ISSUE BRIEF
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Designing a Medicare Help at Home Benefit: Lessons from Maryland's Community First Choice Program

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ABSTRACT

ISSUE: Medicare does not cover home- and community-based services (HCBS) that help beneficiaries function independently at home. The financial burden of uncovered personal care services puts beneficiaries with physical or cognitive impairment at risk of nursing home placement.

GOAL: Analyze trends in paid and unpaid personal care and expenditures under a model Medicaid Community First Choice (CFC) program in Maryland.

METHODS: Trends were analyzed using Maryland Medicaid claims data and standardized assessment information. Quantitative analysis was supplemented by interviews with Maryland officials and experts.

FINDINGS: Maryland introduced CFC in 2014. By the end of 2016, enrollment had reached 11,573. The majority of participants were over age 65 (55%) and dually eligible for both Medicare and Medicaid (65%). Expenditures per person per year were stable at $21,000 between 2014 and 2016. Mean hours of paid personal assistance per participant averaged 29 hours per week, with slightly higher levels of utilization for dually eligible enrollees than for Medicaid-only enrollees. Weekly mean hours of informal support declined slightly. Unpaid informal care continued at a high rate, even though payment is permitted for personal care from family members and other previously unpaid caregivers.

CONCLUSION: Maryland's experience points to: a targeted benefit that will augment support from family members and other unpaid caregivers, a stable per-person cost, and increased take-up rates of eligible enrollees over time.

KEY TAKEAWAYS

- **Medicare does not cover home- and community-based services to help people function independently at home, which can put beneficiaries with physical or cognitive impairment at risk of being placed in nursing homes.**

- **Maryland implemented the Community First Choice benefit, authorized by the Affordable Care Act, to cover home- and community-based long-term services under Medicaid.**

- **The benefit has supplemented — rather than substituted for — informal support from family and other caregivers and has resulted in stable per-person spending since it was launched in 2014.**

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BACKGROUND

Nine million community-dwelling Medicare beneficiaries age 65 and older — about one-fifth of all beneficiaries — have serious physical or cognitive limitations and require long-term services and supports (LTSS) that are not covered by Medicare. Nearly all have chronic conditions that require ongoing medical attention; three-fourths have three or more chronic conditions and are considered high-need, high-risk patients.[1]

Gaps in Medicare coverage and the lack of integration of medical care and LTSS can have serious consequences for beneficiaries, including high out-of-pocket expenses.[2] Medicaid covers LTSS for low-income Medicare beneficiaries, but only one-fourth of elderly Medicare beneficiaries with serious physical or cognitive limitations are covered by Medicaid.[3] Without a home- and community-based benefit in Medicare, the majority of individuals with physical or cognitive limitations will face difficulty obtaining needed care or incur financial burdens.

Further, without personal home care, access to senior day care, or support from family caregivers, some older adults needing assistance may lose their ability to live independently and risk being institutionalized in a long-stay nursing facility, with costs eventually covered by Medicaid. Not integrating medical care with LTSS also contributes to avoidable hospitalization and emergency room use and makes it more difficult to substitute less-costly social services for high-cost medical care.[4]

One policy option is to add a limited personal care and home- and community-based services (HCBS) benefit to Medicare. A Medicare Help at Home policy proposal that covers up to 20 hours of personal care a week (or up to $400 a week of other HCBS) has attracted interest from federal and state policy officials and advocacy organizations.[5] The benefit and premium are gradated with income, targeting more assistance to those with modest incomes. Potential benefits include: enhanced quality of life and ability to continue living independently; reduced financial burden for high-need beneficiaries and a limited need to spend down to Medicaid status; lower Medicare costs through care coordination; and delivery system reform that integrates acute care and LTSS.[6] Yet, moving forward will require addressing concerns — that such a benefit would be costly; would substitute for unpaid family caregiving; could be difficult to implement due to workforce shortages and require training of personal care workers; and could introduce the possibility of fraud or harm to beneficiaries. In this issue brief, we examine Maryland's experience with Community First Choice (CFC), a Medicaid HCBS benefit option authorized under Section 2401 of the Affordable Care Act. Exploring the experiences of the Maryland CFC program is instructive in addressing concerns with covering home- and community-based care under Medicare.

WHAT IS COMMUNITY FIRST CHOICE?

Maryland was one of the first states to adopt the CFC benefit, an approach to covering personal care services through qualified organizations that employ personal care providers — including family members — and assume responsibility for ensuring quality and controlling costs. Under CFC, states may cover personal attendant services under their Medicaid plans and receive the enhanced federal medical assistance percentage (FMAP) of 6 percentage points for enrollees otherwise eligible for institutional nursing home care.

Individuals may be eligible for CFC if they have incomes up to 150 percent of the federal poverty level, are eligible for Medicaid, and require an institutional level of care. For individuals with higher incomes to qualify, they must be eligible for nursing facility services under the state plan or be participating in an existing state waiver program. Attendant services and supports must be provided to all who qualify statewide without targeting of specific populations. Unlike other long-term services and support programs that limit the enhanced FMAP to a specified time period, there is no time limit for the enhanced 6 percentage point match for CFC services.

The services offered through CFC enable participants to live and actively participate in their communities. These services help participants in "activities of daily living" or ADLs (e.g., bathing) and "instrumental activities of daily living" or IADLs (e.g., meal preparation). In addition, CFC services include care coordination; personal emergency response systems; items that substitute for human assistance, like home meal delivery; environmental assessments for fall risks or other factors; and nurse monitoring, for example, to ensure patients take medications.

COMMUNITY FIRST CHOICE IN MARYLAND, 2014–2016

Enrollment Trends and Demographics

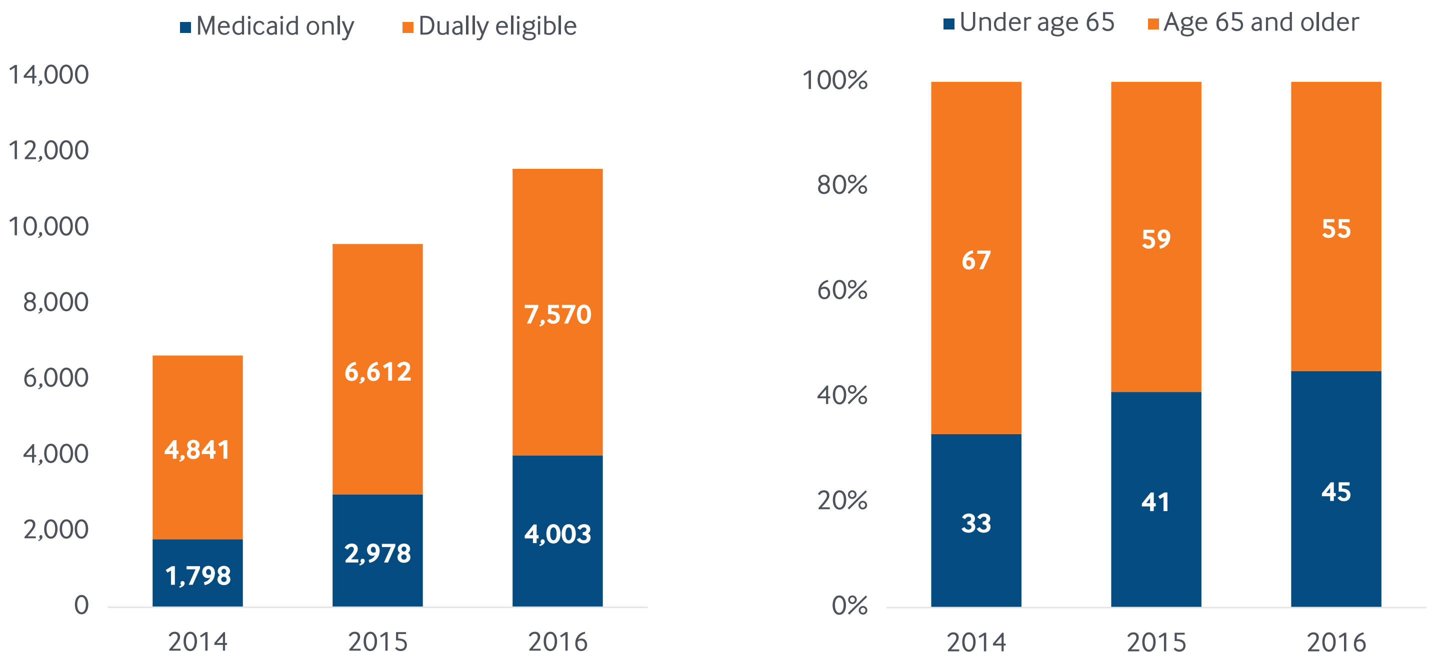
Maryland introduced CFC in 2014. By the end of 2016, enrollment in CFC had reached 11,573, including individuals who had been previously covered under a Medicaid HCBS benefit and people who were newly eligible. In 2016, the majority of CFC participants were over age 65 and dually eligible for Medicare and Medicaid (Exhibit 1).

Maryland's experience suggests that enrollment will grow over time as unmet needs are addressed and take-up rates of eligible individuals increase. Using standardized assessment instruments to determine eligibility and level of assistance needed makes it possible to manage utilization by individual enrollees, estimate the maximum number of enrollees, and project trends toward full participation over time.

CFC Expenditure Trends and Costs per Participant

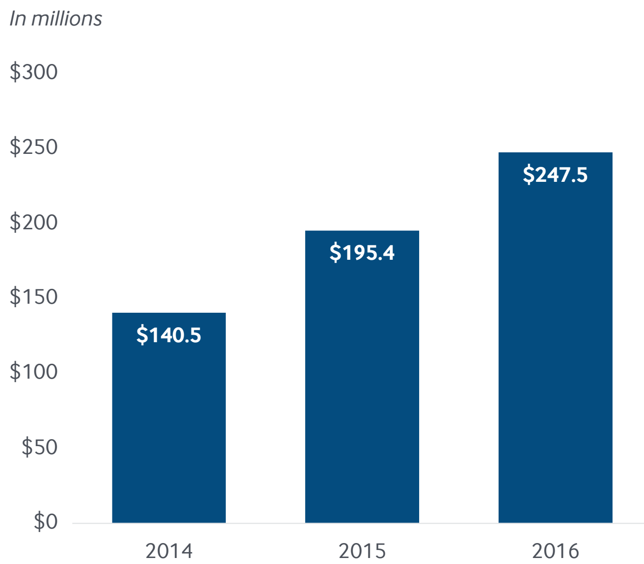
CFC expenditures increased in parallel with enrollment growth, from $140.5 million in 2014 to $247.5 million in 2016 (Exhibit 2).[7] Per-member per-year expenses have been stable at about $21,000 (Exhibit 3).

Exhibit 1. CFC Participants, by Eligibility Status and Age, 2014–2016



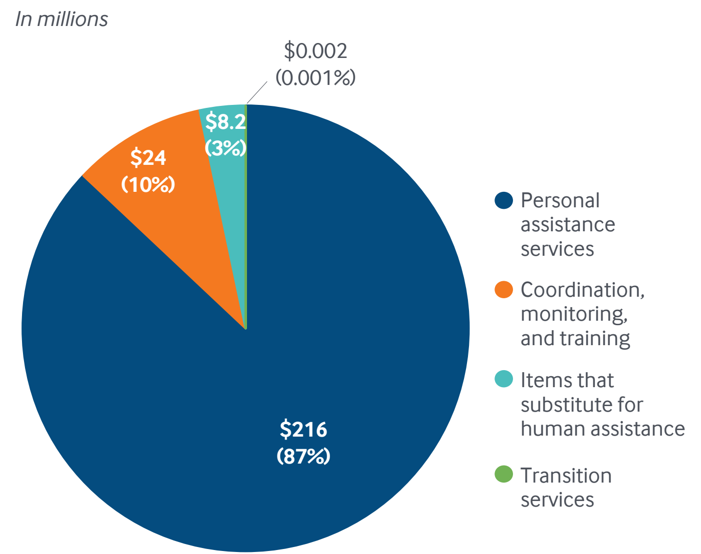
Data: Hilltop Institute analysis of Maryland Medicaid Community First Choice program data, 2014–2016.

Exhibit 2. Total CFC Expenditures, 2014–2016



Data: Hilltop Institute analysis of Maryland Medicaid Community First Choice program data, 2014–2016.

Exhibit 4. CFC Expenditures by Service, 2016



Data: Hilltop Institute analysis of Maryland Medicaid Community First Choice program data, 2014–2016.

Exhibit 3. CFC Expenditures, 2014–2016

	Number of participants	Total expenditures	Per-member per-year costs
2014	6,639	$140,478,083	$21,160
2015	9,590	$195,396,768	$20,375
2016	11,573	$247,537,508	$21,389

Data: Hilltop Institute analysis of Maryland Medicaid Community First Choice program data, 2014–2016.

Exhibit 5. Average Hours of CFC Personal Assistance per Week, 2014–2016

	Number of participants	Mean hours (per member per week)	Standard deviation	Percentage change (since 2014)
2014	6,639	43	48	
2015	9,590	32	33	–33.1%
2016	11,581*	29	26	

Data: Hilltop Institute analysis of Maryland Medicaid Community First Choice program data, 2014–2016.

* The total number of participants varies slightly from the numbers reported elsewhere in this report because of an additional month's worth of data in the Medicaid Management Information System at the time this analysis was completed.

The stability of cost per person is reassuring. It suggests that the total cost of providing a HCBS benefit under Medicare or state Medicaid programs can reasonably be estimated by applying the per-member per-year cost to the estimated number of eligible individuals and making reasonable assumptions about trends in take-up rates.

The vast majority (87%) of CFC expenditures were for personal assistance services (Exhibit 4). The average Medicaid enrollee used 43 hours of personal assistance services per week in 2014 and 29 in 2016 (Exhibit 5). Expenditures for coordination, monitoring, and training services totaled $24 million (10%), while items that substitute for human assistance cost $8.2 million (3%).

Maryland's experience indicates the greatest expenses will be in personal assistance services. Other expenses, such as coordination, monitoring, training, and services that substitute for human assistance, such as telemonitoring, are relatively modest.

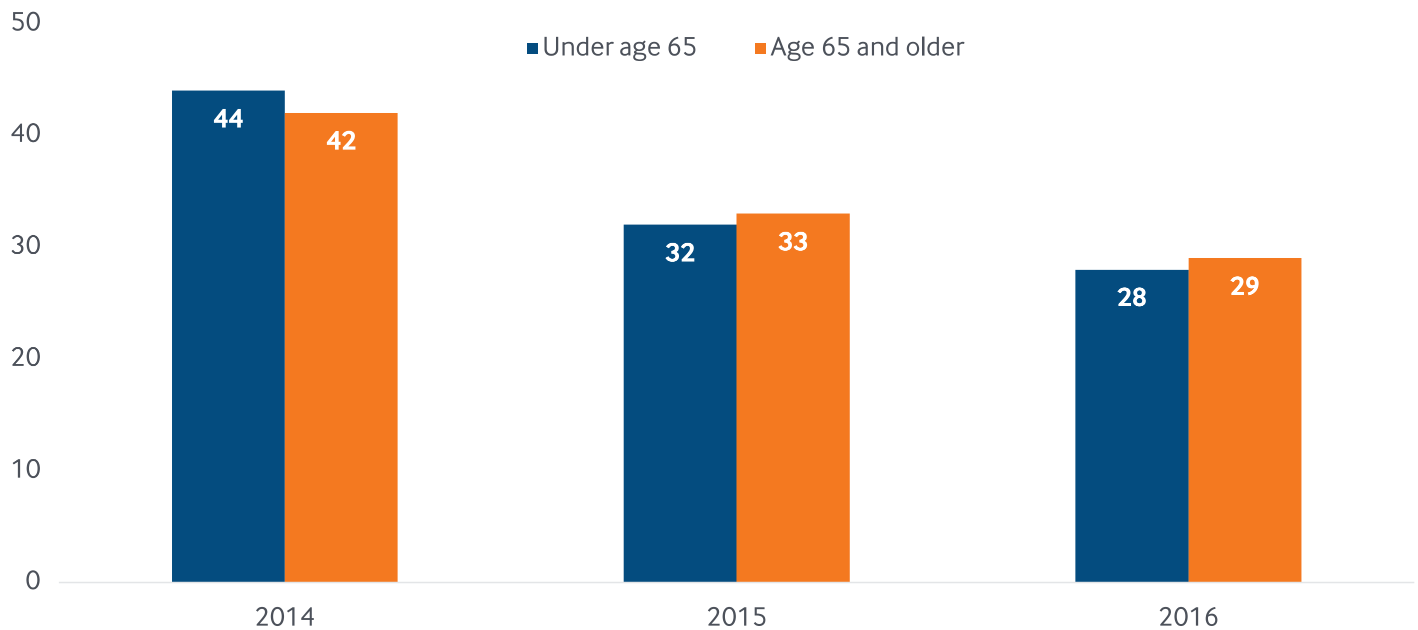
Personal Assistance Services

The mix of participants affects the number of mean hours of personal assistance. Newly eligible individuals were less disabled and required fewer hours of assistance, lowering the mean number of hours of assistance. Overall, the average number of personal assistance hours decreased from 2014 to 2016 (Exhibit 6).

Dually eligible individuals consistently used more personal assistance services than individuals who only received Medicaid. The mean number of hours per member per week declined over the reporting period for both groups, with the decline more pronounced for Medicaid-only participants (Exhibit 7).

Exhibit 6. Average Hours of CFC Personal Assistance per Week, by Age, 2014–2016

Mean hours per member per week



Data: Hilltop Institute analysis of Maryland Medicaid Community First Choice program data, 2014–2016.

Exhibit 7. Average Hours of CFC Personal Assistance per Week, by Insurance Status, 2014–2016

		Number of participants	Mean hours (per member per week)	Standard deviation	Percentage change (from 2014)
Dually eligible	2014	4,830	43	47	–29.9%
	2015	6,617	33	32	
	2016	7,599	30	26	
Medicaid only	2014	1,809	42	51	–39.8%
	2015	2,973	30	32	
	2016	3,982	25	24	

Data: Hilltop Institute analysis of Maryland Medicaid Community First Choice program data, 2014–2016.

Informal Support Services

Informal support services consist of family members, neighbors, friends, or coworkers helping individuals who require assistance with ADLs and IADLs. In some situations, informal supports may be an alternative to more costly care.[8]

To gauge the effect of CFC services on the use of informal support, we compared the number of hours of informal care used per week before and after one year of CFC enrollment. The mean number of informal support hours per week before CFC participation was 35.9. This dropped to 28.3 hours per week after one year of CFC participation. The minimum number of hours used per week was 0 and the maximum was 168, both pre- and post-CFC (Exhibit 8).

Coverage of home- and community-based care services, therefore, appears to augment support from family members and other unpaid caregivers rather than largely displacing it. However, to determine any causal substitution effect would require a more rigorous statistical evaluation.

Individuals under age 65 received significantly more hours of informal support (46.5) than individuals older than 65 (27.4) pre-CFC. For the younger population, parents are often the providers of informal support. Post-CFC, younger individuals experienced a greater reduction in informal support hours compared to older individuals (10 vs. 5.6); however, the percentage decrease was comparable (22% vs. 20%) (Exhibit 9).

QUALITATIVE ANALYSIS

Interviews with Maryland state officials, participants, and experts showed that the state achieved stability in per-person spending and was able to meet the personal care needs of enrollees using a personal care assistance workforce with safeguards to ensure enrollee safety and prevent fraud and abuse.[9]

Maryland's CFC program administrators created a method for targeting services to help prevent overutilization. Local health departments conduct standardized assessments of beneficiaries; based on the results, each person is grouped into one of seven state-determined budget categories. As these are suggested budgets, there is flexibility to exceed the budget if needed. Currently, Maryland Medicaid officials estimate that about 50 percent of participants are either within 10 percent of their guideline or spending below it. Services are provided through an agency model of care that employs the personal care workforce. However, enrollees may recommend a family member or other caregiver who becomes an employee of a licensed agency.

Exhibit 8. Weekly Hours of Informal Support, Pre- and Post-CFC

	Number of participants	Mean hours	Standard deviation	Minimum	Maximum
Pre-CFC	3,090	35.9	43.3	0	168
Post-CFC	3,090	28.3	35.1	0	168

Data: Hilltop Institute analysis of Maryland Medicaid Community First Choice program data, 2014–2016.

Exhibit 9. Weekly Hours of Informal Support, by Age, Pre- and Post-CFC

	Number of participants	CFC status	Mean hours	Difference (in hours)*	Percentage change
Under age 65	1,367	Pre	46.5	–10.0	–22%
		Post	36.4		
Age 65 and older	1,723	Pre	27.4	–5.6	–20%
		Post	21.9		

Data: Hilltop Institute analysis of Maryland Medicaid Community First Choice program data, 2014–2016.

* Difference in hours may not may not equal pre minus post mean hours because of rounding.

Before implementing CFC, Maryland Medicaid leaders made infrastructure and workforce investments to monitor care quality and minimize fraud. Maryland launched the In-Home Support Assurance System, an automated system that tracks hours of service by personal care providers. These data, along with case management information, nurse monitoring reports, and additional billing records, are compiled in the "LTSSMaryland" database. Based on this information, the program also conducts regular audits to ensure care quality and spot fraud. Nurses, who are employed by the state, conduct site visits and assess care quality.

LIMITATIONS

Maryland's CFC program is in its early stages. Because different populations were enrolled at varying times during the three-year implementation period, findings related to changes in the population mix and hours of personal assistance over time cannot be interpreted as a true trend. It will take a longer time period to see if the major findings persist, including the stability in cost per person served and continuing high levels of unpaid personal care. Maryland invested resources into ensuring a qualified personal attendant workforce with built-in safeguards to ensure quality and prevent fraud. This may not be easily replicated if a similar benefit is more broadly adopted by Medicare or state programs.

On the key issue of whether the program substitutes for unpaid services, the analysis does not permit conclusive evidence of causality. Eligible participants were not randomly assigned to receive benefits; only trend data pre- and post-adoption are available.

POLICY IMPLICATIONS FOR MEDICARE

Maryland's experience with the Medicaid Community First Choice benefit design and care model is encouraging. The program addresses a number of concerns that arise from adding a Help at Home personal care benefit to Medicare. Concerns of substitution for informal care are largely unfounded; rather, a targeted Help at Home benefit (e.g., 20 hours per week) will likely augment rather than supplant unpaid informal support. Maryland has recruited a qualified personal care workforce. These individuals are employed by a licensed agency, which can also hire family members and other informal caregivers who are trained and monitored to ensure quality care, without undermining continuing unpaid family support.

Not surprisingly, given the existence of waiting lists for HCBS, Maryland found a significant unmet need for personal care among Medicaid beneficiaries. CFC participation has continued to grow steadily in the early years as beneficiaries of various programs have transitioned into CFC. Maryland's experience suggests that participation by those eligible grows over time. If Medicare added a similar benefit, it would likely experience high growth in its early years. The benefit could help to minimize spend-down to Medicaid and alleviate pressure on state Medicaid budgets. Maryland has shown that it is possible to define eligibility, assess functional status and hours of needed care, establish per-person budgets appropriately, and stabilize spending per person. Relative to costly institutional care, provision of home- and community-based care has the potential to support independent living longer and achieve savings.

DATA AND METHODS

The analysis reports on trends in CFC participation, utilization, and expenditures using Maryland Medicaid claims data, as well as observed longitudinal variation in participants' informal supports using interRAI assessments. The analysis of informal support services was limited to the 3,090 CFC participants who had completed both an initial and annual interRAI assessment and were not receiving HCBS through another Medicaid program. InterRAI assessments were used to determine how many hours of informal support CFC participants received. As a rough proxy to determine possible substitution of informal caregiving hours for paid caregiving hours, the initial interRAI assessment, completed to determine eligibility for the program, provided information on pre-CFC hours of informal support, and the first annual interRAI assessment post-enrollment was used to determine post-CFC hours.

NOTES

1. Karen Davis, Amber Willink, and Cathy Schoen, "Medicare Help at Home," *Health Affairs Blog,* Apr. 13, 2016, http://healthaffairs.org/blog/2016/04/13/medicare-help-at-home/.

2. Cathy Schoen, Karen Davis, and Amber Willink, *Medicare Beneficiaries' High Out-of-Pocket Costs: Cost Burdens by Income and Health Status* (Commonwealth Fund, May 2017), https://www.commonwealthfund.org/publications/issue-briefs/2017/may/medicare-beneficiaries-high-out-pocket-costs-cost-burdens-income.

3. Amber Willink, Karen Davis, and Cathy Schoen, *Risks for Nursing Home Placement and Medicaid Entry Among Older Medicare Beneficiaries with Physical or Cognitive Impairment* (Commonwealth Fund, Oct. 2016), https://www.commonwealthfund.org/publications/issue-briefs/2016/oct/risks-nursing-home-placement-and-medicaid-entry-among-older; Amber Willink et al., "Physical and/or Cognitive Impairment, Out-of-Pocket Spending, and Medicaid Entry Among Older Adults," *Journal of Urban Health* 93, no. 5 (Oct. 2016): 840–50, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5052151/; and Amber Willink, Karen Davis, and Cathy Schoen, *Improving Benefits and Integrating Care for Older Medicare Beneficiaries with Physical or Cognitive Impairment* (Commonwealth Fund, Oct. 2016), https://www.commonwealthfund.org/publications/issue-briefs/2016/oct/improving-benefits-and-integrating-care-older-medicare.

4. Sarah Ruiz et al., "Innovative Home Visit Models Associated with Reductions in Costs, Hospitalizations, and Emergency Department Use," *Health Affairs* 36, no. 3 (Mar. 2017): 425–32, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1305; and Soeren Mattke et al., "Medicare Home Visit Program Associated with Fewer Hospital and Nursing Home Admissions, Increased Office Visits," *Health Affairs* 34, no. 12 (Dec. 2015): 2138–46, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0583.

5. Davis, Willink, and Schoen, "Medicare Help," 2016; Karen Davis, Amber Willink, and Cathy Schoen, "Integrated Care Organizations: Medicare Financing for Care at Home," *American Journal of Managed Care* 22, no. 11 (Nov. 2016): 764–68, https://www.ajmc.com/journals/issue/2016/2016-vol22-n11/integrated-care-organizations-medicare-financing-for-care-at-home; and Willink, Davis, and Schoen, *Improving Benefits,* 2016.

6. Davis, Willink, and Schoen, "Integrated Care Organizations," 2016; Willink, Davis, and Schoen, *Improving Benefits,* 2016; Ruiz et al., "Innovative Home Visit," 2017; and Mattke et al., "Medicare Home Visit," 2015.

7. These figures do not include preparticipation administrative coordination services.

8. Michele Cecchini, "The Hidden Economics of Informal Elder-Care in the United States," *Journal of the Economics of Ageing* (available online Apr. 9, 2017, in press, corrected proof), https://www.sciencedirect.com/science/article/pii/S2212828X1630055X.

9. Julia Burgdorf et al., *Maryland Medicaid's Support for Family Caregivers: Lessons from an Early Adopter of the Community First Choice Program* (Roger C. Lipitz Center for Integrated Health Care, Johns Hopkins Bloomberg School of Public Health, June 2017, in draft).

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