

Report to the Health and Human Services Interim Committee

Report on Medicaid Long Term Services and Supports

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The Utah Department of Health and
The Utah Department of Human Services

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utah department of
human services

Executive Summary

In response to SB140 and intent language from SB03 from the 2016 Legislative General Session, the Department of Health, in collaboration with the Department of Human Services, developed this report to evaluate the benefits and risks of a variety of Long Term Services and Supports (LTSS) options available to state Medicaid programs.

LTSS provide assistance with activities of daily living to seniors and individuals with disabilities, such as eating, bathing, dressing, preparing meals, and managing medication. LTSS are provided by formal (paid) and informal (unpaid) caregivers, and are funded privately (private insurance or out-of-pocket) and publicly (Medicaid, Medicare and VA benefits). LTSS can be provided in home and community based settings or in settings such as nursing facilities and intermediate care facilities for individuals with intellectual disabilities.

To provide additional context, this report provides background information about the evolution of national LTSS policy, describes important LTSS concepts, and provides information about Utah's current LTSS system.

Since 2005, the Centers for Medicare and Medicaid Services (CMS) have introduced a variety of LTSS initiatives that offer both short-term and ongoing enhanced federal funding to encourage states to participate in the new LTSS programs.

Historically, the Department of Health and the Department of Human Services (Departments) have evaluated new LTSS programs as they have been introduced and have attempted to perform an objective review that considered whether new programs comport within the Departments' strategy of providing LTSS. The Departments' ongoing LTSS strategy has been to implement programs that provide needed services in a manner that allows the State to manage program growth, does not increase entitlement programs, nor leave the state with open-ended funding obligations. The Departments assessed whether enhanced federal funding would be sufficient to cover the projected increases in service utilization and number of individuals served and whether new programs could be implemented within existing appropriations. This is the same evaluation process the Departments used to draft this report. In addition to their own program history and experience, the Departments reviewed research studies and national reports to draw some additional conclusion about LTSS policy.

In addition to cost-related considerations, the Departments acknowledge there are multiple factors, such as quality of life and individual choice, which legislators may consider when making decisions about LTSS coverage policy.

When making recommendations within this report, the Departments use the following terms:

“Recommended Option” describes an option that can be expected to improve programs and services and can likely be accomplished within existing appropriations;

“Recommended, but Subject to Availability of Funding” describes options that can be expected to improve programs and services but that will likely require additional funding. Although the options may require additional funding, implementation would not result in creating a new entitlement program nor loss of State budgetary control;

“Not Recommended” describes programs that will create a new entitlement, result in open-ended budgetary obligations and/or loss of State programmatic control; and

“Requires Additional Evaluation” describes programs that require additional review prior to the Departments making recommendations.

Summary of Recommendations (Detailed recommendation information is found in *Section V. Benefit and Risk Analysis of LTSS Programs*. Specific page numbers for each recommendation are listed below.)

Recommended

1. Redirect current funding from the Division of Services for People with Disabilities' (DSPD) State-only funded programs to DSPD's home and community based waivers. (See Page 22.)

Recommended, but Subject to Availability of Funding

2. Convene a workgroup to evaluate HCBS waiver coverage of housing-related activities and services for seniors and individuals with disabilities. (See Page 19.)
3. Conduct a review of the rates for in-home services (such as respite and in-home behavioral supports) and determine if there is sufficient access to these services. (See Page 20.)

Not Recommended

4. The Money Follows the Person Program. In addition to not being recommended, Utah will not be able to apply for this program unless Congress reauthorizes it to continue beyond September 2016. (See Page 15.)
5. The Community First Choice Option. (See Page 18.)
6. The LTSS Balancing Incentive Program. In addition to not being recommended, Utah is not eligible to apply for this program because it was not reauthorized beyond September 2015 and because Utah has reached the greater than 50 percent of LTSS spending on HCBS threshold. (See Page 18.)

Requires Additional Evaluation

7. The Departments recommend convening a workgroup to evaluate the feasibility of limited HCBS as State Plan Services under 1915(i) Authority for a targeted population(s). (See Page 23.)

To ensure ongoing discussions of current and emerging LTSS issues, the Departments commit to holding regularly scheduled, LTSS Stakeholder forums.

The Departments appreciate the opportunity to compile this report and engage with the Legislature and other stakeholders in conversations about LTSS policy.

I. Introduction

In response to SB140 and intent language from SB03 from the 2016 Legislative General Session, the Department of Health, in collaboration with the Department of Human Services, developed this report to evaluate the benefits and risks of a variety of Long Term Services and Supports (LTSS) options available to state Medicaid programs including:

- Money Follows the Person Demonstration Grants
- Community First Choice Option, 1915(k)
- LTSS Balancing Incentive Program
- Home and Community Based Waivers, 1915(c)
- State Plan Home and Community Based Services, 1915(i)

To provide additional context, the report also provides background information about the evolution of national LTSS policy, describes important LTSS concepts, and provides information about Utah's current LTSS system.

What are Long Term Services and Supports?

LTSS provide assistance with activities of daily living to seniors and individuals with disabilities, such as eating, bathing, dressing, preparing meals, and managing medication. LTSS are provided by formal (paid) and informal (unpaid) caregivers, and are funded privately (private insurance or out-of-pocket) and publicly (Medicaid, Medicare and VA benefits). LTSS can be provided in home and community based settings or in settings such as nursing facilities (NF) and intermediate care facilities for individuals with intellectual disabilities (ICF/ID or ICF).

Services provided in NFs and ICFs are often referred to as institutional care or facility-based care. This report uses the term facility-based care to refer to services provided in NFs and ICFs.

II. National LTSS Policy and Cost Overview

Policy

With the authorization of Medicaid in 1965, state Medicaid programs were required to cover LTSS in nursing facilities as a mandatory service. For more than 15 years, Medicaid's coverage of LTSS was only available if the individual resided in a facility-based setting. In 1981, the Social Security Act was amended to allow LTSS to be provided in home and community based settings as an alternative to care provided in nursing facilities. Programs authorized under 1915(c) of the Social Security Act are commonly referred to as Home and Community Based Services (HCBS) or 1915(c) waivers. Unlike mandatory coverage of LTSS provided in nursing facilities, HCBS waivers were authorized as an optional benefit. These policies make facility-based LTSS a Medicaid entitlement; whereas HCBS is an optional service, not an entitlement.

The Supreme Court case *Olmstead v. L.C.* ruling in 1999 played a significant role in shaping national LTSS policy. The *Olmstead* decision interpreted Title II of the Americans with Disabilities Act and its implementing regulations that require states to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities". The ruling held that states should make reasonable modifications to policies, practices and procedures unless such modifications would fundamentally alter the nature of the service or program.

By the time the *Olmstead* decision was released in 1999, Utah Medicaid was in the process of implementing an innovative nursing facility deinstitutionalization program. This program was, in many ways, a forerunner to the federal Money Follows the Person program that was introduced by the Centers for Medicare and Medicaid Services (CMS) in 2005. Utah's pilot program initially included a few dozen participants, but has grown significantly over time. With the implementation of the New Choices Waiver in 2007, the pilot program was converted to an ongoing

program. In its first year, the New Choices Waiver served 610 individuals. Today this waiver serves approximately 2,200 individuals.

Table 1 - History of Medicaid LTSS - National Timeline

YEAR	ACTION
1965	Medicaid program authorized. Mandatory coverage of LTSS in skilled nursing facilities was included.
1971	Optional coverage of long term services in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID) was authorized.
1981	Optional Coverage of 1915(c) Home and Community Based Waivers, in lieu of LTSS in a facility-based setting was authorized under OBRA 81.
1982	Option to extend Medicaid coverage to children with disabilities, who require facility-based care, but are living at home (Katie Beckett) was authorized under TEFRA
1999	Supreme Court Ruling on the <i>Olmstead Case</i> . The Olmstead decision interpreted Title II of the Americans with Disabilities Act and its implementing regulations that require states to administer their services, programs, and activities “in the most integrated setting appropriate to the needs of qualified individuals with disabilities”. The ruling held that states should make reasonable modifications to policies, practices and procedures unless such modifications would fundamentally alter the nature of the service or program. This case has played a significant role in shaping national LTSS policy.
2005	Money Follows the Person Grant and State Plan HCBS options are introduced through the Deficit Reduction Act (DRA) 2005.
2010	Money Follows the Person Grant is reauthorized, State Plan HCBS options are expanded, and the Balancing Incentive Program and Community First Choice Option programs are introduced through the Affordable Care Act (ACA) 2010.

Cost

Informal/Unpaid Supports – It is estimated that more than fifty percent of LTSS in the U.S. is provided by unpaid caregivers (relatives and friends) in home and community based settings. This type of care is often referred to as informal supports. According to a report, *Rising Demand for Long-Term Services and Supports for Elderly People*, published by the Congressional Budget Office in 2013:

“Providing care imposes costs on informal caregivers in the form of time, effort, forgone wages, and other economic costs. Assuming that informal caregivers provide care similar in value to that provided by home health aides, the Congressional Budget Office (CBO) estimates that the value of that care totaled approximately \$234 billion in 2011. Because many informal caregivers must sacrifice time that might otherwise be spent earning a wage, the value of that care in terms of forgone wages could be even higher.”

Formal/Paid Supports – Medicaid is the primary payer of LTSS. In 2012 Medicaid accounted for 61 percent of total national spending on LTSS. In 2014, LTSS accounted for approximately 25 percent of state Medicaid budgets nationwide. In the same year, LTSS accounted for approximately 22 percent of Utah’s Medicaid budget.

HCBS now Account for the Majority of National LTSS Expenditures – In Federal Fiscal Year 2013, total state and federal LTSS spending was \$146 billion: \$75 billion for HCBS and \$71 billion for institutional LTSS. 2013 was the

Cost of LTSS

- Informal care accounts for over 50% of LTSS in U.S.
 - Value of informal care estimated at \$234 billion nationally
- Medicaid expenditures accounted for 61% of national LTSS spending
- LTSS accounts for approximately 25% of Medicaid budgets across the nation (22% in Utah)
- In 2013, total Medicaid LTSS spending nationally was \$146 billion
 - For the first time - > 50% of spending went to HCBS rather than facility-based care
- In 2011, Utah reached the threshold of > 50% of LTSS spending on HCBS

first year HCBS accounted for a majority of national Medicaid LTSS expenditures. In 2011, Utah reached the threshold of spending greater than 50 percent of total LTSS spending on HCBS.

III. Important LTSS Concepts to Consider

Operational Concepts -

Meeting Facility-Based Level of Care Criteria – What Does that Mean?

In order to receive Medicaid-reimbursed, facility-based or HCBS waiver LTSS, a person must meet facility-based level of care criteria. Meeting facility-based level of care means that the person’s clinical needs (cognitive and physical conditions) must be at a severity level that the person would require the type of care and services provided in a facility-based setting. One of the new LTSS initiatives, 1915(i) State Plan HCBS, does not require a person to meet this level of care requirement, but allows states to target program enrollment to specific populations. With this program, states are able to expand services to individuals whose clinical acuity is less severe than those who meet facility-based level of care.

The Difference between the Medicaid State Plan and a Medicaid Waiver

Every state with a Medicaid program has a “State Plan”. The State Plan provides the details of a state’s Medicaid program. State Plans describe covered mandatory and optional services, rate-setting methodology, and program eligibility. While states have considerable flexibility in designing their State Plans in terms of what optional services to cover, service limitations, provider qualifications, and rate setting, state Medicaid programs must comply with many mandatory federal regulations. Some important examples include:

- *Stewardship* – Services must be available to Medicaid enrollees throughout the state.
- *Comparability* – A Medicaid-covered benefit generally must be provided in the same amount, duration and scope to all individuals. A state cannot limit a benefit package to a certain target population nor can it limit the number of individuals served.
- *Free Choice of Providers* – Medicaid recipients must be free to choose a provider from any willing, qualified provider who is enrolled to deliver Medicaid services.

If a state is interested in forgoing some of the requirements described above, it can apply to CMS for a “Waiver”. It is important to note that some federal provisions are eligible to be waived and some are not.

States can use waivers to target coverage to a specific group, restrict enrollees to a specific network of providers, or extend Medicaid coverage to groups not typically covered. Through waivers, states can target service coverage to a certain geographical area and can limit the number of individuals enrolled.

Some of the LTSS options discussed in this report are delivered under the State Plan and others are delivered through waiver authority.

HCBS Waiver Cost Neutrality Determination Methodology: Aggregate versus Individual

To successfully operate an HCBS waiver, states must ensure that the cost of providing HCBS are less than or equal to the cost that would have been incurred had the person received services in a facility-based setting. States have the option to perform the cost neutrality calculation on an individual basis or in the aggregate of all individuals served in the waiver. Utah currently performs aggregate cost neutrality determinations for its waivers. Aggregate cost neutrality provides administrative flexibility and it does not require the State to monitor each person’s costs on an ongoing basis with the intent to disenroll individuals at the point their service costs reach a set dollar amount. Individual cost neutrality would upset the stability of the individual receiving HCBS, who might have to move in and out of facility-based LTSS due to fluctuations in his or her costs. Individual cost neutrality would not improve the quality of life for individuals served and performing the ongoing calculations for more than 8,000 people would be administratively burdensome.

Service Provider Models: Agency-Based and Self-Directed Services

Typically, State Plan services are provided through a traditional, agency-based provider model, such as a home health agency. Historically, HCBS waivers have allowed greater flexibility to consumers who prefer to hire and manage their providers under a self-directed services model. The self-directed services model allows the program participant to become the employer of those who provide their Personal Care or Attendant Care services. When services are offered under the self-directed services model, services that support the person's self-direction are also provided. Supportive services include Financial Management Services and Information & Assistance in Support of Self-Directed Services. Financial Management Services facilitate the employment of individuals by the waiver client or designated representative including: (a) provider qualification verification, (b) employer-related activities including federal, state, and local tax withholding/payments, fiscal accounting and expenditure reports and (c) Medicaid claims processing and reimbursement distribution. Information & Assistance in Support of Self-Directed Services is available through case managers or other service providers to assist/train individuals how to recruit, hire, train, approve time sheets, schedule and discipline employees.

Unlike general State Plan services, newer HCBS LTSS options: Community First Choice 1915(k) and HCBS State Plan Services 1915(i) allow services to be provided through both agency-based and self-directed services methods.

HCBS Waiver Enrollment - Waiting List versus Open Application Periods

Within the HCBS waiver application, state Medicaid agencies must describe how they manage entrance into the waiver. When the number of individuals seeking HCBS waiver services exceeds the number of available waiver slots, states can maintain a waiting list or choose to manage enrollment through open application periods. Some of Utah's waivers have waiting lists and some manage enrollment through open application periods. See Table 3 for details.

Theoretical Concepts -

Welcome Mat/Woodwork Effect – What is it?

The “welcome mat” or “woodwork” effect are terms used to describe the increased aggregate costs Medicaid could experience due to programs being expanded to increase the availability of home and community based services. The theory holds that if LTSS are expanded in a way that encourages use of Medicaid-funded home and community based services (services that many consider to be more desirable than receiving services in institutional settings), then LTSS eligible participants will “come out of the woodwork” to enroll in the HCBS programs. The theory recognizes that although HCBS services are generally less-costly on a per-person basis, the total Medicaid program expenditures could rise due to the increased utilization of available services as well as an increase in the number of individuals served.

A 2013 article in *Health Affairs* describes the following:

“The extent of the woodwork effect and its true risks are the subject of considerable debate. Some policymakers and budget officials believe that the woodwork effect’s increased costs are unacceptable, whereas others believe that these costs are ethically justified by the increased number of people who receive needed services in their homes and communities. Because “woodwork effect” has a negative connotation, some researchers and advocates prefer to call it the “welcome-mat effect,” which more positively conveys the process of providing a program’s services to eligible individuals who were not previously enrolled.”ⁱ

Should Policy Makers Consider Quality of Life and Other Values that are Difficult to Quantify when Conducting Risk/Benefit Analysis?

The Departments' analysis of new LTSS program options shows that implementing new programs will likely result in increased costs and less state budgetary control than Utah's current LTSS programs. Although the Departments' analysis is based on projected increases in number of individuals served and service utilization, legislators may want to also take into consideration difficult-to-quantify values, such as quality of life, when evaluating the potential impact of the LTSS programs reviewed.

A 2014 article in *The Yale Law Journal* addresses a similar question:

*“On January 18, 2011, President Obama issued Executive Order 13,563, titled “Improving Regulation and Regulatory Review.” In this Order, the President affirmed cost-benefit analysis (CBA) as the appropriate method of determining the suitability of regulation by executive agencies. At the same time, President Obama’s Order indicated that agencies, in conducting CBA, “may consider (and discuss qualitatively) values that are difficult or impossible to quantify, including equity, human dignity, fairness, and distributive impacts.” Of these benefits, “human dignity” is the major addition to previous Executive Orders. The inclusion of human dignity among the factors that agencies are authorized to consider in CBA leads to difficult questions. CBA frequently features strenuous attempts to attach dollar values to the advantages and disadvantages of regulation. Yet dignity is often viewed as a quintessential example of a value impervious to monetization. How, then, could dignity possibly be incorporated into CBA?”*ⁱⁱ

Will Offering Additional HCBS Programs Prevent Individuals from Entering Facility-Based Care or Just Increase the Number of Individuals Receiving HCBS?

Intent language from SB03 asks the Departments to study options to maximize the number of people kept out of nursing homes and in their own homes and communities. While the Departments are strong proponents of the many positive impacts HCBS have on the lives of individuals receiving services, legislators might also consider whether covering additional HCBS programs such as the Community First Choice 1915(k) option will actually result in a decrease in facility-based admissions. As described previously, to receive Medicaid-reimbursed, facility-based or HCBS waiver LTSS, a person must meet facility-based level of care criteria. One issue to consider is whether there is a difference between those who “meet” facility-based level of care and those who will actually “access” facility-based care.

A 2013 article in the *Journal of Aging & Social Policy*, states the following:

*“Many patients in home and community-based services (HCBS) are not people who, without HCBS, would be in nursing homes. Those attracted to HCBS tend to be people who are younger, better supported, less dependent, and more mentally intact than their nursing home counterparts. Studies show that only about a quarter of the clients selected as likely to enter nursing homes within the coming year are likely to do so, even though they receive no HCBS. Of the 43 studies reported, more than two-thirds had rates of control group nursing home admission of less than 20%. Most patients would also be likely to have experienced only a short nursing home stay even if they were admitted. The result: Receiving HCBS reduced nursing home use rates on average by only a small percentage, not enough to offset the costs of HCBS.”*ⁱⁱⁱ

IV. Utah’s Current LTSS Coverage

In 2013, a study was conducted by the University of California, San Francisco: *Cost-efficiency in Medicaid long-term support services: the role of home and community based services*^{iv}. The authors performed a state-by-state analysis to measure the cost-efficiency of state LTSS programs. Researchers used a sophisticated data analysis methodology that considered multiple state-specific variables. Generally, when cost-efficiency was compared among states, higher efficiency states served more individuals than lower efficiency states with the same expenditure. States were categorized into one of four groups: High Efficiency States, Moderate Efficiency States, Low Efficiency States and Very Low Efficiency States. Utah was listed as one of the twelve states in the High Efficiency category.

Utah’s continuum of Medicaid-funded LTSS is comprised of an array of programs that help to meet the diverse and individual needs of seniors and individuals with disabilities. Utah’s continuum includes eight HCBS waivers, State

Plan Home Health and Personal Care services, nursing facility services and services provided in intermediate care facilities for individuals with intellectual disabilities. Utah began operating its first HCBS waiver in 1987. In SFY 2015, 11,854 individuals received HCBS and 7,685 individuals received services in facility-based settings.

Cost-Efficiency of LTSS Programs – Where does Utah Rank?

One of Utah’s HCBS waivers, the New Choices Waiver, serves the specific purpose of assisting individuals living in nursing facilities to move back into community based settings. The policy focus of the remaining waivers is to prevent or delay the need for facility-based care. Some HCBS waivers provide a broad array of services, including residential services in assisted living facilities, group homes and supervised apartments, while others include a more limited service package that is intended to meet the needs of the person in their own home or apartment.

- In a 2013 study of States’ LTSS programs, Utah’s LTSS System was listed as 1 of 12 highly-efficient state programs.

In State Fiscal Year 2015, the majority (52%) of Utah Medicaid LTSS spending was for home and community based services (HCBS) rather than institutional care.

Table 2 - Historical Utah Medicaid LTSS General Fund Expenditures

State Fiscal Year	Facility-Based Costs (NF or ICF/ID)	HCBS Costs	Total LTSS Costs	Facility-based Percentage of Total Costs	HCBS Percentage of Total Costs
2011	\$61,811,300	\$63,354,800	\$125,166,100	49.4%	50.6%
2012	\$64,589,300	\$64,434,500	\$129,023,800	50.1%	49.9%
2013	\$66,530,100	\$71,795,00	\$138,325,500	48.1%	51.9%
2014	\$67,754,200	\$69,325,600	\$137,079,800	49.4%	50.6%
2015	\$68,756,200	\$74,926,600	\$143,682,800	47.9%	52.1%

HCBS Waivers

Table 3 - Summary of Utah's HCBS Waivers (FY2015)

Waiver Name	Original Approval Date	Ages Served	Level of Care NF or ICF/ID	Number Served	Residential Services Available or In-Home Only	Waiting List and Number of Individuals Waiting
Acquired Brain Injury Waiver	1995	18+	NF	117	Residential	Yes - 91
Aging Waiver	1992	65+	NF	689	In-Home Only	None
Community Supports Waiver	1987	All Ages	ICF/ID	4,911	Residential	Yes – 2,289
Physical Disabilities Waiver	1998	18+	NF	133	In-Home Only	Yes – 27
Medicaid Autism Waiver ¹	2012	2 through 6	ICF/ID	368	In-Home Only	None – Enrollment Closed
Medically Complex Children's Waiver	2015	0 through 18	NF	N/A ²	In-Home Only	None – Enrollment through Open Application Periods
New Choices Waiver	2007	18+	NF	1,957	Residential	None for NF Applicants Enrollment through Open Application Periods for ALF Applicants
Technology Dependent Waiver	1995	All Ages, but Must Enroll Before Age 22	NF	141	In-Home Only	Yes - 76
TOTALS				8,316		2,486

New Choices Waiver – The primary purpose of this waiver is to assist individuals who have been residing in nursing facilities, for at least 90 days, to move into HCBS. This waiver is primarily a nursing facility deinstitutionalization program that serves a similar function as the Money Follows the Person program. In addition to placing individuals from nursing facilities into community based services, the waiver allows a limited number of individuals who have been long-term residents of assisted living facilities (ALF), for at least 365 days, to enroll in the waiver, if capacity is available. The Department of Health oversees the day-to-day operations and receives the state funding appropriation for this program.

Waiver for Individuals Aged 65 and Older (Aging Waiver) – This waiver provides services to seniors in their own homes or the home of a loved one. This program seeks to prevent or delay the need for nursing facility

¹ The Medicaid Autism Waiver is being phased out due to federal guidance provided in July 2014. This guidance requires states to provide autism related services to all individuals eligible under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program rather than HCBS.

² The Medically Complex Children's Waiver was approved by CMS with an effective date of October 1, 2015. Since its implementation, the program has served 187 children.

care. The Department of Human Services oversees the day-to-day operations and receives the state funding appropriation for this program.

Waiver for Individuals with Acquired Brain Injuries – This waiver provides services to adults who have an acquired brain injury. Services are provided in an individual’s own home, or for those with more complex needs, in a residential setting. This program seeks to prevent or delay the need for nursing facility care. The Department of Human Services oversees the day-to-day operations and receives the state funding appropriation for this program.

Community Supports Waiver for Individuals with Intellectual Disabilities and Other Related Conditions – This waiver provides services to children and adults with intellectual disabilities. Services are provided in an individual’s own home, or for those with more complex needs, in a residential setting. This program seeks to prevent or delay the need for services provided in an ICF. The Department of Human Services oversees the day-to-day operations and receives the state funding appropriation for this program.

Waiver for Individuals with Physical Disabilities – This waiver provides services to adults who have physical disabilities. Services are provided in an individual’s own home or the home of a loved one. This program seeks to prevent or delay the need for nursing facility care. The Department of Human Services oversees the day-to-day operations and receives the state funding appropriation for this program.

Medicaid Autism Waiver Program – This program serves children with autism spectrum disorders, ages 2 through 6 years. The primary service provided in this program is Applied Behavior Analysis. The Department of Human Services oversees the day-to-day operations and the Department of Health receives the state funding appropriation for this program.

Medically Complex Children’s Waiver Pilot Program – This program serves children from birth through 18 years of age who have complex, chronic medical conditions associated with disabilities, technology dependencies, ongoing involvement of multiple specialty services/providers and/or frequent or prolonged hospitalizations or skilled nursing facility stays. The Department of Health oversees the day-to-day operations and receives the state funding appropriation for this program.

Technology Dependent Waiver – This waiver provides services to individuals with technology dependency who are under 22 at the time of program enrollment. Services are provided in an individual’s own home or the home of a loved one. This program seeks to prevent or delay the need for nursing facility care. The Department of Health oversees the day-to-day operations and receives the state funding appropriation for this program.

State Plan Home Health and Personal Care Services

The current State Plan offers both Home Health and Personal Care services. Home health and personal care services are provided in community based settings and offer skilled nursing services, assistance with Activities of Daily Living (ADLs), and medication management. These services are provided by agency-based providers and are not available through the self-directed services model. These services are available to all Medicaid eligible individuals who meet the prior authorization criteria (including HCBS waiver participants). In SFY15, 5,349 people received these services.

Nursing Facility and Intermediate Care Facility Services

In SFY 2015, 7,685 people received services in facility-based settings: 6,823 people received services in nursing facilities and 862 received services in ICFs.

Nursing Facilities – There are currently 79 facilities certified under the nursing facility/skilled nursing facility category. Of the 7,667 certified beds in these facilities, in March 2016, the total census for the month was 4,763 occupied beds. This equates to an overall nursing facility occupancy rate of 62 percent. Of the 4,763 occupied beds,

2,766 (58 percent) were funded by Medicaid. The remainder were funded by other sources such as private pay, Medicare or VA contract. See Figure 1 below.

Nursing Facility Census by Payment Source

March 2016

(7,667 Total Beds)

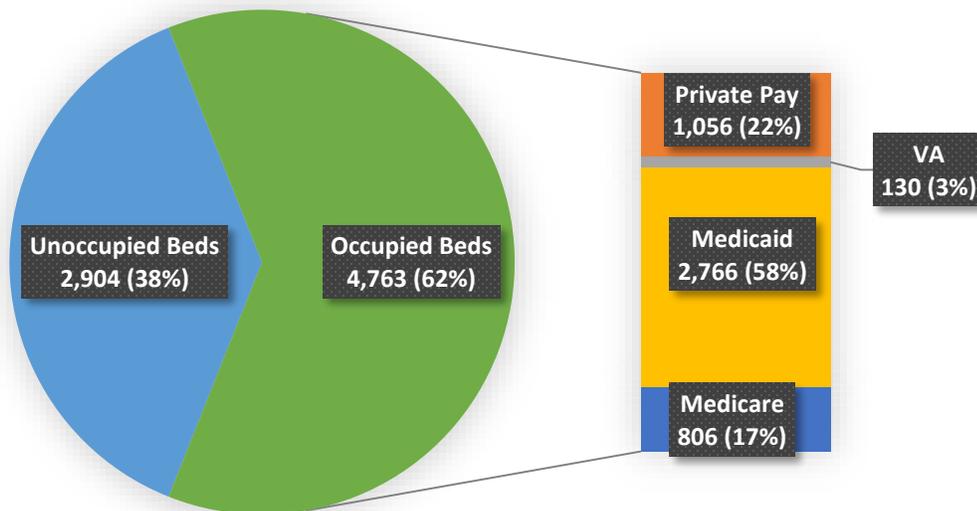


Figure 1 - Nursing Facility Census by Payment Source

Intermediate Care Facilities for Individuals with Intellectual Disabilities Services – There are currently 18 facilities certified under the ICF/ID category: The Utah State Developmental Center (USDC) and 17 privately-owned facilities. In March 2016, of the 903 certified beds, 783 were occupied – an 87 percent occupancy rate. The USDC, with 194 of the 260 beds occupied, has a lower census (75 percent) than the privately-owned facilities. For the 17 privately-owned facilities, 589 of 643 beds were occupied (92 percent). Of the 783 total occupied beds, 99 percent were funded by Medicaid.

Privately Owned ICF/ID Census by Payment Source

March 2016
(643 Total Certified Beds)

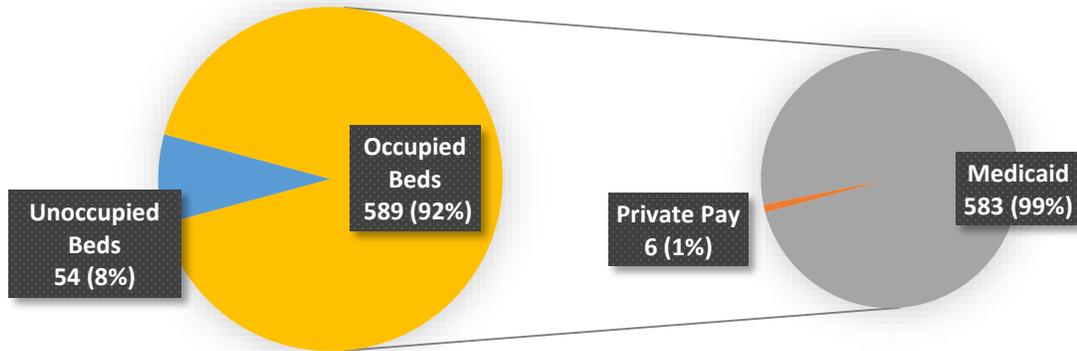


Figure 2 - Privately Owned ICF/ID Census by Payment Source

Policy Impact of Institutional Occupancy Rates

Low Nursing Facility Occupancy Rates

The impact of low nursing facility occupancy rates is an important factor to consider when evaluating Utah's LTSS system. Nursing facility occupancy rates have seen a gradual decline over the past several decades. Because of the predictably low occupancy rates in Utah's nursing facilities, Utah Medicaid is able to make certain decisions about programs like the New Choices Waiver (NCW). When a nursing facility resident enrolls in the NCW, the person vacates a bed at the facility that will generally not immediately refill with another person seeking nursing facility care. In terms of Medicaid costs this means that when a person being served in a generally higher cost setting (nursing facility) moves into a generally lower cost setting (HCBS) and the bed doesn't immediately refill, the result is overall cost savings to Medicaid. Since its inception in 2007, in spite of increases in the number of recipients served, the Department of Health has not requested additional funding to support the New Choices Waiver because of the cost saving achieved when a Medicaid client is moved from a more costly setting to a less costly one.

High ICF/ID Occupancy Rates

When evaluating implementation of new LTSS programs, the high ICF occupancy rate is an important factor to consider. If Utah were to implement a new program that involves moving a person from the ICF to HCBS (such as Money Follows the Person), high ICF occupancy rates would likely have a significant budgetary impact. The reason high ICF census would result in a budgetary impact is that when an ICF bed is vacated by someone moving into HCBS, there is a high likelihood that the ICF bed will backfill quickly. This results in Medicaid being responsible for LTSS payment for both the person moving out of the facility into HCBS and the new person who has filled the ICF bed.

Utah experienced this phenomenon in the late 1990s when it initiated a program known as the "ICF/ID Portability Program". The program was intended to assist individuals to move from ICFs to HCBS, with the idea that HCBS was less costly than facility-based services. The funding for the program was described through an interagency agreement between the Department of Health (DOH) and the Department of Human Services (DHS) with the idea

that DOH would provide the State funding for any person who originally received services in an ICF but moved into HCBS. Conversely, DHS would be responsible for providing the State funding for anyone who started out in HCBS but moved into an ICF. The program did not have any limits on the number of participants. The program was operated for a few years, but was eventually discontinued due to the increased cost incurred by the DOH. As individuals became aware of the option to receive ongoing HCBS services after living in an ICF for a short-term stay, individuals from the Division of Services for People with Disabilities (DSPD) waiting list quickly began refilling the ICF beds and the ICFs became a revolving door for those ultimately seeking access to HCBS.

The original program resulted in unsustainable program and budgetary growth because there was no limit placed on the number of participants who could be served. In the mid-2000s, a revised program, known as the “ICF/ID Transition Program” was introduced. This program is still in place today and provides a limited number of individuals, who have been residing in ICFs, for at least a year, with a mechanism to receive HCBS. This program is sustainable because the Department of Health establishes a limit on the number of individuals who can be served in the program on annual basis.

V. Benefit and Risk Analysis of LTSS Programs

As requested by the Legislature, the Departments evaluated the benefits and risks of a variety of Long Term Services and Supports (LTSS) options available to state Medicaid programs including:

- Money Follows the Person Demonstration Grants
- Community First Choice Option, 1915(k)
- LTSS Balancing Incentive Program
- Home and Community Based Waivers, 1915(c)
- State Plan Home and Community Based Services, 1915(i)

Money Follows the Person (MFP) Demonstration Grant

Overview - Originally authorized by the Deficit Reduction Act of 2005 and reauthorized by the Affordable Care Act through FFY 2016. The last grant solicitation period closed August 2012. If Congress does not reauthorize this program after September 2016, Utah will not have the opportunity to apply for MFP. There has been no federal information provided to states to suggest this program will be reauthorized and reauthorization of MFP was not included in the president’s proposed budget for Federal Fiscal Year 2017.

MFP seeks to increase states’ use of HCBS and reduce the use of facility-based services by providing states with an enhanced Federal Medical Assistance Percentage (FMAP) rate. The enhanced FMAP rate is available for program participants who transition from an institutional setting into the community. For Utah, the enhanced FMAP rate would be 85 percent and would apply to services participants receive in the first 365 days after transition. After the first 365 days, the enhanced FMAP rate would end and all ongoing expenditures would be eligible for the standard FMAP rate (approximately 70 percent).

Institutional residents are eligible for MFP after they have lived in a facility, on a Medicaid-funded stay of at least 90 days. The idea is that after individuals meet the 90-day stay requirement, they are eligible to have the “money follow the person” from the facility-based setting to an HCBS setting. Residents from both nursing facilities and ICFs are eligible to participate.

Typically, “money following the person” does not mean that the person is able to take the exact amount of funding that Medicaid would have spent on the individual had he or she remained in a facility-based setting, to be used for their HCBS. More commonly, the “money follows the person” concept acknowledges that Medicaid was paying for the person’s facility-based services: when the person leaves the facility, that funding remains accessible to pay for the person’s HCBS. As a person leaves facility-based care, the person’s needs are evaluated and HCBS are provided to meet the person’s needs. In many circumstances, the cost of HCBS services will be less and Medicaid savings can be achieved. In other cases, it may be more costly to serve a complex person in HCBS. Since Utah Medicaid

determines program cost neutrality in the aggregate, this method allows both individuals whose services cost less and those whose may cost more to be served in HCBS.

Conceptually, MFP has some of the same characteristics as Utah’s New Choices Waiver: 1) The policy intent of both programs is to assist eligible individuals to move from facility-based LTSS into HCBS and 2) Both require a 90-day facility-based stay prior to program enrollment, although MFP’s definition of a qualifying stay is more restrictive than the New Choices Waiver. The most significant difference between the two programs is the MFP requirement to include ICFs as institutions from which individuals can transition, whereas the New Choices Waiver only allows individuals to transition from nursing facilities. See program comparison in Table 4 below.

Table 4 - New Choices Waiver and Money Follows the Person Comparison

Program Characteristic	New Choices Waiver	Money Follows the Person Grant
FMAP for HCBS	70/30	85/15 for the first 365-day post-transition period, then 70/30 thereafter
FMAP for State Plan Services	70/30	70/30
Institutional Level of Care Requirement	NF Only	NF and ICF/ID
Institutional Length of Stay Requirements	90 Day Stay – Any Funding Source	90 Day Stay - Medicaid Funded Only

Utah Implementation Evaluation –

If the program were to be reauthorized, policymakers could consider the following implementation benefits and risks.

Benefits: Because MFP requires ICFs to be included as a facility from which individuals could move, the most significant benefit of MFP would likely be that more people with intellectual disabilities would receive HCBS.

Under MFP, states are required to estimate the number of individuals who would be moved from each type of facility and into HCBS waivers. If Utah estimated moving ten ICF residents per month into HCBS, by the end of the grant period, an additional 600 individuals with intellectual disabilities would receive HCBS.

For nursing facility residents, the New Choices Waiver already functions in the same way as MFP. Since Utah is already consistently moving approximately 500 individuals from NFs into the NCW each year, the enhanced funding would result in cost savings in the first year of the grant. In all subsequent years, the program would result in increased costs to the Medicaid budget because any savings achieved by the enhanced funding for those moving into the New Choices Waiver, would be outpaced by the additional cost of serving more individuals coming out of ICFs.

Risks: While the availability of enhanced funding for the first 365 days post-transition is attractive, the requirement to include ICF/ID level of care would result in significant additional costs.

High Occupancy Rates and ICF/ID Welcome Mat/Woodworking Effect – As noted previously, ICF occupancy rates are consistently greater than 90 percent. There are 2,289 individuals on the waiting list for DPSD services. MFP would enable anyone residing in ICF for greater than 90 days to move back into the community with Community Supports Waiver (CSW) services. Many individuals on the DSPD waiting list would likely be willing to reside in an ICF for 90 days with the promise of moving into the community with HCBS for their lifetime. In spite of savings achieved by those moving from NFs into the NCW, at the rate of moving 10 individuals per month from ICFs to HCBS, over the 5-year grant period, the Departments estimates that MFP would result in increased ongoing, general fund costs of approximately \$6.75Million per year. See Table 5 below.

Table 5 - Money Follows the Person Cost Estimate³

MFP Program Year	General Fund Savings from Enhanced Match Rate	Additional Costs Related to increased CSW Enrollment ⁴	Net General Fund Cost
Year 1	\$1,757,304.00	\$945,323.28	(\$811,980.72)
Year 2	\$1,757,304.00	\$2,646,789.84	\$889,485.84
Year 3	\$1,757,304.00	\$4,348,256.40	\$2,590,952.40
Year 4	\$1,757,304.00	\$6,049,722.96	\$4,292,418.96
Year 5	\$1,757,304.00	\$8,507,332.80	\$6,750,028.80

While the Departments project increased cost associated with MFP, they acknowledge there are other determinants which legislators could consider. In a 2013 article by the Department of Housing and Urban Development, *Measuring the Costs and Savings of Aging in Place*, the authors state:

“Some researchers and aging-in-place advocates argue that policymakers’ focus on controlling costs is having a detrimental effect on the quality and availability of HCBS care...Others argue that those who spend so much time and energy examining how to reduce costs are focusing on the wrong area; instead, they should be emphasizing the emotional, social, and health benefits of aging in place.”

Recommendation: (Not Recommended)

The MFP program is scheduled to end September 2016, and there is no indication that it is likely to be reauthorized.

For the following reasons, the Departments do not recommend applying for the MFP program if it is reauthorized beyond September, 2016:

- MFP program requirements would negatively impact the more generous New Choices Waiver admission policy that permits program admission with a 90-day facility stay, regardless of funding source, whereas, MFP only allows a 90-day Medicaid stay;
- The State is already accomplishing much of the MFP policy intent through the New Choices Waiver and the ICF/ID Transition Program;
- With additional appropriations, modifications can be made within the State’s existing programs to make improvements and serve more individuals within parameters set by the State (See *Current or New HCBS 1915(c) Waivers and Other State LTSS Programs, Recommendations* section on pages 18 and 19 of this report);
- By making modifications to the current 1915(c) waivers, the State retains more programmatic and budgetary control; and
- The temporary enhanced FMAP gained by MFP would likely be outpaced by the ongoing cost of new enrollees coming from ICFs.

³ Cost estimates do not reflect potential administrative costs associated with managing the MFP program

⁴ Assumes enrollment of 120 ICF/ID clients per year into the Community Supports Waiver

Community First Choice Option

Overview - The Community First Choice Option (CFC), authorized under section 1915(k) of the Affordable Care Act, allows states to provide HCBS attendant services and related supports to eligible Medicaid clients under their State Plan. States are eligible to receive a six percent enhanced FMAP rate for these services. However, this enhanced FMAP does not apply to other services individuals may receive. Services must be offered statewide with no caps on enrollment. CFC is only available to individuals who meet facility-based level of care and who are otherwise eligible for Medicaid under the existing eligibility standards.

Although CFC is authorized as a State Plan benefit, it has some similarities to both typical State Plan benefits and HCBS waiver requirements. It also has significant differences from current Personal Care State Plan benefit and lacks the ability to implement certain limitations that HCBS waivers allow. See Table 6 for comparison.

Table 6 - Community First Choice State Plan, Personal Care State Plan and HCBS Waiver Comparison

Program Characteristic	CFC State Plan	Personal Care State Plan	HCBS Waiver
FMAP Rate	76/24	70/30	70/30
Must Meet Institutional Level of Care	Yes	No	Yes
Person-Centered Support Plan Required	Yes	No	Yes
Self-Directed Services Delivery Method Required	Yes	No	Optional
Quality Assurance System and CMS Reporting Required	Yes	No	Yes
Ability to Limit Services to a Target Population	No	No	Yes
Ability to Cap Program Enrollment	No	No	Yes
CMS Application Renewal Required	No	No	Yes – every 5 years
Can be used in Conjunction with HCBS Waiver Attendant Services	No, State must remove attendant care services from HCBS waivers	Yes	N/A
Must Have a Development and Implementation Council	Yes	No	No

Utah Implementation Evaluation –

Benefits: While Utah currently offers Personal Care as a State Plan service, the benefit is limited to a maximum of 60 hours per month and the services must be provided by a traditional, agency-based provider. Under the CFC option, individuals who meet facility-based level of care would be eligible to received Personal Care service through a self-directed services model and would not be limited to 60 hours per month. Self-directed services provide additional flexibility that allows Medicaid clients to hire neighbors, friends or relatives (other than spouses or the parents of minor children). These employees are more likely able to provide services at the time of the client’s choosing rather than relying on an unknown caregiver sent by an agency that will likely have more rigid scheduling requirements.

Risks: Because CFC is available as a State Plan benefit, the State would have limited tools available to limit the growth of the program, creating an open-ended budget obligation, While the availability of enhanced funding is attractive, the Departments’ analysis shows that the saving achieved by the enhanced FMAP would be expended on increased service utilization (through use of additional hours of Personal Care Services and utilization of new services required under CFC, such Personal Emergency Response Services) for individuals already receiving

services. If more individuals enrolled in the program than those who are currently receiving similar services, CFC would result in additional costs.

In March 2016, there were 49,224 seniors and individuals with disabilities enrolled in Medicaid. If we estimate one percent of those individuals will enroll in CFC services, the Medicaid program would provide a new array of services to 492 individuals. If the Department estimates CFC costs to be similar to the annual costs of services provided in the Physical Disabilities waiver (similar service packages), even with the 6 percent enhanced FMAP, for these services, the estimated annual increase to general fund costs would be \$2,067,876. The estimate is for service costs only and does not include the significant additional administrative costs that would be associated with this program.

Table 7 - Estimated Annual Cost to Serve an Additional One Percent of Frail Medicaid Clients

Number of Individuals	Annual General Fund Cost per Person	Total Annual General Fund Cost
492	\$4,203	\$2,067,876

In December 2015, the Office of the Secretary of Health and Human Services submitted a final report to Congress on the implementation of the CFC option. The report identifies the following with regard to financial considerations of CFC:

“Some states note that the 6 percentage point increase in FMAP is insufficient to cover populations that move from waivers or the State Plan Personal Care Benefit into CFC, because of the additional hours individuals receive. In addition, new enrollees have enrolled under CFC. In states experiencing an upsurge in enrollment, CFC implementation has led to increased costs, well beyond the additional 6 percentage points in federal service match.”

And

“...when considering CFC, states expressed concerns about the financial impact on already-constrained state budgets. This was true of states that ultimately pursued CFC and those that did not. Even in states with existing HCBS infrastructure, states anticipated there would be new costs associated with CFC and the additional 6 percentage point in FMAP would not cover the costs of implementing, providing and evaluating the CFC benefit. This concern was amplified by the statutory requirement that for the first 12-month period of CFC implementation, the state must maintain or exceed the level of state expenditures for HCBS attributable to the preceding 12-month period. In a time of uncertainty for state budgets, ambiguous or indeterminate costs prevented states from choosing CFC. In some states there was uncertainty about future HCBS costs due to increasing population of adults with intellectual disabilities or developmental disabilities (I/DD), of which, a large proportion reside in community-based settings....According to state officials, costs for this population are growing more than any other HCBS population because individuals with disabilities are living longer. At least two states that adopted CFC, and at least one state that did not, expresses a preference for covering the developmental disabilities population under 1915(c) waiver services due to cost/utilization controls already discussed. These states expressed fear that the growing costs of providing services to this population under CFC would have a major impact on their already-strained state budgets. The states who have adopted CFC despite this concern are still evaluating the ways to control costs within the program restrictions.”^{vi}

CFC has substantial administrative functions that typical State Plan services do not and CFC would have a significant impact on current HCBS waiver operations. The CFC requirement that individuals meet institutional level of care adds a level of administrative oversight that does not exist with other State Plan benefits. In this case, on an initial and annual basis, the State would have to develop a new system to employ clinicians to conduct institutional level of care determinations on all CFC applicants. To implement CFC, the State would be required to amend its HCBS waivers to remove Personal Care or Attendant Care service coverage. This action, the transition and the additional coordination between State Plan and HCBS waiver benefits will result in a significant administrative burden. These requirements along with other administrative requirements will result in substantial increases to administrative costs.

Recommendation: (Not Recommended)

For the following reasons, the Departments do not recommend applying for the CFC option:

- As experienced in other states that have adopted CFC, the enhanced FMAP would likely be outpaced by the cost related to increased utilization of services and increased numbers of participants served;
- The inability to target the population or limit the number of individuals served will result in loss of budgetary control and will obligate the state to an ongoing, open-ended funding requirement.
- Programmatic requirements of CFC would be highly disruptive to HCBS waiver programs that currently provide Attendant Care services;
- While the Departments agree that CFC would serve additional individuals, for reasons similar to those stated in the 2013 article in the *Journal of Aging & Social Policy*, referenced on Page 7 of this report, it is unlikely that the availability of Attendant Care services provided in CFC will result in a significant decrease in nursing facility admissions.

One of the CFC requirements is to establish a Development and Implementation Council. Since states are already required to seek public feedback for any HCBS waiver amendments or renewals, the Departments believe a mandatory process is already in place to ensure the State accepts and responds to stakeholder feedback, but the Departments see the value in having a forum to meet with LTSS stakeholders on a regular basis. Accordingly, the Departments commit to holding LTSS meetings with stakeholders at regular intervals. The Departments recommend meeting at least annually, but meetings could be more frequent as topics warrant.

Long Term Services and Supports Balancing Incentive Program

Overview – The Balancing Incentive Program, authorized under the Affordable Care Act, provides financial incentives to states to increase access to community based LTSS. The Balancing Incentive Program provides enhanced funding (two percent FMAP increase) to serve more individuals in home and community based settings. To participate in the Balancing Incentive Program, a State must have spent less than 50 percent of total Medicaid LTSS expenditures on HCBS in fiscal year 2009. States must have also submitted an application in which they agreed to meet a variety of programmatic and structural reform requirements. This program’s authorization ended in September 2015. Unless the program is reauthorized by Congress, additional states will not be able to apply.

With HCBS expenditures at 49.75 percent in FY09, participation in the program would have entitled Utah to a two percent FMAP increase for certain HCBS over a five-year period. The enhanced match was for restricted use and was identified as the “Rebalancing Fund”. These restricted funds are to be used to support activities that contribute to rebalancing the State’s LTSS system toward community based care. States are required to receive advance approval for the use of the rebalancing funds.

Recommendation: (Not Recommended)

Utah is not eligible for this program because it was not reauthorized beyond 2015 and because Utah has exceeded the 50 percent of LTSS spending on HCBS threshold.

Current or New HCBS 1915(c) Waivers and Other State LTSS Programs

1915(c) Waivers

Overview – HCBS waivers are optional programs available to states under Section 1915(c) of the Social Security Act. HCBS waivers allow states to provide LTSS in the community settings in lieu of facility-based care. To be eligible for HCBS, the person must meet the same medical acuity threshold as a person served in a nursing facility or an intermediate care facility. This requirement is known as *meeting institutional level of care*.

1915(c) waiver authority allows states to:

- Deliver HCBS that cost less than or are equal to the cost that would have been incurred if the person had received facility-based LTSS. This requirement is known as the cost-neutrality determination.
- Declare less-restrictive financial eligibility requirements than typical community Medicaid (Certain income and assets can be exempted and is similar to facility-based eligibility requirements).
- Declare the target populations to be served
- Specify the services to be covered
- Cap program enrollment
- Limit participation to geographical areas within the state

One important point to consider is that although HCBS waivers are not considered a mandatory service, once enrolled, an individual is entitled to the waiver services for which the person has a demonstrated need. The services cannot be denied or limited based on cost.

Utah Implementation Evaluation –

Benefits: HCBS waiver authority allows states to impose caps on the number of individuals served and the services to be covered. Consequently states have more budget predictability and control than other Medicaid services that do not allow for these types of limitation.

Risks:

Implementing the following recommendations have the potential to improve programs and services, but the Department recognize that availability of funding is a significant factor for legislators to consider.

Recommendations:

Subject to the availability of funding, the Departments recommend the following changes to some of the State’s current HCBS waivers:

Recommended, but Subject to Availability of Funding

1) Modifying administrative waiver activities and waiver services to include coverage of housing-related activities and services to support program participants’ ability to identify and secure housing, and sustain tenancy.

One of the criticisms disabilities advocates have of the New Choices Waiver is that the majority of program participants are served in assisted living facilities. Availability and sustainability of housing options, other than assisted living facilities, is one of the barriers to assist individuals to move out of nursing facilities to live in their own homes or apartments. In other waivers, the Departments struggle with having sufficient resources to help individuals with housing-related activities including sustaining tenancy, when the person’s disability interferes with their ability to be a successful tenant.

In June 2015, CMS published an informational bulletin titled, “*Coverage of Housing-Related Activities and Services for Individuals with Disabilities*”.^{vii} This bulletin provides guidance to state Medicaid agencies regarding permissible administrative activities that can be performed at the state level “that support collaborative efforts across public agencies and the private sector that assist a state in identifying and securing housing options for individuals with disabilities, older adults needing LTSS, and those experiencing chronic homelessness”. To directly address housing issues faced by those in need of LTSS in the community, subject to availability of funding, changes could be made to 1) support administrative level positions that would be responsible to perform State-Level Housing Related Collaborative Activities and 2) add a new service titled “Housing and Tenancy Sustaining Services” to some of the waivers.

These services could significantly improve housing options and tenancy sustainability for individuals served in HCBS. Because this option has not yet been fully developed and recognizing the need for stakeholder input, the Departments recommend convening a workgroup to further develop this concept. The workgroup could develop recommendations for a potential program and estimate utilization and cost of implementation. The Departments could then report findings to the Legislature.

2) Conduct a review of DSPD waiver rates for in-home services, such as respite and in-home behavioral supports, and determine if the rates support sufficient access to these services.

Respite Service Rates

Respite services provide temporary relief to parents or caregivers from the day-to-day care they provide to the individuals with disabilities. In recent stakeholder meetings conducted by DSPD, caregivers have reported difficulty finding providers. Providers have reported that the rates for respite are too low to make the service feasible for them to provide supports. There have been anecdotal reports of budgets being underspent due to families being unable to find and retain respite staff.

A comparison of select western states was conducted and discovered that respite rates in Utah are comparable to surrounding states. See table 8 for select states hourly rate.

Table 8 - Multi-State Comparison of FY16 Respite Rates (Per Hour)

Utah	Wyoming	Nevada	New Mexico	Montana	Idaho
\$ 12.80	\$ 13.96	\$ 15.52	\$ 19.20	\$ 15.76	\$ 9.56

Behavior Consultation Service Rates

Behavioral consultation services provide support to waiver participants and caregivers designed to teach and facilitate positive behaviors and inhibit maladaptive behaviors. These services provide for the treatment of the individual and the training of the family and caregiver.

The Community Supports Waiver (CSW) currently provides behavior consultation services to individuals whether they also receive in-home supports or out of home, residential services. Stakeholders report insufficient reimbursement levels for behavior consultation in the existing CSW and the need for higher rates to obtain highly qualified staff who are certified to provide Applied Behavioral Analysis. The highest behavior consultation level in the current rate structure (Behavior Consultation Level III-BC3) is \$15.80 per quarter hour (FY16 rate level). In contrast, the Medicaid Autism Waiver compensates at \$20.00 per quarter hour. A comparison to a few western states was conducted to determine if the CSW BC3 rate of \$15.80 was typical. See Table 9 below.

Table 9 - Multi-State Comparison of FY16 Behavioral Consultation Rates (Per Quarter Hour)

Program / State	Equivalent Rate (Quarter Hour)
Colorado	\$25.32
Nevada	\$22.02
New Mexico	\$24.81
Utah Autism Waiver	\$20.00
Utah Community Supports Waiver	\$15.80

Of the 3,000 individuals receiving in-home supports, 770 were identified, through their most current Supports Intensity Scale score, as being in need of behavior consultation services (behavior section score was greater than five, or at least one behavior item was marked “Extensive support needed”). The cost to provide behavioral consultation services to this group of people with rates similar to the Medicaid Autism Waiver would be approximately \$543,000 in general fund.

The Departments believe in-home services rates is an area where additional time is needed to conduct a rate review and consider if a request for additional funding is appropriate.

LTSS Programs Funded by the State or Other Sources

The Department of Human Services currently oversees some limited LTSS programs that are funded by either state funds only or a combination of state funds and other sources. Typically individuals receiving these services may not quite meet some aspect of Medicaid eligibility (e.g., level of medical acuity or poverty level) or the individual may be on a waiting list for HCBS waiver services. Programs include:

The Home and Community Based Alternatives Program (Alternatives Program) – Is a statewide program and DHS is the umbrella agency with oversight responsibility provided by the Division of Aging and Adult Services (DAAS). This program is implemented through the local Area Agencies on Aging (AAAs) and provides in-home services to frail, low-income seniors. The Alternatives Program is funded primarily by state dollars, but other limited funding sources include: Federal (non-Medicaid) and local community funds, program fees, voluntary and public contributions.

The Alternatives Program serves between 800-825 individuals per year at an annual, per-person cost of approximately \$4,800. Typically, individuals participating in this program are those who may not qualify for some aspect of Medicaid eligibility (e.g., level of medical acuity or poverty level). This program has a waiting list of approximately 700 individuals. The state fund cost to serve individuals on the waiting list would be approximately \$3,360,000.

DSPD operates three, state-only funded programs that provide individuals on the HCBS waiver waiting list with limited services. Typically, these individuals are those who are not highly ranked on the waiting list but for whom limited services meet the majority of their needs.

Supported Employment Program – In FY15, the Supported Employment Program provided assistance with job development and placement, intensive on-the-job training and supervision by a job coach to 409 individuals who are on the waiting list for HCBS waiver services. The annual, per-person cost of the Supported Employment Program is about \$1,195. The total program cost for FY15 was \$488,395 in ongoing, general funds.

Service Brokering – In FY15, the Service Brokering Program provided assisted individuals with obtaining community supports, including those services outside of the scope of services paid for by DSPD, to 84 individuals who are on the waiting list for HCBS waiver services. The annual, per-person cost of the Service Brokering Program is about \$292. The total program cost for FY15 was \$24,531 in one-time, general funds.

Respite and Family Skill Building – In FY15, the Respite and Family Skill Building Program provided limited services to temporarily relieve parents and caregivers from the day-to-day care they provide to 654 individuals who are on the waiting list for HCBS waiver services. Families also received assistance with developing skills to live independently in the community. The annual, per-person cost of the Respite and Family Skill Building is about \$2,146. The total program cost for FY15 was \$1,404,000 in one-time, general funds.

To allow for more individuals, at the lower end of the waiting list, to receive limited services through the HCBS waivers, during the 2013 Legislative General Session, UAC (62A-5-102.4c) was modified to create a pathway that allows 15 percent of new waiting list appropriations to be allocated to individuals who only need respite services. The logic behind this statutory change held that if the State only allows HCBS waiver entrance to those with the most severe needs, who have the highest “critical needs score”, the State may be missing the opportunity to provide

minimal in-home services that would have the effect of preventing or delaying the need for more intensive, more costly, out-of-home services.

Since it is logical to expect that the needs of individuals with disabilities will likely increase over time, it is not surprising that the needs have grown for many individuals who originally entered services with a respite only need. Experience has also shown that the majority of the increased need was for in-home services, such as behavior consultation or supported living.

Recommendation:

Recommended Option

The Departments recommend that legislators consider modifying the respite-only definition of allowing entrance into the CSW to include the need for some additional, specific, in-home services. The Departments recommend redirecting some portion of the ongoing and one-time funding that is currently appropriated for the Supported Employment, Service Brokering and Respite and Family Skill Building programs to HCBS waivers to serve those who have limited specific, in-home service needs. In this way, the State could maximize the use of federal Medicaid dollars without the need for additional State funds. This proposal is a different approach to managing entrance to HCBS waivers than is typically done nationally, and the Departments acknowledge that the ability to implement this process would be contingent upon CMS approval.

Because this option has not yet been fully developed and recognizing the need for stakeholder input, the Departments recommend convening a workgroup to further develop this concept. The workgroup could develop recommendations for a potential program and estimate utilization and cost of implementation. The Departments could then report findings to the Legislature.

Implementing HCBS as State Plan Services under 1915(i) Authority

Overview - Originally authorized by the Deficit Reduction Act of 2005 and modified under the Affordable Care Act, Section 1915(i) of the Social Security Act gives states the option to offer a variety of HCBS under the State Plan rather than through an HCBS waiver program. In addition to serving those who meet nursing facility level of care, program eligibility requirements must be established to assure that states serve individuals who have care needs that are less than nursing facility level of care. Services must be provided statewide and states cannot impose limits on the number of individuals served. However, states can define a target group of individuals who may receive the services. Some states have used 1915(i) authority as a mechanism to provide targeted services to individuals with substance use disorder and/or serious persistent mental illness. The program will allow states to serve individuals who have incomes up to 300% of Supplemental Security Income and create a new Medicaid eligibility category to provide full Medicaid benefits to individuals who receive services under a 1915(i) program.

Utah Implementation Evaluation –

Benefits: While Utah currently offers Home Health and Personal Care services as State Plan benefits, these services must be delivered by a traditional, agency-based provider. Under the 1915(i) HCBS State Plan services, both individuals who meet institutional level of care and those who do not, would be eligible to receive HCBS through both traditional, agency-based and self-directed services models. Self-directed services provide additional flexibility that allows Medicaid clients to hire neighbors, friends or relatives (other than spouses or the parents of minor children). These employees are more likely able to provide services at the time of the client's choosing rather than relying on an unknown caregiver sent by an agency that will likely have more rigid scheduling requirements.

In addition, the services that states could offer are broader than those that can be provided under the current State Plan benefits, for example, Indiana currently operates three 1915(i) HCBS programs: 1) Offers respite, family support, training and other supportive services for children with serious emotional disturbances; 2) Offers a single service known as behavioral and primary healthcare coordination to individuals who demonstrate impairment in self-

managing their healthcare needs due to mental illness; and 3) Offers a variety of services such as therapy and behavior support services, addiction counseling, peer support, medication training and support and care coordination/case management.

Risks: Many of the financial and administrative risks identified under the CFC option would apply to this new State Plan option. With 1915(i) authority, concerns would be further amplified due to HCBS services being available to both those who meet facility-based level of care and those who do not. This requirement could result in a large increase in both the number of individuals served and the state budget.

Recommendation:

Requires Additional Evaluation

Because the 1915(i) State Plan option allows the State to target populations to be served, the Departments believe that this option could potentially be used, at some point in the future, to target services to specific population(s) that don't meet facility-based level of care (as is required in 1915(c) waiver options). At this time, the Departments do not have any recommendations about specific target populations which could be served, but some examples could include individuals with Dementia/Alzheimer's Disease, or those with Substance Use Disorder and/or Serious Mental Illness. The Departments recommend convening a stakeholder workgroup to further evaluate potential target populations and services to be covered. The workgroup could develop recommendations for a potential program and estimate utilization and cost of implementation. The Department could then report its findings to the Legislature.

See Table 10 below for a comparison of various LTSS program requirements.

Table 10 - HCBS Waiver and State Plan Options Comparison^{viii}

Program Requirements	HCBS Waiver 1915(c)	HCBS State Plan Option 1915(i)	Community First Choice 1915(k)
Level of Care	Must meet institutional level of care	Institutional level of care not required	Must meet institutional level of care
Application Process	HCBS waiver application	State Plan amendment, must have multiple State Plan amendments if cover different target groups	State Plan amendment
Approval Duration	Initial Application: 3 Years Renewal: 5 Years	One-time approval; or if using targeting option, renewal every 5 years	One-time approval
Reporting	Annual reports	Annual reports	Annual reports on expenditures, utilization and quality measures
Public Input	Required for substantive changes	Regulation is silent	Must create a Development and Implementation Council that includes a majority of members who are seniors, those with disabilities and their representatives
Target Groups	May define and limit the target group(s) served	May define and limit the target group(s) served	No targeting
Limits on Number Served	Allowed	Not allowed	Not allowed
Waiting Lists	Allowed	Not allowed	Not allowed
FMAP	Standard	Standard	6% increase from standard

Participant-directed Services	Allowed	Allowed	Required
Person-centered Support Plan	Required	Required	Required
Cost-effectiveness Requirements	Average annual cost per person served under HCBS waiver cannot exceed average annual cost of facility-based care for each target group served	None	None

VI. Conclusion

The Departments acknowledge that this report is a reflection of the Departments’ program history and experience, and that, although additional research studies and national reports were reviewed to draw some conclusion about LTSS policy, this report reflects one vantage point. Additional formal research and review by an independent entity could be valuable to the policy discussion.

The Departments appreciate the opportunity to prepare this report and look forward to the opportunity to engage in further conversation with legislators and other stakeholders about Utah’s ongoing, LTSS strategy.

ⁱ Julie Sonier, Michel H Bourdreaux, and Lynn A Blewett, 2013. “Medicaid Welcome-Mat Effect of the Affordable Care Act Implementation Could be Substantial,” Health Affairs, 32:6, 1319-25.

ⁱⁱ Rachel Bayefsky, 2014. “Dignity as a Value in Agency Cost-Benefit Analysis,” The Yale Law Journal, 123:6, 1626-2133.

ⁱⁱⁱ William G. Weissert PhD & Lucy Fredrick MPH (2013) The Woodwork Effect: Estimating it and Controlling the Damage, Journal of Aging & Social Policy, 25:2, 107-133, DOI: 10.1080/08959420.2013.766073

^{iv} Chattopadhyay et al, SpringerPlus 2013, 2:305. Cost-efficiency in Medicaid long-term support services: the role of home and community based services

^v <https://huduser.gov/portal/periodicals/em/fall13/highlight2.html>

^{vi} <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/cfc-final-report-to-congress.pdf>

^{vii} <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf>

^{viii} Adapted from: <http://www.nasdds.org/resource-library/medicaid-hcbs-authorities/comparative-analysis-chart-of-medicaid-hcbs-1915-1115-waivers-and-state-pla/>