services to enable an individual who is at risk of placement in a nursing facility and who meets income and resource requirements to remain in his or her community home	• Age 60 years or older • Resides in a home that they own or rent, or lives in an unlicensed home of a relative or friend • Has no alternate means available to secure needed services and/or supports • Has been determined to be clinically eligible for nursing facility level of care (as determined by State regulation N.J.A.C. 8:85-2.1) • Is a US citizen or a qualified alien	• Is not financially eligible for Medicaid managed LTSS or other family care program • Asset limit: Countable resources must be less than $40,000 for a single person or $60,000 for a couple (excludes value of a home and personal effects) • Cost sharing: Enrollees with income above FPL are assessed income-related copayments of $15 to $120 per month	• Based on the results of a clinical assessment, plan of care developed collaboratively by participant and his or her care manager • All JACC participants receive care management services • Other plan of care services may include respite care, homemaker services, environmental accessibility adaptations, personal emergency response systems, home-delivered meal service, caregiver/recipient training, social adult day care, adult day health services, special medical equipment and supplies, transportation, chore services, attendant care, or home-based supportive care • Participants may opt for self-direction or Participant-Employed Providers option. They must have the capacity and desire to self-direct. • Cost cap on services: Overall cost cap of $600 per month, plus cost caps for individual services	Monthly caseload: About 1,300–1,500 State Fiscal Year (SFY) 2017 total enrollment: 2,153 Wait list: About 500	Annual appropriation: $10,000,000	Capped at $7,200 per year; $600 per month

PROGRAM NAME	PROGRAM START DATE, ADMINISTERING AGENCY	PURPOSE	ELIGIBILITY		SERVICES, BENEFIT DESIGN, COST CONTAINMENT STRATEGIES (SERVICE LIMITATIONS, COST CAPS)	CASELOAD, WAIT LIST	FUNDING, EXPENDITURES	COST PER PERSON SERVED
			AGE, CLINICAL ELIGIBILITY/CARE NEEDS, ASSESSMENT PROCESS	FINANCIAL ELIGIBILITY AND COST SHARING				
North Dakota Service Payment for the Elderly and Disabled (SPED)	1983 Department of Human Services, Aging Services Division Administered by County Social Service Agencies at the local level	Provides services for people who are older or physically disabled and who have difficulty completing tasks that enable them to live independently at home Provides and pays for a variety of services to sustain individuals in their homes and communities, especially rural communities	• Older adults and people with physical disabilities • Based on an assessment: impaired in four ADLs or in at least five IADLs, totaling eight or more points, or if living alone totaling at least six points • Impairments must have lasted or are expected to last three months or more • Is not eligible for a Medicaid waiver • Need for service is not due to mental illness or intellectual disability • Person is capable of directing own care or has a legally responsible party • Person has needs within the scope of covered services, or if under age 18 is screened for nursing facility level of care	• Inability to pay for services; liquid assets less than $50,000 • Two cost-sharing, sliding-fee schedules: one for people with less than $25,000, and one for people with more than $25,000 but less than $50,000 in assets • May not be eligible for a Medicaid waiver	• Adult day care • Adult foster care • Case management • Chore services • Emergency response system • Environmental modifications • Extended person care/ nurse education (education given by a nurse to an enrolled qualified service provider who provides medical care specific to a client's needs) • Family home care (reimburses a family caregiver who meets the relationship requirements defined by state law and resides in a client's home 24 hours per day) • Homemaker • Home-delivered meals • Nonmedical transportation • Personal care services • Respite care	SFY 2017, average monthly clients: 1,025	State general funds SFY 2017: Annual appropriation: $7,766,914 Annual expenditures: $6,079,199	SFY 2017, average monthly cost per client: $494

PROGRAM NAME	PROGRAM START DATE, ADMINISTERING AGENCY	PURPOSE	ELIGIBILITY		SERVICES, BENEFIT DESIGN, COST CONTAINMENT STRATEGIES (SERVICE LIMITATIONS, COST CAPS)	CASELOAD, WAIT LIST	FUNDING, EXPENDITURES	COST PER PERSON SERVED
			AGE, CLINICAL ELIGIBILITY/CARE NEEDS, ASSESSMENT PROCESS	FINANCIAL ELIGIBILITY AND COST SHARING				
North Dakota Expanded Service Payment for the Elderly and Disabled (Expanded-SPED or Ex-SPED)	1994 Human Services, Aging Services Division Administered by County Social Service Agencies at the local level	Pays for in-home and community-based services for people who would otherwise receive care in a licensed basic care facility Targeted to low-income older adults who may require some ADL assistance but whose primary need is for help with IADLs or supervision at home or in a more structured environment (e.g., adult foster care)	• Older adults (ages 60+) or adults ages 19–59 with disabilities • Individual is not severely impaired in the ADLs of toileting, transferring, eating • Impaired in three or four IADLs: meal preparation, housework, laundry, or taking medications • Has health, welfare, or safety needs, including supervision or structured environment, otherwise requiring care in a basic care facility, and has needs within the scope of covered services	• Low income: Must be enrolled in or financially eligible for Medicaid or Supplemental Security Income	• Adult day care • Adult foster care • Case management • Chore services • Emergency response system • Environmental modification • Extended personal care/ nurse education • Family home care • Homemaker • Home-delivered meals • Nonmedical transportation • Personal care services • Respite care	Average monthly clients: 140 (SFY 2017)	State general funds: SFY 2017 Total appropriation: $798,984 Total expenditures: $686,514	Average monthly cost per client: $408 (SFY 2017)

PROGRAM NAME	PROGRAM START DATE, ADMINISTERING AGENCY	PURPOSE	ELIGIBILITY		SERVICES, BENEFIT DESIGN, COST CONTAINMENT STRATEGIES (SERVICE LIMITATIONS, COST CAPS)	CASELOAD, WAIT LIST	FUNDING, EXPENDITURES	COST PER PERSON SERVED
			AGE, CLINICAL ELIGIBILITY/CARE NEEDS, ASSESSMENT PROCESS	FINANCIAL ELIGIBILITY AND COST SHARING				
North Dakota Dementia Care Services (DCS) Program	2010 House Bill 1043 (passed in 2009) directed Department of Human Services to contract with private provider to develop and implement statewide DCS program DCS program administered by Alzheimer's Association of Minnesota-North Dakota	Provides care, consultation, and training to caregivers to address individual needs that arise during various stages of dementia One-on-one assistance enables individuals and their caregivers to better manage care and make more informed decisions about services and treatment	Eligibility not based on age, diagnosis, or income Individuals with dementia and their caregivers eligible to receive care consultation, education and training, and referral services Anyone eligible to participate in educational sessions on dementia	• No income eligibility restrictions • No cost to individuals for program services	• Care consultation including assessing needs; identifying issues, concerns, and resources; developing care plans; making referrals; and providing education and follow-up • Training for caregivers to manage care needs for individuals with dementia • Facilitate with referrals to appropriate care and support services • Information and training to medical professions, law enforcement, caregivers, and the public regarding dementia symptoms, benefits of early detection and treatment, and services available for individuals with dementia and their caregivers	July 1, 2015–June 30, 2017 Individuals with dementia served: 861 Caregivers served: 1,838 Care consultations: 2,358	State general funds SFY 2015 expenditures: $500,410 SFY 2016 expenditures: $478,039	NA

PROGRAM NAME	PROGRAM START DATE, ADMINISTERING AGENCY	PURPOSE	ELIGIBILITY: AGE, CLINICAL ELIGIBILITY/CARE NEEDS, ASSESSMENT PROCESS	ELIGIBILITY: FINANCIAL ELIGIBILITY AND COST SHARING	SERVICES, BENEFIT DESIGN, COST CONTAINMENT STRATEGIES (SERVICE LIMITATIONS, COST CAPS)	CASELOAD, WAIT LIST	FUNDING, EXPENDITURES	COST PER PERSON SERVED
Oregon Project Independence (OPI)	1975 (traditional program) 2005 (disability pilot) Department of Human Services, Aging and People with Disabilities Division	Provides individuals over the age of 60, regardless of income, with in-home services to help them stay in their own homes, to promote self-determination and aging in place Optimizes eligible individuals' personal and community supports to reduce the risk of out-of-home placement and prevent or delay spend down to more expensive Medicaid-funded long-term care[a]	Traditional program: • Older adults (ages 60+) • People diagnosed with Alzheimer's disease or a related disorder Disability pilot: • People with physical disabilities ages 19–59 (pilot, not statewide) • Must need in-home services (i.e., need assistance with ADLs, IADLs) • Need assessed using (a) the Client Assessment and Planning System and (b) a risk assessment tool that assesses the risk of out-of-home placement • Applicant assigned a Service Priority Level that varies from 1 (highest need) to 18 (lowest)	• May not be enrolled in Medicaid • Eligibility not limited based on income or assets • Income-related fees apply.[b] • Services provided at no cost to families with net incomes at or below 150% of FPL • People with income between 150% and 400% of FPL pay sliding scale fee (of 5% to 90% of service costs) • For people with income above 150% of FPL, fees apply to all services except service coordination • People with net income above 400% of FPL pay full cost of services	• Traditional program services delivered statewide (36 counties) through the network of 17 designated AAAs • OPI complements services provided under Older Americans Act • Disability pilot limited to 12 counties (7 AAAs) • OPI provides essential services, such as personal care, home care and chore assistance, adult day care, service coordination, registered nursing (teaching/delegation of nursing tasks to caregivers), and home-delivered meals • No cost or hour caps • Other authorized services for which OPI funds may be expended are authorized on a case-by-case basis by the director of the department. Other authorized services may include (a) services to support community caregivers and strengthen the natural support system of individuals, (b) evidence-based health promotion services, (c) options counseling, or (d) assisted transportation options that allow individuals to live at home and access the full range of community resources.	As of January 25, 2017: 1,806 in the traditional program; the pilot program is serving 293 adults with disabilities[c] Wait list: Yes, in some areas	State general fund financing. Some counties add local funds, which gives the state and AAAs flexibility in how to use the funds to meet local needs. OPI funding fluctuates depending on state general fund availability: $26.6 million for 2015–17 biennium $20.6 million for traditional OPI; $6 million for the disability pilot Annualized budget: $13.3 million (2015–17)	Average monthly cost per case is $332 per month.[d]

[a] A 2014 study showed that over an 18-month period, only 19 percent of Oregon Project Independence consumers converted to Medicaid services. See Oregon Department of Human Services, "Fact Sheet: Oregon Project Independence," (Salem, OR: Oregon Department of Human Services), https://olis.leg.state.or.us/liz/2017R1/Downloads/CommitteeMeetingDocument/98479.

[b] For people with income above 150 percent of FPL, fees apply to all services, except service coordination.

[c] Oregon Department of Human Services, "Fact Sheet: Oregon Project Independence."

[d] A 2012 study found that Oregon Project Independence consumers use 24 percent of the average hours used by a Medicaid beneficiary. Cited in Oregon Department of Human Services, "2017-19 Agency Budget Request."

PROGRAM NAME	PROGRAM START DATE, ADMINISTERING AGENCY	PURPOSE	ELIGIBILITY		SERVICES, BENEFIT DESIGN, COST CONTAINMENT STRATEGIES (SERVICE LIMITATIONS, COST CAPS)	CASELOAD, WAIT LIST	FUNDING, EXPENDITURES	COST PER PERSON SERVED
			AGE, CLINICAL ELIGIBILITY/CARE NEEDS, ASSESSMENT PROCESS	FINANCIAL ELIGIBILITY AND COST SHARING				
Pennsylvania OPTIONS	1990 Administered by the Department on Aging Local administration by AAAs OPTIONS is part of PENNCARE. PENNCARE has three programs: (a) OPTIONS; (b) aging services, which include meals, home health, employment services, and recreation at senior centers; and (c) attendant care for personal care services to adults with physical disability who age out from the attendance care program, which serves individuals under age 60	HCBS program for consumers ages 60+ to assist them in maintaining independence with the highest level of functioning in the community and to delay the need for more costly services	• Age 60+ • Citizen or lawful permanent resident • Experiences some degree of frailty—mentally or physically—that affects daily function • Consumers who receive OPTIONS service must be assessed using Needs Assessment Tool (NAT) or NAT-Express • Must receive care management services—with the exception of individuals who receive transportation and Non-Congregate/In-Home Meals only[e] • May be clinically or financially ineligible for Medicaid LTSS • May be assessed with a level of care determination of Nursing Facility Eligible or Ineligible • If clinical eligibility for nursing facility care is met, then resident must be financially ineligible for Medicaid	• No income or resource tests for eligibility, but income-related cost sharing applies • Sliding scale fee (2%–98% of service plan costs) applies for individuals with income > 133% and < 300% of FPL • Full cost paid by consumer above 300% of FPL • Cost sharing based on countable monthly income (countable income excludes 30% flat disallowance for Medicare Part B premiums, food stamps, LIHEAP payments, reverse mortgages) • Consumers with countable income above 300% of FPL pay full costs • Cannot receive Medicaid LTSS • Must apply for Medicaid if close to financial eligibility[f] • Mandatory Medicaid Eligibility Determination Process does not apply to individuals who need care management or in-home meal service (alone or in combination)	AAAs are required to offer the following OPTIONS services: • Care management • In-home meal service • Older adult daily living services • Personal care services AAAs may offer additional services according to their local policies as funds are available: • Emergent services (for an immediate need owing to a critical event such as cover services, overnight shelter, or emergency supplies) • Home health services • Home modifications ($15,000 limit) • Home support services (including assistance with IADLs, laundry, shopping, meal preparation, etc.) • Personal emergency response system • Pest control/fumigation • Specialized medical transportation • Supplemental services (which cannot be provided now because of the waiting list for core services)	Total people served (2017): 67,436 Does not meet nursing facility level of care: 59,156 Meets nursing facility level of care: 8,280 Wait list: Yes	Lottery funds $336 million for all PENNCARE programs OPTIONS: Primarily Aging Block Grant; lottery $170.6 million in 2017 (state + federal)	Care plan cost cap is $765 per month. Exceptions may be granted (in rare instances). $9,180 per year

[e] Non-Congregate/In-Home Meals consumers will be assessed using the Needs Assessment Tool Express, and care management can be provided by a case aide who is supervised by a care manager or a care management supervisor.

[f] Pennsylvania Policy Procedure Manual, Appendix F.4, (Harrisburg, PA: Pennsylvania Department of Aging, November 19, 2014), http://www.aging.pa.gov/publications/policy-procedure-manual/Documents/Appx%20F.4%20Financial%20Threshold%20for%20Mandatory%20Medical%20Assistance%20Eligibility%20Determination%20Process.pdf.

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Pennsylvania Caregiver Support Program	1990 Department of Aging Local administration by AAAs	To provide financial assistance to primarily qualified caregivers who assist dependent low-income older adults	Individuals who care for a spouse, relative, or friend who requires assistance owing to disease or disability. The program also supports individuals ages 55 and older who are caring for related children.	Financial assistance available to qualified caregivers based on income. Households with incomes up to 200% of FPL are eligible for 100% of the maximum benefit. The benefit decreases by 10% for every 20% increase in income. Households with incomes above 380% of FPL are not eligible for the program.	Reimburses caregivers up to $200 per month for out-of-pocket expenses on services and supplies. It can be used for respite care, transportation, incontinence supplies, and education and counseling for caregivers. Provides one-time grants of up to $2,000 for home modifications and assistive devices, including wheelchair ramps, grab bars, and chair lifts	5,256 families in FY 2017/18	Total in 2017/18 = $17.1 million $12.1 million from the lottery, which is an overmatch; remainder comes from the Older Americans Act	$200 per month; one-time grant of $2,000 for home modifications and assistive technology
Washington Medicaid Alternative Care (MAC)[g]	Launched September 2017 Department of Social and Health Services	To support unpaid caregivers who are avoiding or delaying the need for more intensive Medicaid-funded services	For unpaid caregivers caring for a Medicaid-eligible person who meets nursing home level of care Individual must be age 55+, live in a home setting, and be a state resident	Individuals who are eligible for Medicaid but not currently using Medicaid-funded LTSS No cost sharing or estate recovery	Up to $573 per month in assistance. People who choose services must make a choice between receiving this program's services or traditional LTSS services, such as those in the Medicaid HCBS waiver or Community First Choice.	57	Billed services in first year: $35,437	About $350 per month

[g] Monthly caseload projections for MAC and TSOA are 1,348 in 2018; 5,315 in 2020; and 6,906 in 2021. Total funding for the MAC and TSOA demonstration, including services and administration, is $19.5 million in 2018; $37.2 million in 2019; $53.7 million in 2020; and $57.9 million in 2021. Given how new this demonstration is, state administrators are reviewing the targets in light of the first year's actuals and determining reasonable projections going forward. Source: Email and phone interview communications with Washington Aging and Long-Term Support Administration, October 2018.

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Washington Tailored Supports for Older Adults (TSOA)	Launched September 2017 Department of Social and Health Services	Supports older individuals and their families to avoid or delay impoverishment	To provide services and supports to individuals ages 55 and older with low incomes who currently do not meet Medicaid financial resource eligibility criteria but do meet functional criteria for care	Income limit of 300% of the Federal Benefit Rate or $2,250 per month for a single individual. If an applicant is married, the income of the spouse is not considered. The asset limit for a single individual is $53,100, and married couples can have assets up to $108,647. Some assets not counted toward this limit and include one's home, regardless of equity value; home furnishings; a vehicle; and burial funds up to $1,500 for the applicant and $1,500 for his or her spouse	Up to $573 per month in assistance; may include the following benefits and services: • Adult day care/adult day health • Caregiver training and education (for Alzheimer's caregivers) • Counseling/support groups • Home modifications, such as the addition of grab bars or wheelchair ramps • Housekeeping/errands • Information regarding caregiving • Meal delivery • Personal emergency Response systems • Respite care • Specialized medical equipment/supplies • Training—assists caregivers in gaining knowledge and skills to provide care • Transportation—for delivery of services • Personal care assistance and nurse delegation, such as medication administration and testing of blood glucose levels, in place of respite care, available for seniors who do not have an unpaid caregiver	616 family caregivers/individuals (dyad) 1,549 individuals	Billed services in first year: $495,763 (for dyads) $1.5 million (for individuals)	About $350 per month

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Washington Family Caregiver Support Program	1989 Department of Social and Health Services Local administration by AAAs	To support unpaid family caregivers, so they may continue to provide care to their loved ones	Caregivers and care receivers must be at least 18 years old. Caregivers are assessed using the evidence-based TCARE® Assessment process. Eligibility for services is determined by TCARE® burden scores and the amount of time spent caregiving.	Services targeted to lower-income families; cost sharing on a sliding scale applies only to those who receive respite services and have incomes above the state median income	Provides services to unpaid caregivers who provide supports to adults using evidence-based TCARE® to assess the burdens, stresses, and uplifts experienced by caregivers, to guide the choice of interventions, such as training/education, counseling, respite, equipment/supplies, and wellness therapies	5,460	$11 million state funding $3 million Older Americans Act Title 3E	Average: $2,564/ year
Washington Senior Citizens' Services Act	1977 Department of Social and Health Services	Provides older individuals, regardless of income, with in-home services to help them stay in their own homes, to promote self-determination and aging in place Funding also used to match Older Americans Act funding	Eligible individuals are ages 65+; OR ages 60+, and either unemployed or working 20 hours a week or less AND They must also have a physical, mental, or other type of impairment, which without services would prevent them from remaining in their home Need determined locally and services available vary by AAA	Nonexempt resources not to exceed $10,000 for a single person or $15,000 for a family of two, increased by $1,000 for each additional family member of the household Income at or below 40% of the state median income will have services without cost sharing; a sliding-fee basis available for those with higher incomes	Determined locally by the AAA Some services provided at no charge regardless of income or need requirements. These services include, but are not limited to, nutritional services, health screening, and access services.	About 6,000	$8,417,481 state funds	Highly variable

NA = Not Available

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