CLASS Technical Assistance Briefs

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Paving the Way for Successful CLASS Implementation: An Overview of the CLASS Technical Assistance Brief Series

By Lisa R. Shugarman

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief provides an introduction to The SCAN Foundation's CLASS Technical Assistance Brief Series, which explores many of the critical issues to be considered for successfully implementing CLASS.

Background

The passage of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148) on March 23, 2010 laid the foundation for long-term care systems transformation. A key cornerstone is the Community Living Assistance Services and Supports (CLASS) Plan, a voluntary, publicly-administered long-term care insurance program. The Secretary of the U.S. Department of Health and Human Services (HHS) is tasked with implementing this new program by 2012 and there are many issues to consider for successful implementation.

A major challenge of the current system of care is the inability of middle-income individuals to access the range of available supports and services to help them remain in their homes and communities when facing functional limitations. Over 10 million Americans need supports and services today due to disabling conditions, and this figure will likely grow due to population aging.[1] In 2008, the cost of this care totaled $264 billion, comprising public, private, and in-kind expenditures.[2]

Americans are living longer with greater chronic illness burden and functional impairment. Public policy has resulted in a range of supports for older Americans in the spheres of health and income security. These policies include Medicare and Medicaid as public policies that address health security, supported by retiree health insurance and Medigap policies on the private side. Social Security is the largest public policy linked to income security, supported by defined retirement benefits and 401(k)'s and other retirement vehicles on the private side.

Policy development, both public and private, has fallen short in addressing "functional security," the support for functional needs of Americans who have a disability. Public policy has not been substantially changed since 1965

when Medicare and Medicaid became law. However, the population in need of support has changed as average life expectancy has increased from 69 to 78 years. Financing for these supports and services has predominantly been the role of federal and state governments through Medicaid, with more limited support from programs authorized through the Older Americans Act. Medicaid, the joint federal/state program for low-income Americans, provides a safety net covering 40 percent of the long-term care bill.[2] Medicaid requires individuals to spend down their income and assets to poverty levels in order to receive this kind of care and only guarantees nursing home and limited home health coverage. It does not require states to provide the broader range of home- and community-based services that are not only the preference of most Americans, but also more cost-effective on a per-person annual basis.

Personal out-of-pocket spending on long-term care services is the second highest category, equaling 29 percent of all long-term care spending.[2] Out-of-pocket spending covers only a portion of need. Families are constantly making trade-offs about what to spend their limited resources on, and older Americans often go without needed supports when it is a choice between funding services and paying the rent or utility bills. Approximately 42 percent of people in the United States age 45 and over have saved less than $25,000 for retirement.[3] This figure also does not account for the contributions of unpaid caregivers who are often overlooked in discussions of long-term care financing. Approximately 87 percent of those who need supports and services nationally receive assistance from unpaid caregivers. There are 65.7 million unpaid caregivers nationally, two-thirds of whom provide care to adults age 50 and older.[4] The estimated value of unpaid caregiving is substantial – approximately $375 billion – increasing the total cost of long-term care by 150 percent.[5]

Private long-term care insurance covers approximately seven percent of all long-term care expenditures. Currently, there are approximately 6-7 million policies in force, reflecting a market penetration of less than 10 percent.[6] This small percentage reflects the low enrollment rates nationally in private long-term care insurance offerings. Private plans are often costly and underwritten, leaving them out of reach for a large portion of the population.

The absence of coherent long-term care (functional security) policy, the low uptake of costly private long-term care insurance, and low savings rates among those nearing retirement have made the purchase of long-term supports and services prohibitive for many individuals. As a result, middle-class Americans are generally not prepared to pay the $6,000 per month for nursing home care or the $1,800 per month for part-time help in the home.[7] With so little saved and few affordable options for coverage, middle-income Americans are particularly vulnerable, given the startling reality that 70 percent of Americans over 65 will need long-term care support at some point in their lives.[8] A March 2010 poll of California voters by The SCAN Foundation and the UCLA Center

for Health Policy Research found that, regardless of political affiliation, adults 40 and over are worried about long-term care costs and are unprepared to pay for these services.[9]

Community Living Assistance Services and Supports Independence Benefit Plan

A new era of reforming the system of care for adults with functional needs begins with the Community Living Assistance Services and Supports (CLASS) provision of the ACA. This is a critical step toward ensuring working Americans will have an affordable way to plan for and access supportive services in the setting of their choice without immediately impoverishing themselves to Medicaid eligibility. CLASS fundamentally reframes the concept of living with functional limitations from one of sickness and poverty to one of independence, choice, and personal responsibility.

The law creates the CLASS Independence Benefit Plan, which is a voluntary, publicly administered long-term care insurance plan for employed individuals with no underwriting or exclusion for pre-existing conditions. Based on a risk pool concept, it offers a lifetime benefit for people with significant difficulty performing daily living tasks as determined by an eligibility assessment. Premiums will be age-rated, with younger people paying considerably less and older adults more. People who are fully vested and meet the eligibility threshold for functional impairment will receive a cash benefit that can be used to purchase a variety of supports and services, including personal care, home modifications, adult day programs, assisted living, or institutional care.

By law, CLASS is not funded by tax dollars and must be actuarially sound for 75 years. HHS Secretary Kathleen Sebelius recently acknowledged that CLASS, as specifically codified in law, will need modifications prior to launch. The law provides the Secretary with substantial authority to make the needed changes ensuring optimal functioning of CLASS.

On January 28, 2011, the Office of Community Living Assistance Services and Supports (CLASS Office) was established within the Administration on Aging. Under the leadership of the Assistant Secretary for Aging, Kathy Greenlee, the CLASS Office will oversee the administration and management of CLASS, including the setting of premiums, the development and implementation of rules for enrollment and eligibility systems, and the payment of benefit.[10] Aspects of the program, such as premium amounts, eligibility, criteria, and form in which the benefit will be distributed remain to be determined.

The CLASS Office will have the expertise and guidance of two critical advisory panels. First is the Personal Care Attendants Workforce Advisory Panel, which is the Department's statutory public advisory body on personal care attendant workforce issues related to CLASS.

Given that an available and well-trained workforce is a critical component of the long-term care system necessary for successful CLASS implementation, HHS solicited nominations for the Personal Care Attendants Workforce Advisory Board on June 16, 2010.[11] Second is the Independence Advisory Council, which will advise the CLASS Office and the HHS Secretary on the determination of monthly premiums and the financial solvency of the program. Nominations for the CLASS Independence Advisory Council were solicited on November 16, 2010.[12] Membership for both of these advisory panels has not yet been announced.

The SCAN Foundation CLASS Technical Assistance Brief Series

The HHS Secretary is tasked with implementing CLASS by October 2012, with many implementation decisions to be considered and made. Full implementation of CLASS requires knowledge transfer from various sectors, including the research community and existing program operations. The SCAN Foundation developed the CLASS Technical Assistance Brief Series as a way to gather that extant knowledge from a broad range of academic, private, and public sector experts on the issues critical to successful implementation of CLASS. Given the complexity of these pressing implementation issues, each brief in this series answers a clear and distinct question pertinent to implementing CLASS.

To build the most consumer-focused benefit, the CLASS Office needs to consider the types of services and supports most individuals with disabilities might need to remain as independent as possible. Given the many ways one might become disabled – at birth, by an accident early in life, or as an older adult – there is not a "one-size-fits-all" approach to addressing the needs of individuals with functional limitations. Kicking off the Technical Assistance Brief Series is a brief by Gitlin and colleagues (#1) describing how the CLASS cash benefit might be used by beneficiaries. It outlines a broad range of products, services, technologies, and environmental modifications that the authors argue should be permitted as part of the CLASS benefit.[13]

The next three briefs in the series (#2, #3, and #4) answer questions from the private long-term care insurance perspective about systems for determining eligibility for benefits, methods for assessing need, and the ways insurance companies define eligibility through the measurement of activities of daily living and cognitive impairment.[14-16] Briefs #5, #6, and #7 address these same issues from the Medicaid personal care services perspective.[17-19] In total, these six briefs chronicling assessment from both the private long-term care insurance and public personal care services perspectives illustrate current models used for eligibility determination that can inform the critical benefit and eligibility design activities the CLASS Office must develop.

Most current long-term care service programs in either the private or public arena are based on a fixed benefit model in which the participant is assessed and, if eligible, receives a set of services provided in the setting most appropriate to their needs. The CLASS Plan offers a cash benefit allowing the beneficiary to determine what services they need and are willing to purchase. This approach provides the beneficiary much more flexibility to arrange for the broad range of products, services, technologies, and environmental modifications described in Brief #1, but also requires the capacity to make the important decisions to ensure that the funds are used appropriately. A series of five briefs (#8 through #12) detail the experience of the Cash and Counseling (C&C) model, now in operation in 15 states as a participant-directed home- and community-based services program. C&C participants manage their own budgets for supportive services and can arrange a broad array of services. An important lesson learned from C&C is that a broad and flexible definition of allowable spending is important (Brief #8). A flexible spending plan was associated with increased safety, comfort, mobility, independence, ability to perform tasks and helped participants maintain their independence in their chosen communities.[20-24]

The CLASS statute requires that the HHS Secretary establish procedures that would allow the use of debit cards to access cash benefits. In addition, CLASS expressly allows beneficiaries to use their cash benefit to pay friends or family members to provide personal care services. Acting as an employer requires important knowledge about and compliance with tax and employment laws and regulations. Not all beneficiaries will have this skill set or will want this responsibility. CLASS requires every state to assess existing entities that could serve as fiscal intermediaries. The authors of these briefs illustrate through the C&C model how financial management services can support beneficiaries serving as employers. These providers can also facilitate fiscal accountability and reporting to ensure that benefits are not spent on unauthorized goods or services. Briefs #9 through #12 consider what is known about the use of debit cards and financial management services, and how this information could be utilized in CLASS.[21-24]

In order for CLASS to be successful, enrollment must be sufficient to ensure that the monthly premium is affordable. The more people that enroll, the greater the ability to spread the insurance risk, which can help keep premium costs down and thus increase its attractiveness to working adults. For people to choose enrollment in CLASS, they must be aware that it exists and that planning for future long-term care needs is essential. How the CLASS Office and others develop messages and marketing materials for the plan will have a significant impact on enrollment. Marketing messages must not only be targeted to individual purchasers, but also to their employers as potential conduits for enrollment activities. In Briefs #13, #14, and #15, Eileen Tell describes lessons learned from the *Own Your Future* campaign and employer and buyer profiles to identify best practices in achieving strong participation rates and opportunities for cost-effective marketing of CLASS.[25-27]

Brief #16 considers a key issue from a supply-side perspective, namely what workforce infrastructure is needed to meet the new and growing demand for services? CLASS will provide eligible individuals with cash in hand, ready to purchase services, so it is imperative that they be able to buy what they want to remain independent. In this last brief of the current series, Seavey and Manquard focus on "matching service registries." These are labor market intermediaries that facilitate consumer direction, in order to ensure that the personal care attendant workforce is matched appropriately to beneficiaries in an effective and efficient manner.[28]

CLASS, like most innovative efforts in the 21st century, builds on key ideas from times past and charters new waters that transform the financing of supportive services from Medicaid as a government safety net toward personal planning, choice, and responsibility. CLASS is fundamentally about ensuring that all Americans have choice and access to the services and supports when needed to remain independent members of society. We hope this series will shed light on some key implementation issues that have not yet been addressed in the public debate, and foster active discussion on how to pave the way for successful implementation of CLASS so that adults with functional limitations and their families gain financial security while living with independence, dignity, and choice.

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Supporting Individuals with Disability Across the Lifespan at Home: Social Services, Technologies, and the Built Environment

By Laura N. Gitlin, Sarah L. Szanton, and Eva H. DuGoff

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief describes the broad needs of individuals with disability and the wide range of supportive and environmental solutions that can allow for the most independent living possible. Using the evidence from research, the brief suggests how findings on social and environmental supports for individuals with disability can inform implementation of CLASS.

Introduction and Overview of Disability

Disability is a condition that can affect anyone - young and old, rich and poor, women and men, or any race or ethnic group. An estimated 35-43 million adults (18+) in the United States have a physical or cognitive impairment that interferes with their daily functioning.[1] A person can be born with a disability as in the case of Mike who has cerebral palsy, or it can occur in young adulthood from an accident and persist throughout a lifetime.

Mike, a 28 year old with cerebral palsy, is no longer ambulatory. He is too heavy for his parents to lift him from bed and they are at risk of injury when transferring him from his wheelchair to the bathtub. He and his parents would both benefit from an assistive device that holds his weight while he transfers.

Having a disability can also occur late in life such as in the case of Mrs. H., who was previously very active and now at the age of 76 experiences significant limitations in her ability to take care of herself.

Since 76 year old Mrs. H. broke her hip, she has difficulty using her steep stairs and also getting into her tub to take a shower. As her only bathroom is on the second floor, she cannot get to the bathroom on time. She is also showing signs of memory loss. Her daughter who lives close by is very anxious about her well-being and checks in on her almost daily to assure she is safe and taking her medications. Mrs. H. would benefit from a stair lift or a first floor powder room. She also needs a walker to safely move around her first floor, and a grab bar and tub bench for safe bathing. An electronic medication dispenser and monitoring devices might help Mrs. H's daughter keep Mrs. H safe at home.

Disability affects individuals unpredictably as they age and experience illness and other life events. Such is the case of Mr. J who, after a stroke and the loss of his wife, has significant difficulties living alone.

"...there is no uniform trajectory of disability; thus, there is no single social or environmental solution that is right for all people with a disability..."

Since his stroke, 80 year old Mr. J. has difficulty bathing due to poor balance and muscle weakness. He needs grab bars, and training for both using a tub bench and getting into and out of the tub safely. He also wants to go to adult day care for strengthening exercises and group depression treatment as he is a recent widower and feels very lonely. His benefits could pay for his transportation to adult day care.

Disability is not a static state. A complex and dynamic condition, it reflects the relationship between an individual who experiences interference in normal bodily functions caused by disease, trauma or other condition, and that person's social and physical environment over the life course.[2]

Disability can pose minimal to significant challenges to an individual's ability to engage in everyday activities of living such as bathing, dressing or preparing meals, or to enjoy life, and age at home or in the residence of a person's choice. The challenges posed by disability are driven largely by factors that are external to the person – those demands imposed by social and physical environmental conditions. For example, in the case of Mrs. H., prior to her hip fracture, she had no difficulties going up and down her stairs or getting in and out of her tub to shower. However, following hip surgery and accompanying increased severe arthritis, her physical environment now presents a significant barrier to her ability to bathe or to go upstairs to use her bathroom.

Social and physical environmental problems can be changed to compensate for an individual's losses. Mr. L., for example, cannot leave his home and return to work due chiefly to one barrier – the front steps of his home. Such a physical impediment can take a toll on individuals and their family members both emotionally and financially, putting them at risk of accidents such as falls and unnecessarily curtailing activities, both of which can lead to relocation or institutionalization. In contrast, supportive environments that are matched to individual competencies and needs can result in desirable person-centered outcomes. Simple and supportive environmental solutions for Mrs. H. such as a stair glide, first floor powder room, and grab bar in her bathroom – or in the case of Mr. L – a ramp outside his home, a car modified for use by hands – would enable each of them to remain productive and self-supporting, thereby reducing their risk of having to move to a more costly setting such as assisted living or a nursing home.

Fifty-five year old Mr. L. recently had both knees amputated due to diabetes. He is unable to leave his home. He is becoming increasingly isolated and depressed as he is unable to return to work or see his family or friends. Mr. L would benefit from a ramp in the outside of his home, a stairglide, and opportunities to see his friends and family along with work accommodations to enable his full participation.

The good news is that social and environmental conditions can be modified to accommodate changing needs associated with physical or cognitive losses and

support independence. There are many existing technologies, services, and environmental modifications that can help individuals with disability stay engaged in life and function independently.

Guiding Principles for Identifying Allowable Solutions under the CLASS Plan

As illustrated by the case examples above, there is no uniform trajectory of disability; thus, there is no single social or environmental solution that is right for all individuals with a disability or which endures for a person's lifetime. Existing research on minimizing the impact of disability points to 9 essential principles (Table 1) that should be used to guide CLASS Plan purchases to enhance the supportive qualities of social and environments. The guiding principles, listed in Table 1, reflect evidence showing that: 1) the needs of individuals with disability change over time; 2) individual control over choice of solutions enhances self-efficacy and well-being; 3) solutions must not only enhance safety, function, and independence but also enable persons to participate in meaningful activities that assure quality of life and dignity; 4) solutions should not just be confined to home settings, but enable people to function in different environments including community and work; and 5) supportive approaches must take into account the needs and abilities of families or caregivers who provide assistance to individuals with disability to maximize

TABLE 1 **Evidence-informed Principles for Guiding Use of CLASS funds:**

- Heterogeneity of need (one size does not fit all)
- Recognition that disability is a multidimensional, dynamic and variable processes
- Need for on-going assessment and reassessment
- Importance of enabling an individual to engage in meaningful activities (e.g., self-care and leisure pursuits) that promote social connectedness and positive physical and mental health
- Need for supportive services spanning home, community and work environments
- Training individual and/or family caregiver in use of any technologies for effective and safe use
- Support needs of family caregivers to enable their continued effective assistance to persons with disability
- Sensitivity to cultural preferences and health literacy
- Solutions should focus on prevention, risk reduction, maintenance of independence at home as well as other needs including socialization and work.

benefit to both.

Possible Solutions that can be Purchased

A broad range of solutions have been identified in research as potentially helpful to individuals with disability and should be allowed under the CLASS Plan. Solutions can be purchased on the open market to promote the ability of individuals with disabilities to remain in their residence of choice and live with better quality of life with dignity and independence. These solutions include specific strategies, physical objects, and services such as training in the use of assistive devices or specific strategies to save energy. The appendix shows 12 broad categories of supportive solutions: 4 are related to the social environment and 8 are related to the physical environment. The specific items listed under each broad category are illustrative and not intended to be exhaustive. Here we describe in more detail each of the categories.

The Social Environment:

Helping individuals with disability through strategies that involve the social environment are critical to maintaining independence. As shown in the appendix, there are 4 broad categories that can be considered.

1. *Personal assistance* refers to help with taking care of the home or an individual's everyday needs including bathing, toileting, dressing, preparing meals, or shopping. For example, people frequently relocate to a nursing home because they cannot safely bathe or cook meals for themselves. An individual, such as Mr. L., who lives alone could purchase personal assistance for a few hours a day to keep clean, receive nutritional meals, and bathe safely, which would minimize risk of falls, poor nutrition, and further decline or frailty.
2. *Training in device use and simplifying self-care tasks* can compensate for physical and/or cognitive losses. For example, sometimes people cannot bathe themselves because they do not know how to safely get into or out of a tub. Individuals may also expend so much energy performing a particular task that they put themselves at risk of a fall and are unable to participate in other important activities because they become too fatigued. A professional occupational therapist can train an individual to use a feature such as a grab bar. He or she can also train in specific strategies to make it easier to carry out tasks which save energy so that the person can then engage in all the activities he or she needs or chooses to, such as bathing, getting dressed, preparing meals, getting around in the home or community, or socializing with friends and family.
3. *Supportive services and coordination of care* could pay for a care manager to assess the participant for types of helpful services that are needed, refer the participant to reliable providers, and coordinate and prioritize care needs. A care manager could also help with coordination of care and ensure that the individual's medical and supportive service needs are linked and properly addressed. This is currently a large gap

in the services available for individuals with disability and which requires a lot of time, effort, and skill that is best carried out by a care manager.

4. *Caregiver training and support* could include respite time as well as counseling and training in specific care techniques for the family caregiver. Families of individuals with disability are often the hidden patient. Providing support to the caregiver such as respite can help that person provide better and sustained care to the individual with disability. Also, training family caregivers in use of health technologies and specific techniques such as transferring a person in and out of bed or a car can enable a caregiver to minimize his or her own back strain and risk of personal injury. Caregivers can also be trained to modify the home environment to make it safer and more supportive of a person with a cognitive or physical disability.

The Physical Environment

Helping individuals with disability through strategies that involve the physical environment are also critical to maintaining independence. As shown in the appendix, there are 8 broad categories that can be considered.

1. *Home repair and maintenance of devices* allows individuals to live safely and with quality of life in their home environment. Participants may need to repair their stairs, railings, floors, or pay for routine maintenance and servicing of assistive devices including hearing aids, eye glasses, or wheelchairs. Tightening wall-to-wall carpeting, repairing steps or loose tiles, and securing loose wires are additional examples of basic home repairs that can enable people to stay safe in their homes and function better day-to-day. Also, devices described below, such as computers or health information technologies may need to be upgraded, maintained, or repaired. Maintaining their proper and safe operation can be critical to the daily well-being of individuals with disability.

2. *Digital technologies* include computers, and other software and hardware that can be adapted to help adults with a disability function at home or work. Examples include voice-activated computers or voice-activated telephone dialers. A voice-activated computer could assist an individual to remain connected to a social network. Also, newly emerging consumer electronics devices including home networking gear and smartphones can enable easier data sharing, networking, access to health information, and monitoring of health conditions, medications, financial, or other daily essentials.

3. *Health technology* can be purchased that can inform the individual with disability as well as communicate important information such as weight, heart rate, blood pressure, and blood sugar levels to health care providers. This can allow for better monitoring and control of health conditions on an on-going basis, thereby reducing doctor's visits or unnecessary hospitalizations. Health technology can also include new "exergames," which allow participants to increase their exercise with the results being sent to a health provider for monitoring and alerts.

"The CLASS Plan has the promise to enable individuals with disability to continue to live at home and meaningfully participate in their communities independently, safely, in control, and with dignity."

4. *Smart home technology* can be used to monitor and help individuals with a disability remain safely at home by, for example, providing an alert that a person has fallen, turning off a stove's burner that has been left unattended, and allowing the participant to video chat with a family caregiver or health provider who is located at some distance. There are also beds which can monitor sleep patterns and toilets that can monitor blood glucose and protein with a built-in alert. Newly emerging technologies that provide cueing for grooming or toileting, for example, may be beneficial to individuals with cognitive disabilities who would benefit from this level of assistance in carrying out daily activities. Robotics is also an emerging area that promises to benefit individuals with cognitive and physical disabilities. Robots can retrieve or carry objects, assist with daily routines, alert an individual to an unsafe condition, and carry out functions such as vacuuming, cleaning, lawn-mowing, and a wide range of other personal services.

5. *Home modifications* may include ramps for wheelchairs, stair glides, rails or banisters, grab bars in the bathrooms, handrails in corridors of long hallways, lowered door thresholds, widened doors for wheelchair access, and/or lowered shelves that allow a person to reach important items such as clothes, food, or a microwave oven. Additional examples include first floor powder rooms to allow easy access for toileting, additional lighting, storage, and moving appliances to more accessible locations.

6. *Assistive devices* may include mobility aids such as canes, walkers, or scooters, or a wide range of devices for daily tasks including reachers for dressing or obtaining objects that are placed out of reach, raised toilet seats, or tools with built up handles such as an opener that can make it easier to open a jar for someone with severe arthritis.

7. *Medical and other supplies* could include bandages, incontinence supplies, over-the-counter medicines, and other supplies useful in managing the symptoms of the disabilities that are often not covered by Medicare.

8. *Transportation* includes paying for others to transport individuals with disabilities to a clinic or doctor's office or modifications to a car that enable an individual to drive independently.

Considerations for CLASS Plan Design and Implementation

The primary challenge for individuals with disability is navigating unsupportive home, community, and/or work environments. The CLASS Plan has the promise to enable individuals with disability to continue to live at home and meaningfully participate in their communities independently, safely, in control, and with dignity. We recommend that the design and implementation of the CLASS Plan be guided by the 9 principles outlined in Table 1. As there is no single solution, assistive device, or technology that meets the needs of all persons with disability, allowing people to choose the services and technologies that best address their unique needs as they change over time is critical.

"Based on the broad ranges of needs and services of this diverse group, the CLASS Plan should make every attempt to maximize flexibility in how funds are used and for specific services and objects that are covered. Individuals with disability and their family members are in the best position to make decisions as to what they need to manage day to day. "

As displayed in the appendix, there is a broad range of products, services, technologies, and environmental modifications that should be allowed for coverage using CLASS Plan funds to eligible beneficiaries. Furthermore, as health technologies are advancing rapidly, new products will become available that should be allowed for purchase under the CLASS Plan. Allowances should also be provided for supportive services and technologies that enable family members to continue in their caregiving roles. In addition, as each person with a disability has unique needs that change over time, access to on-going care coordination, assessment, and reassessment would be critical to the success of the CLASS Plan and is essential to helping people with disability remain at home.

Based on the broad ranges of needs and services of this diverse group, the CLASS Plan should make every attempt to maximize flexibility in how funds are used and for specific services and objects that are covered. Individuals with disability and their family members are in the best position to make decisions as to what they need to manage day to day. Flexible approaches to spending including the use of cash or a debit card with few non-allowed purchases (such as alcohol) would provide the most effective structure. Of importance is that there should be no limits on spending related to care management or assessments because change in function can happen suddenly or at unpredictable times in the life course of individuals with disability.

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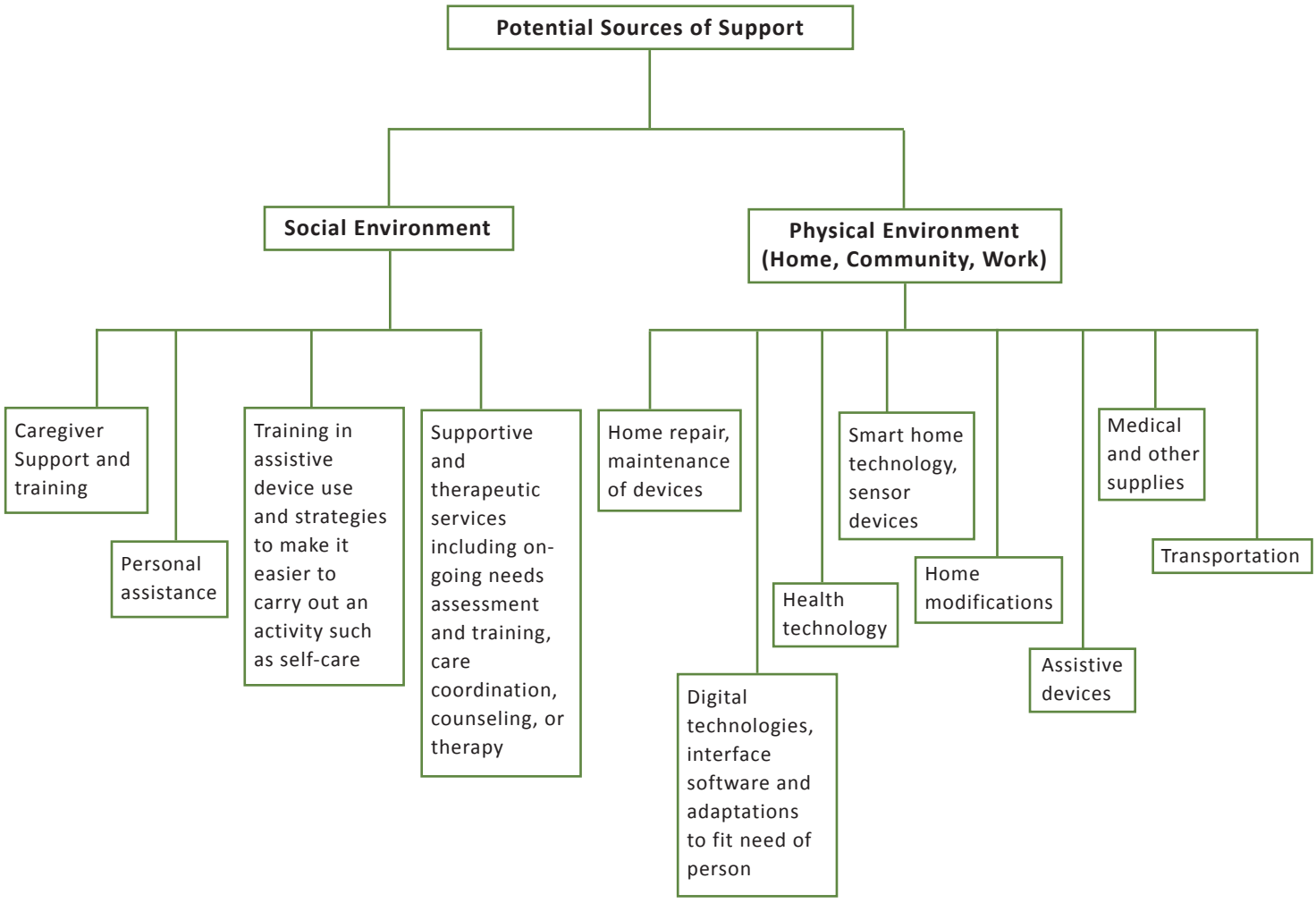
APPENDIX Outline of Potential Sources of Support for Individuals with a Disability



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CLASS Technical Assistance Brief Series

Spring 2011 • No. 2

The Historical Development of Benefit Eligibility Triggers Underlying the CLASS Plan

By Marc A. Cohen, Jocelyn Gordon, and Jessica Miller

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief provides background on the historical development of benefit eligibility triggers in the private long-term care insurance market. Such a review is important because understanding how these triggers came into being, and the intent and forces that shaped their development, can provide important information to those charged with implementing the CLASS Plan.

Introduction and Overview of Historical Development of Long-Term Care Benefit

LifePlans reviewed the legislative history of the National Association of Insurance Commissioners' (NAIC) Long-Term Care Insurance Model Regulation as well as the relevant IRS code and HIPAA legislation to construct the timeline for the development of benefit eligibility triggers. As well, we reviewed polices as far back as the early 1980s and surveyed key individuals involved in insurers' claims management units to obtain their insights.

Long-term care (LTC) insurance has been selling in the marketplace for the better part of 30 years, although early versions of the insurance covered only nursing home care and was called "Nursing Home Insurance." Through the 1970's and up to the late 1980's, the coverage was theoretically linked to the structure of Medicare coverage. Like many supplemental private health insurance policies, Nursing Home Insurance focused on what Medicare "did not cover." Medicare paid for skilled nursing home care for up to 100 days after a 3-day prior hospitalization and private insurance picked up coverage where Medicare ceased.

If care was initially considered to be "medically necessary" by Medicare, private insurance carriers offered continued coverage for custodial care even after a skilled need was no longer present. In essence, this extended available coverage from a limited amount of skilled nursing care (paid by Medicare) to a much more generous amount of skilled and custodial nursing home care (paid by private insurance and also by Medicaid for selected populations).

The insured-for-event in early policies, that is, the benefit trigger, was defined in terms of an individual's need for "medically necessary" care in a nursing home. Insurers varied in how they

"The insured-for-event in early policies, that is, the benefit trigger, was defined in terms of an individual's need for 'medically necessary' care in a nursing home. "

defined "medically necessary" and a typical insurance policy contract might have read that *"...Medically Necessary means care that is appropriate to the diagnosis, widely accepted by the practicing peer group based upon scientific criteria, and not experimental, investigative or randomized."*[1] Or it could be defined to mean *"...that admission to a nursing home is required due to injury or sickness and there exists a level of functional incapacity which makes a continued nursing home stay appropriate and reasonable."*[2] Either way, in most cases, benefits were payable when a doctor certified that there was an underlying need for the care. Diagnoses and prognoses were viewed as particularly important pieces of information justifying the medical necessity determination.

"A combination of factors including the dearth of insured data on which to base LTC pricing, a rapidly changing service delivery environment, and uncertainty about knowing when a physician would deem an insured's care as medically necessary led companies to a search for more predictable benefit trigger criteria."

The concept of medically necessary care as an LTC insurance benefit trigger did cause challenges for companies. In particular, as actuaries designed and priced policies, there was little basis on which to develop an estimate for future morbidity. It was very difficult to predict the circumstances under which a physician would certify that an individual required medically necessary care in a nursing home especially as the nature of that service modality changed. A combination of factors including the dearth of insured data on which to base LTC pricing, a rapidly changing service delivery environment, and uncertainty about knowing when a physician would deem an insured's care as medically necessary led companies to a search for more predictable benefit trigger criteria.

Another factor was also at work. While definitely growing, relatively sluggish sales of LTC insurance policies in the 1980s suggested that the then current product design was not going to reach a broader part of the public. Selling insurance to cover something that no one wanted to access – nursing home care – did not seem to be an attractive value proposition for fueling growth in the market. It was clear that for the coverage to sell, it needed to pay for custodial services where people desired them most – in their own homes. The need for a change in policy design, coupled with the expansion in public coverage for more home and community-based care led the industry to begin looking for benefit eligibility triggers that would allow them to cover such care. To work, the triggers had to:

- be clearly related to the need for the underlying services being insured;
- have widespread acceptance among the medical/professional community providing services to aging populations;
- be clearly defined in a manner that would allow them to be put into an insurance contract and easily understood by consumers; and,
- be easy to measure and administer using standard tools and methodologies.

In the late 1980's and early 1990s, insurers began to understand that the factors related to utilization of LTC services were based on functional and/or cognitive deficits. As carriers began to provide limited coverage for home care, they also added an additional pathway for benefits: deficits in Activities of Daily Living (ADLs) and/or cognition. Thus, throughout the beginning of the

"In the late 1980's and early 1990s, insurers began to understand that the factors related to utilization of LTC services were based on functional and/or cognitive deficits."

decade, policies tended to fall into one of two categories with respect to benefit triggers: (1) Triple Trigger policies that had three pathways to benefits − ADL limitations **or** Cognitive impairment **or** Medical necessity and (2) Double Trigger policies − ADL limitations **or** Cognitive impairment.

The ADLs were based on the standard Katz scale and included bathing, dressing, toileting, transferring, continence, and feeding.[3] These original ADLs were then slightly adapted and included in insurance contracts as a basis for determining eligibility for benefits. Their use implied a move away from a focus on underlying injury or sickness as the primary pathway to benefit eligibility toward a focus on the insured's functioning. In fact, in early insurance contracts, the language even stipulated that care would be considered necessary when there was a need for continual one-to-one assistance in performing a certain number of ADLs (e.g., 3 or more) or when continual supervision was necessary because of a cognitive impairment, ***even*** if there was no underlying injury or sickness.[4] An early definition for cognitive impairment read as follows: You are considered cognitively impaired if there is a *"...deterioration or loss in intellectual capacity which requires continual supervision to protect yourself or others as measured by clinical evidence and standardized tests that reliably measure your impairment in the areas of: short or long term memory; orientation to person (such as who you are), place (such as your location), and time (such as day, date and year); and your deductive or abstract reasoning."*[5]

"Their use implied a move away from a focus on underlying injury or sickness as the primary pathway to benefit eligibility toward a focus on the insured's functioning."

The most common test used to measure the presence of cognitive impairment was the Short Portable Mental Status Questionnaire (SPMSQ) and the more comprehensive Folstein. An important component of the early policy language was that it included a requirement for *"clinical evidence and standardized tests."*[6]

It is worth noting that through the early 1990s carriers made slight variations on ADL definitions and some defined functional dependence (i.e., the benefit trigger) in terms of the numbers of ADL deficiencies (e.g., 2 or 3 limitations), others included mobility as an ADL, and still others, used Instrumental Activities of Daily Living (IADLs). Unfortunately, during this period insurers in part competed for business on the basis of benefit trigger definitions. This led to confusion in the marketplace and a backlash among consumer advocates.

The Regulatory and Legal Framework

The first reported interest in developing a regulatory framework for private long-term care insurance was in 1985 when a series of conferences between legislators, regulators and industry representatives were held; there was also growing interest in Congress in the area of nursing home insurance.[7] As a result of a sustained effort, the NAIC adopted the first Model Act for LTC insurance in December 1986, followed by the first model regulation in 1987. Many states adopted these model regulations. In fact, by 1989, more than two-thirds of states had adopted the NAIC

model act and/or regulation.[8] The model regulations became the reference point for companies developing or modifying policies they were selling − or intended to sell − in the marketplace.

Soon thereafter, in December 1988, the first attempt aimed at modifying benefit eligibility triggers occurred. The regulation included prohibitions against prior hospitalization requirements as a condition for receipt of institutional benefits and in 1989, the same requirement was eliminated for home care benefits. It was not until 1995, however, that a new section – Section 27 – was added to the Act that provided for standards on benefit triggers. Regulators, consumer representatives, and the industry expressed widespread support for greater standardization in part because of a general sense that the medical necessity standard was problematic. Actuaries could not accurately predict morbidity under this standard, consumers did not have a good sense of when they would qualify for benefits, and regulators could not determine if benefits were being paid appropriately.

"HIPAA provided the most explicit definitions for tax qualified benefit eligibility triggers and these are in effect to this day."

Given the growing use by carriers of ADLs as components of the benefit eligibility triggers, an NAIC working group, which was established in 1994, decided to focus on ADLs and more specifically, on three key elements: (1) the definition of ADLs to be included in the Act; (2) the actual number that should be used to trigger eligibility for benefits; and (3) the level of impairment that would be used to determine a person's ability or inability to perform. By this time, an industry standard had already been developing based on the six Katz ADLs. The working group built on this standard. The group recommended – and the model was drafted on this basis – that if a policyholder was unable to perform three out of six ADLs they would qualify for benefits; companies were also given the right to establish a somewhat lower threshold of two of six ADL limitations. In both cases, the group decided that the standard for assistance needed to be hands-on (i.e., physical assistance from another person) and not stand-by (i.e., verbal queuing or the presence of another person nearby to prevent possible injury) in determining eligibility. Moreover, cognitive impairment was added as a benefit trigger.

Throughout the 1990s, policymakers were looking for ways to encourage individuals to purchase private LTC insurance. To that end, and as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), under certain circumstances both the premiums and benefits of LTC policies received preferential tax treatment. HIPAA provided the most explicit definitions for tax qualified benefit eligibility triggers and these are in effect to this day. Namely, an individual had to be certified as "chronically ill" and had to incur "qualified long-term care expenses." These terms were explicitly defined in Interim Guidance Notice 97-31.

With respect to the first term "a chronically ill individual" defined under Section 7702B (c)(2)(A) had to be certified by a licensed health care practitioner as unable to perform without substantial assistance from another

individual at least two of six ADLs for a period of at least 90 days due to a loss of functional capacity. This was referred to as the "**ADL Trigger.**" The "**Cognitive Trigger**" was defined to mean the individual required substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment. Finally, the "**Similar Level Trigger**" gave authority to the Secretary's of the Treasury and DHHS to define another trigger for individuals having a level of disability similar to the level of disability described in the ADL Trigger.

The Federal government provided interim guidance regarding the precise definitions of some of these terms and this guidance has remained in effect ever since.[9] Noteworthy is the fact that to this day, the "Similar Level Trigger" has not been defined. While a variant of this trigger is included in the CLASS Plan it will likely not result in an additional definition, since the two other triggers (ADL and Cognitive) appear to be sufficient in identifying those individuals who present with a need for LTC services and are widely accepted by regulators, insurers, and consumer groups. The CLASS Plan also includes a fourth trigger "presumptive disability" for those who are in the process of being discharged (or were recently discharged) from a facility if they were there for LTC.

"As insurers were challenged with trying to price policies in a rapidly changing service delivery environment, and consumers were demanding coverage for home care, the focus on functional and cognitive triggers developed naturally."

In 1998, the Senior Issues Task Force (which was part of the NAIC) was charged with the task of reviewing the LTC Insurance Model Act and Regulation for compliance with the HIPAA triggers, and in 2000, they completed an update to the Model Regulation which added a new section – Section 28. The purpose of this section was to assure that the benefit eligibility standards for qualified LTC insurance policies were consistent with HIPAA. Because both the federal requirement − detailed in Section 213, 7702B and 4980C of the Internal Revenue Code – and the NAIC Model Act relied on the same six ADLs as well as definitions for cognitive impairment, there was no need to change the standard model act in any significant manner. The major change in HIPAA, which then was incorporated in the Model Regulation, had to do with an additional requirement that a licensed health care practitioner needed to certify that with respect to ADLs, the individual had to be unable to perform them for a period of no less than ninety days.

For a timeline of the key milestones in the development of benefit eligibility triggers, see the appendix titled "Key Milestones in the Development of Benefit Eligibility Triggers."

Considerations for CLASS Plan Design and Implementation

The development of benefit eligibility triggers in private LTC insurance demonstrates how the risk management and product development needs of insurers and the "benefit clarity" needs of consumers led to a generally well accepted and agreed-upon pathway to insurance benefits. As insurers were challenged with trying to price policies in a rapidly changing service delivery

"Understanding how these triggers came into being will further support their proper use and implementation in the CLASS Plan."

environment, and consumers were demanding coverage for home care, the focus on functional and cognitive triggers developed naturally. Such triggers were clearly related to the need for the underlying services being insured for, had widespread acceptance among the medical/professional community, could be defined in an understandable way in insurance contracts, and could be measured and administered using standard tools and methodologies. The role of the NAIC was to ratify and clarify what was already becoming an industry standard and assure consistency with HIPAA which strengthened the status of these triggers by conferring tax qualification status on policies that met them. Understanding how these triggers came into being will further support their proper use and implementation in the CLASS Plan.

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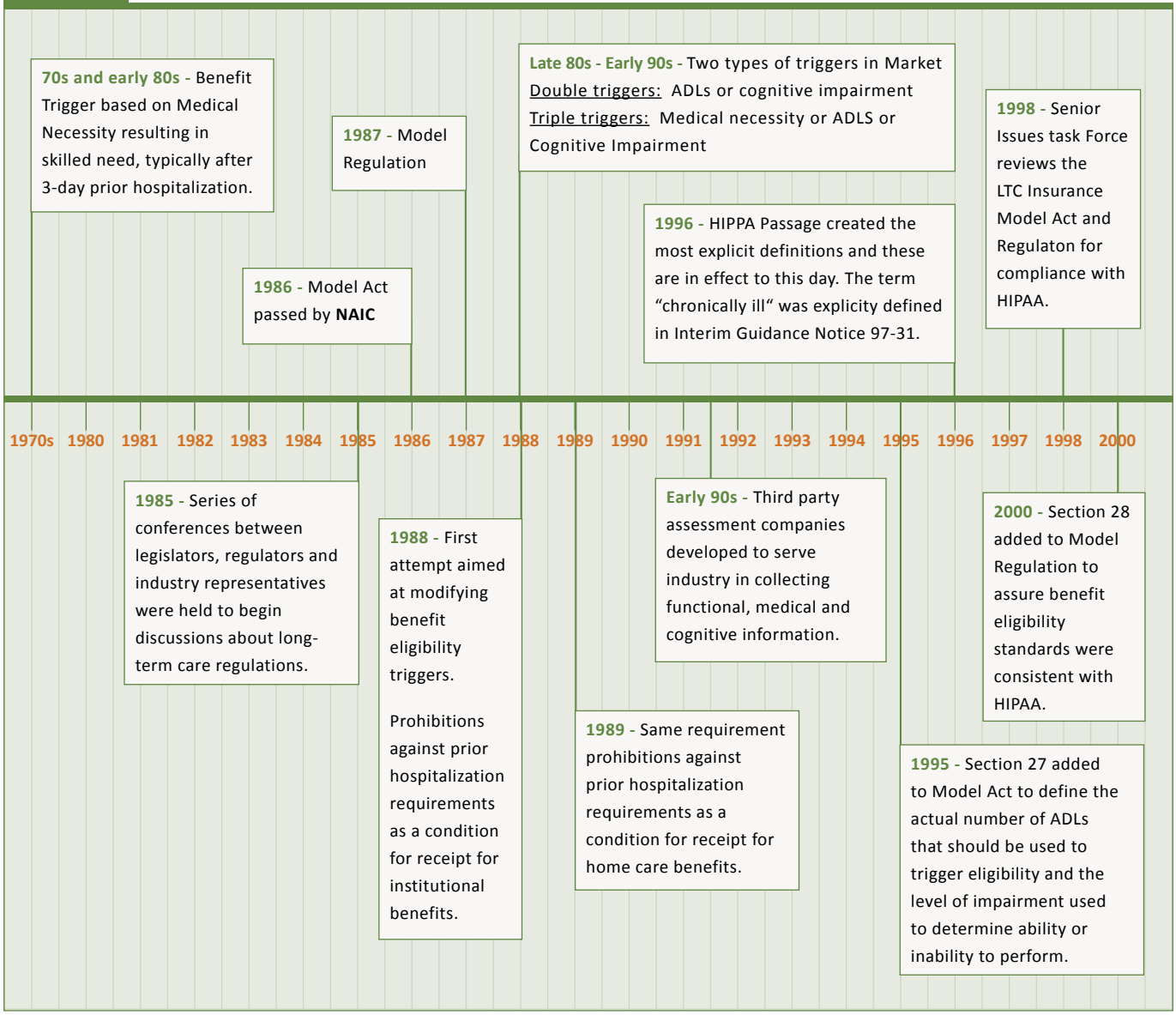
APPENDIX Key Milestones in the Development of Benefit Eligibility Triggers



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CLASS Technical Assistance Brief Series

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Understanding How Long-Term Care Benefit Triggers Are Implemented in the Private Insurance Setting

By Marc A. Cohen, Jocelyn Gordon, and Jessica Miller

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief provides information about how long-term care insurers implement benefit eligibility triggers in the private insurance market both from a contractual and process perspective. The way in which companies have operationalized benefit eligibility triggers can inform the development of regulations for the CLASS Plan.

Introduction and Overview of Insurance Contract Language

In order to better understand in a more concrete way how insurers apply benefit eligibility triggers[1] LifePlans conducted a structured survey with key individuals involved in the claims management process from 13 major long-term care insurance carriers representing the vast majority of policies sold in the market. We also examined a set of long-term care (LTC) insurance contracts from several of the largest insurance companies selling in the market today to understand if and how these contracts are similar to or different from regulations governing LTC insurance contracts and each other. The key regulations have been developed by the National Association of Insurance Commissioners (NAIC) and adopted by a majority of the states where private LTC insurance is sold. The regulation governing private LTC insurance is the NAIC Model Regulation, which was adopted in 1986 and updated over the years.[2]

One of the strongest tools that insurers have to manage the underlying risk associated with the insurance policy is the contract language itself. In essence, the insurance policy represents a contract between the individual policyholder and the insurance company. As such, it is enforceable in a court of law. Thus, it is not surprising that LTC insurance contract language related to benefit eligibility triggers generally mirrors the NAIC Model Regulation and HIPAA definitions found in the IRS code. Given the fact that policies must be filed in all 50 states, the NAIC Model regulation and HIPAA requirements made it easier for insurers to make very minimal adjustments to their contracts based upon state requirements, but have a uniform way – from a contract standpoint – of expressing the standards for benefit triggers. In essence, to assure the tax qualification status of the insurance, the

"One of the strongest tools that insurers have to manage the underlying risk associated with the insurance policy is the contract language itself. "

contracts needed to contain language that defined all the component requirements of the IRS code.

Upon review of seven different policy contracts filed with the Florida Insurance Department from four of the major long-term care insurance companies accounting for more than 60% of all sales, we found that the wording for the ADL definitions was exactly the same as that found in the NAIC Model Regulation. That is, all of the LTC contracts reviewed used the same definitions for the six basic ADLs. Furthermore, the wording for the other terms detailed in the IRS code (Chronic Illness, Severe Cognitive Impairment, Substantial Assistance, and Substantial Supervision) were all similar enough that while it may have differed slightly across contracts, there did not appear to be any discernable implication for how benefits would be adjudicated.

Implementation of Benefit Eligibility Triggers in Practice

Definitions and Measurement of ADLs

While the high level definitions contained in the insurance contract language are virtually identical across the industry, there is latitude in the way that a company can define and measure the performance of each ADL and the existence of cognitive impairment. How this is done in practice is particularly important to companies because it affects how the underlying risk that is being insured for is actually defined, and this has implications for the underlying financial solvency of the products they are selling. In essence, the precise definitions and measurements employed by a company are a key to both predicting and managing the risk that the insurance is designed to ameliorate.

Interviews with long-term care insurance company claims experts showed a great deal of variation across the industry in terms of how HIPAA triggers are actually applied and administered in practice – specifically the way that insurance companies define and measure the performance of each ADL and the existence of cognitive impairment. The activities or sub-components that comprise an ADL often differ as do the ways in which the performance of these activities may be evaluated in terms of determining whether or not "dependence" exists.

For instance, bathing as an ADL is defined by the NAIC Long-Term Care Insurance Model Regulation Act #641 as "washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower."[3] In practice, the act of "washing oneself" is comprised of many components. The table on page 3 illustrates that of ten possible bathing-related tasks, there is absolute consensus among the surveyed companies on only the three tasks which are listed in the definitions contained in the NAIC Model Regulation (shown in the shaded cells).

TABLE Distribution of Companies by Use of Component Parts of Bathing ADL Definition

Components of Definition	Included in Definition of Independence	Not included in Definition
Washing oneself by sponge bath; or in either a tub or shower	100%	0%
The task of getting to or from the tub, shower or sink	23%	77%
Getting into or out of the tub or shower	100%	0%
Obtaining/disposing of water for sponge bath	38%	62%
Turning on/off water or controlling water temperature	54%	46%
Washing the body	100%	0%
Toweling dry all parts of the body	77%	23%
Washing the back	58%	42%
Washing the hair	58%	42%
Washing the feet	58%	42%
Additional items considered	8%	92%

"Upon review of seven different policy contracts filed with the Florida Insurance Department from four of the major long-term care insurance companies accounting for more than 60% of all sales, we found that the wording for the ADL definitions was exactly the same as that found in the NAIC Model Regulation."

As the table shows, some companies are explicit about the parts of the body that one must be able to wash (e.g., the back, hair, or feet) whereas others leave the definition more open ended. This is true for all of the ADLs; they contain the required NAIC component definitions, but then additional components may be added to the definition.

There are two ways that a licensed health care practitioner can make a judgment about an individual's ability to perform their activities of daily living: (1) through self-report, whereby the individual is asked if and how they perform the activities, and (2) through the use of ADL demonstrations. In the latter case, the assessor asks the individual to actually perform the ADL (e.g., transfer between a bed and a chair) or simulate the performance of the ADL (e.g., show how they might dress themselves). Our research indicates that

"While the high level definitions contained in the insurance contract language are virtually identical across the industry, there is latitude in the way that a company can define and measure the performance of each ADL and the existence of cognitive impairment."

almost all companies (93%) require ADL demonstrations during the assessment process in order to determine benefit eligibility based on ADL functioning.

We also uncovered the alternative ways that companies conceptualize a "substantial need" for assistance with a specific ADL. The IRS language around the definition of substantial assistance (i.e., hands-on or stand-by) is perhaps one of the most difficult to define and implement in the assessment process. There are two concepts that confound a straight interpretation of this standard. The first concept is the question of performance adequacy of a specific ADL. Some companies fully take this into account whereas others do not. For example, if an individual can perform an ADL without assistance, regardless of how well they do it, they may be considered independent in that ADL. An alternative viewpoint is that if an individual performs the ADL, but not all elements adequately, then perhaps they have a "need" for assistance. The presence of this need suggests that they are not independent in the ADL, but in fact may require substantial assistance.

The second concept that confounds a straightforward interpretation relates to the issue of "safety" in assessing ADL performance. That is, even if an insured can perform an ADL, if the evaluation is that they cannot do so safely – that is, they may be at risk for adverse consequences when they perform the ADL – the individual may be evaluated as having a need for substantial assistance in this ADL.

Responses from the long-term care insurance companies on these issues varied. Slightly more than two thirds of companies take into account safety as well as adequacy in performance of the ADL in making judgments about whether an individual is dependent or independent for the purposes of benefit eligibility. The other one-third evaluates performance exclusively on the basis of whether the individual can or cannot perform the ADL.

Given the fact that all of the ADLs consist of various definitional sub-components, an additional question arises: Do insurers take into account the scope of assistance required? Put another way, if an individual can perform 3 of 4 sub-components of an ADL, are they considered independent or dependent? Figure 1 shows that three-quarters of the companies surveyed stated that the inability to perform even a single sub-component of the activity is enough for the individual to be evaluated as dependent in that ADL.

"Interviews with long-term care insurance company claims experts showed a great deal of variation across the industry in terms of how HIPAA triggers are actually applied and administered in practice – specifically the way that insurance companies define and measure the performance of each ADL and the existence of cognitive impairment."

FIGURE 1 How Scope is Accounted for in ADL Evaluation

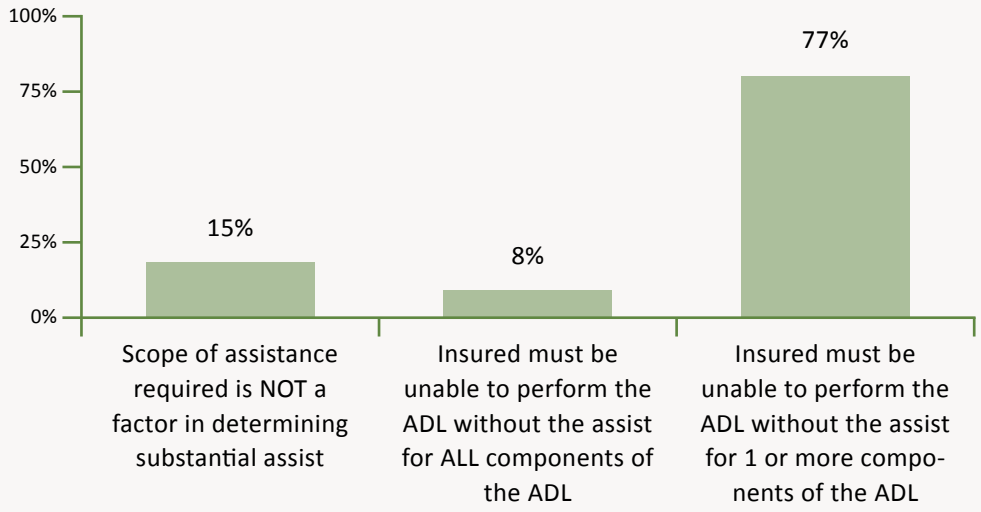
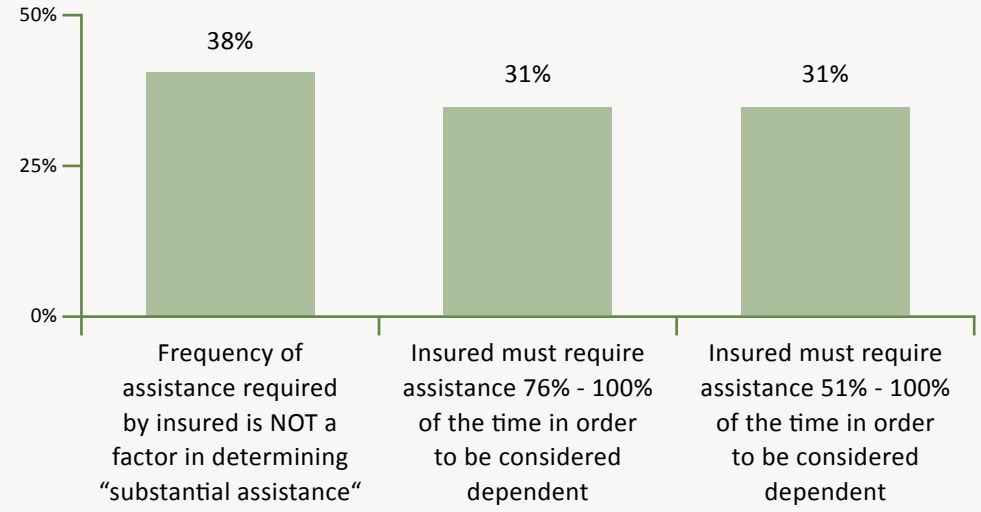


FIGURE 2 How Frequency is Accounted for in ADL Evaluation



"We also uncovered the alternative ways that companies conceptualize a "substantial need" for assistance with a specific ADL."

There is much less consensus on how the frequency of performance – how much of the time an individual requires assistance – should be addressed in the ADL assessment process. Figure 2 shows that roughly two-in-five companies do not even relate to this issue whereas about one-third define "assistance" in part to mean that the individual requires help at least 75% of the time when they are performing the ADL. The other one-third have a somewhat less stringent definition in which an individual who requires assistance at least 50% of the time establishes an ADL dependency.

Cognitive Impairment and the Interplay with ADLs

While cognitive impairment is treated as a separate benefit eligibility trigger in HIPAA as well as the CLASS Plan, there is clearly interplay between having a cognitive impairment and ADL dependencies. An individual can be certified as Chronically Ill if they have a certain level of ADL loss or they require substantial supervision to protect themselves from threats to health and safety due to severe cognitive impairment. When asked whether cognitive impairment is always considered a separate pathway to benefit eligibility or whether it is also taken into account when reporting ADL status, roughly half of the companies reported that they do not focus on the impact of cognition on the performance of ADLs, but rather focus on this as a separate and distinct pathway to benefits. Other long-term care insurers reported that they judge an individual as unable to perform ADLs without stand-by or hands-on assistance if they require cueing, prompting, or directing due to a cognitive impairment.

"Slightly more than two thirds of companies take into account safety as well as adequacy in performance of the ADL in making judgments about whether an individual is dependent or independent for the purposes of benefit eligibility."

This distinction may have little practical implication in terms of benefit eligibility status because even if an individual who needs cueing to perform the ADLs may be assessed as ADL independent, he/she would likely be assessed as severely cognitively impaired and consequently benefit eligible in any case. However, there may be financial implications for the CLASS Plan if it ties benefit amounts to varying levels of disability.

There are a variety of standardized tests for cognitive impairment that are available to insurers. All companies surveyed use the Mini Mental Status Exam (MMSE), also known as the Folstein test, to identify whether an individual has severe cognitive impairment. Many companies also use elements of other tests (e.g., Short Portable Mental Status Questionnaire, Neuropsychology exams, and behavioral evaluations) to corroborate certain test results. Companies do vary greatly in their approach to the "cut-off" score that they use to classify an individual as impaired. While there is agreement about the base test that should be used to measure the presence of cognitive impairment, there is not a high degree of consensus regarding the interpretation of results and whether and how these results should be combined with other tests.

It is noteworthy that these tests have been developed with elderly populations in mind and that their validity has not been well established in specialized population groups such as those suffering mental health issues or the developmentally disabled. If such individuals are in the

work force, they may qualify for the CLASS Plan and thus there is a need to find more sophisticated ways to measure their cognitive status.

Chronic Illness Certification

The third component of the benefit eligibility trigger is that the underlying need for assistance must be expected to last at least 90 days. There is no specific test for this, but rather, the licensed healthcare practitioner – typically a nurse – is expected to render a clinical judgment. The only issue on which companies may vary in their approach relates to the starting date of the 90-day certification. Roughly 25% of the companies surveyed view the assessment date as the time when the 90-day certification begins and the others use another date, most often the date that the disability began as reported by the individual or as documented in a medical record or nursing notes.

"Information provided in this report can assist policymakers to develop strategies and approaches that support the underlying financial viability of the CLASS Plan, as well as maximize opportunities for the public and private sectors to work together to address the nation's LTC financing challenge." [i]

Considerations for CLASS Plan Design and Implementation

The Community Living Assistance Services and Supports (CLASS) provision in the Affordable Care Act requires that an assessment process be developed to determine whether benefits are payable, the degree of impairment that exists, and the amount of benefit that will be paid. The experience of private insurers in applying the HIPAA eligibility criteria in long-term care contracts is clearly instructive for policymakers charged with implementing the CLASS Plan. Information provided in this report can assist policymakers to develop strategies and approaches that support the underlying financial viability of the CLASS Plan, as well as maximize opportunities for the public and private sectors to work together to address the nation's LTC financing challenge.[i]

[i] Additional considerations for implementing benefit eligibility triggers under the CLASS Plan Design and Implementation are presented in The SCAN Foundation's CLASS Technical Assistance Series Brief #4: ("The Independent In-Person Assessment Process").

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CLASS Technical Assistance Brief Series

Spring 2011 • No. 4

The Independent In-Person Assessment Process

Jocelyn Gordon, Marc A. Cohen, and Jessica Miller

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief provides information on the benefit eligibility assessment process in the private long term care insurance industry. It focuses on how long-term care insurers use the information in the adjudication process, who is involved in the process, and how Activities of Daily Living and cognition are assessed. This is particularly important because one of the first responsibilities of those charged with implementing the CLASS Plan is to develop an assessment system for eligibility for CLASS benefits.

Introduction and the Role of the Independent In-Person Assessment in the Adjudication Process

LifePlans interviewed and surveyed managers involved in the claims adjudication process from the majority of long-term care (LTC) insurance carriers selling policies in the market. We asked a series of questions related to the role of the in-person benefit assessment within the claim adjudication process and how individual activities of daily living (ADLs) and cognitive status are measured. We did this by examining a sample of commonly used benefit determination assessment instruments used by carriers.

In the LTC claim adjudication process, insurers focus on managing three types of risks associated with a claim: (1) the risk of a LTC Insured going on claim ("incidence risk"); (2) the risk associated with the insured receiving the appropriate level of service ("intensity risk"); and (3) the risk associated with making sure that the length of time that the individual is on claim is in line with continued underlying need ("durational risk").

Benefit eligibility assessments play a critical role in LTC risk mitigation strategy. Many LTC carriers rely on independently-performed in-person assessments to determine whether the "insured-for event," that is, functional dependence or cognitive decline, has indeed occurred. In essence, information collected on the benefit eligibility assessment serves as the foundation for the proof of loss required to adjudicate the claim. The assessment provides the carrier with independently collected information from a licensed healthcare practitioner and focuses on the following domains: demographics, diagnosis, physical function, cognition and behavior, health service history, home modification, fall history, medication use and administration, current service plans, a general summary of clinical observations, and information on the facility provider or private caregivers (if they are in place).

"Most insurers rely on third-party vendors to supply them with access to a national field network of registered nurses trained to adhere to strict protocols that maximize inter-rater reliability across nurses in various geographical locations and to quickly deploy to the policyholder's home for the assessment."

The focus of the information is to fully understand and evaluate the individual's cognitive and functional status, which is a prerequisite to determining whether they are a chronically ill individual and thus eligible for insurance benefits.

Additionally, face-to-face assessments are used not only as the basis for the benefit eligibility determination but also as a tool in managing the intensity risk. The assessment can be a primary source of information in the development of a plan of care. When this is the case, the assessment instrument includes a more detailed health history, evaluation of the Instrumental Activities of Daily Living (IADLs) which include such things as medication management, meal preparation, housekeeping, laundry, grocery shopping, transportation, money management, telephone use, and a needs assessment. Finally, use of periodic in-person reassessments are required to establish that the level of functional or cognitive impairment requires an ongoing need for service and that the individual is receiving services for the correct amount of time. Thus, the assessment is important information source when managing durational risk. The figure on page 3 shows the process in graphic form.

The Face to Face Assessment Process

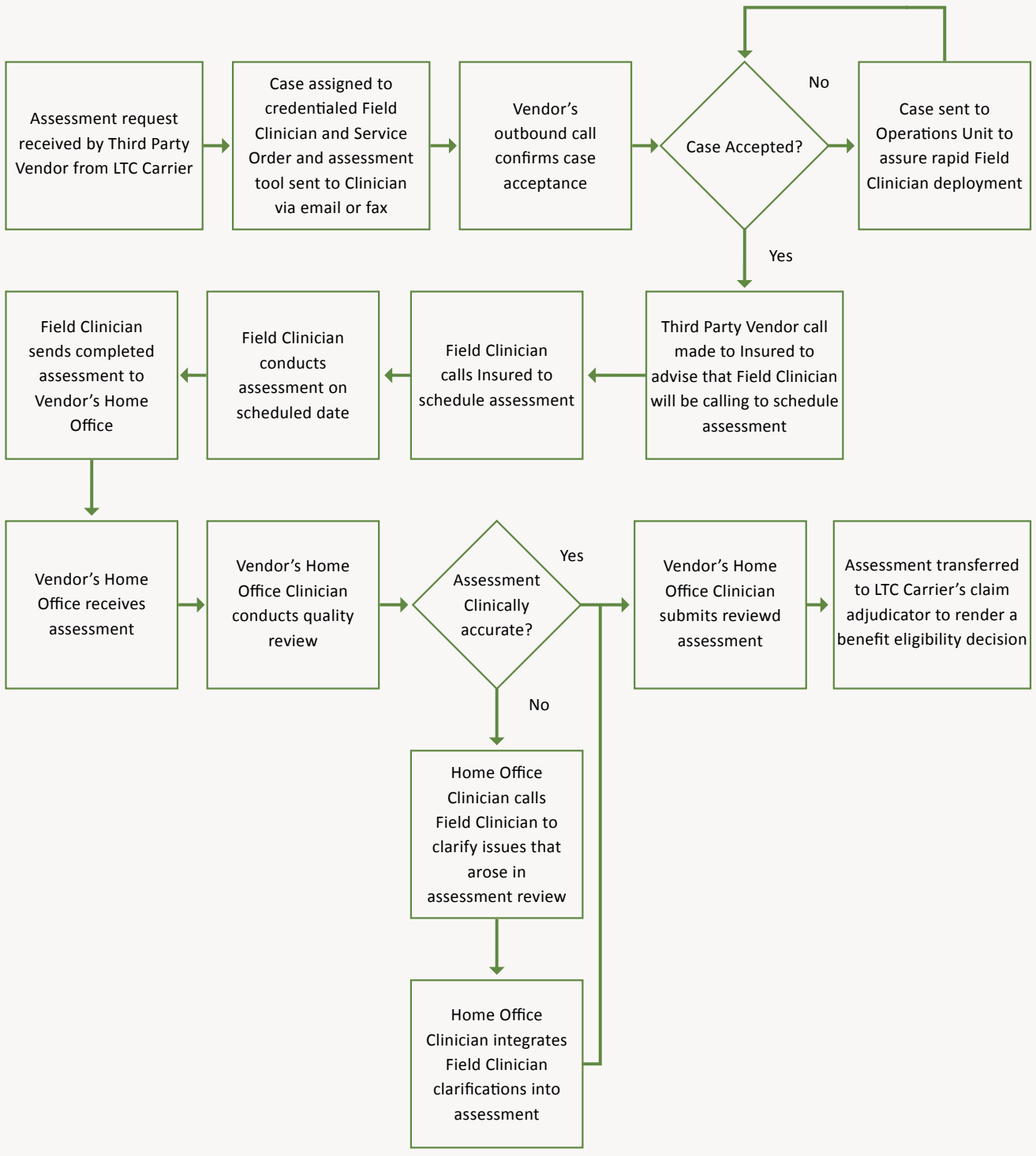
To conduct the in-person assessment, an independent field clinician – almost always a Registered Nurse – visits the Insured at his or her residence or in some cases institutional setting. During the visit, the field clinician gathers personal health, service provider and medication information, and conducts a functional, cognitive, and behavioral assessment. Most insurers rely on third-party vendors to supply them with access to a national field network of registered nurses trained to adhere to strict protocols that maximize inter-rater reliability across nurses in various geographical locations and to quickly deploy to the policyholder's home for the assessment.

The key directive that all clinical assessors must follow is to collect objective information regarding the individual's status. For this reason, while service providers may provide corroborating information, only rarely is such information relied on as the sole source of benefit eligibility information, especially in home settings. This is because of an inherent conflict of interest for a provider: a finding of functional or cognitive dependence enhances the probability that the individual will receive insurance benefits and that the provider will continue to be reimbursed for the ongoing services that they provide. A finding of functional or cognitive independence puts at jeopardy the provider's ongoing source of revenue.

Qualifications of Field Clinicians

Conducting an in-person benefit assessment requires a thorough understanding of chronic illness and the manifestation of specific diagnoses on the functional and cognitive status of the individual. Many LTC carriers require that the clinicians conducting assessments be either registered nurses or licensed social workers, and it is desirable that most have clinical experience working

FIGURE Face-to-Face Assessment Process



"Conducting an in-person benefit assessment requires a thorough understanding of chronic illness and the manifestation of specific diagnoses on the functional and cognitive status of the individual."

"Quality assurance is a critical component to the success of the assessment data collection process."

with older adults. For the most part, the third party vendors who supply these services to LTC carriers assure that these "field clinicians" are licensed, insured, and cleared through a criminal background check. Typically, specific written and detailed instructions are provided on how to complete each section of the assessment and additional education may be provided through web-based media. As well, most vendors provide clinical support in their home office to assist assessors who may be uncertain about various aspects of process requirements as well as specific assessment items. Field clinicians are instructed not to answer any questions related to the insured's long-term care coverage, policy or benefit eligibility status but instead, to focus on the collection of objective information. If the Insured asks questions related to the policy, the assessor is instructed to redirect the Insured to the carrier's claims department.

Quality Assurance

Quality assurance is a critical component to the success of the assessment data collection process. The performance of field clinicians must be monitored and reviewed closely by the home office clinical staff. As is true in any industry, there are varying levels of quality assurance by providers of assessment services. At a minimum, the vendor should conduct an internal clinical review of each assessment evaluating for clarity, consistency, and completeness of information before sending the information on to the LTC carrier for consideration in the claims adjudication process.

Independent In-Person Assessment Process Flow

The process begins when the assessment provider receives a request from a carrier via secured website, file feed, telephonic, or fax order. The third party vendor sends the case to a nurse located in the Insured's area of residence. Special handling instructions along with the precise assessment instrument are typically provided to the assessor electronically to ensure quick turn-around times. The assessor may be required to update the vendor on all steps taken to schedule the appointment with the policyholder so that the information on the progress of the case can be provided to the insurance carrier.

Once the field clinician agrees to take the case, depending on the carrier's protocols, the vendor notifies the Insured that a nurse will be calling to set up an appointment for the assessment. Typically, the field clinician faxes the completed assessment back to the vendor's home office shortly after the assessment is conducted. Rapid turnaround is critical in the face-to-face assessment process, and the vast majority of assessments are completed and available for review by the insurer within two weeks. Once the assessment arrives, it undergoes a quality review by a clinician to ensure that all of the functional and cognitive information needed to adjudicate the claim appropriately has been collected. A general work flow process map highlighting the key elements of the assessment process is presented on the page that follows.

"...the primary purpose of the assessment is to obtain objective information related to the cognitive and functional status of the individual."

Assessment Content

As mentioned, the primary purpose of the assessment is to obtain objective information related to the cognitive and functional status of the individual. What follows is a brief description of how this information is collected and scored for the purposes of assessing this status.

Cognition

Assessments currently employ a number of tools to evaluate the insured's cognitive ability. The tools most commonly used by long-term care insurers are the Mini-Mental State Exam (MMSE) and the Short Portable Mental Status Questionnaire (SPMSQ).

The Mini-Mental State Examination (MMSE) is the most commonly used quantitative instrument in screening for moderate or severe cognitive impairment.[1] The two part test includes thirty (30) questions that cover the following seven (7) cognitive domains: orientation to time and place, registration, attention, calculation, short term recall, and language and construction (e.g., ability to write a sentence and ability to copy a drawing). The first part of the exam requires solely verbal responses. The second part evaluates the Insured's ability to write a sentence, name objects, follow verbal and written commands, and copy a complex polygon design.

While the total number of correct answers is summed for a possible maximum score of 30, most normal elderly persons typically score a mean between 27 and 28. Patients with dementia, depression with cognitive impairment, and affective disorders form a continuum with mean scores for these groups of 9.7, 19, and 25 respectively. While research has found the test to be reliable, other factors like education, occupation, and cultural background also influence MMSE scores. Typically, an individual in the private LTC insurance market, an individual may be coded as having "severe cognitive impairment" if he or she scores less than twenty three (23) on the MMSE. The MMSE is relatively insensitive to early or mild forms of cognitive impairment and is thus an appropriate tool to determine if an Insured is meeting the severe cognitive impairment trigger in tax-qualified LTC policies.

The SPMSQ, developed by Pfeiffer et al. is a second assessment tool used for detecting cognitive impairment.[2] The test requires approximately five to ten minutes to administer and is designed to identify individuals who have intermediate or long-term memory loss or dementia and is accurate over 92% of the time. The SPMSQ is comprised of ten (10) questions that assess the cognitive domains of orientation and working memory.[3] A score of less than six (6) can lead to a classification of severe cognitive impairment.

Neither the SPMSQ nor the MMSE alone can be used to determine severe cognitive impairment for tax-qualified policies. To determine if an insured is severely cognitively impaired, the SPMSQ and MMSE results are considered in conjunction with responses to behavior questions included on the assessment and with the need for verbal cueing assistance with the Activities of Daily Living.

"...the assessment and benefit eligibility process is enabling claims adjudicators to accurately determine eligibility in line with contract language, which is in conformance with HIPAA eligibility criteria."

Function

In-person assessments evaluate an individual's functional ability through a comprehensive set of questions about the ability to complete the six standard activities of daily living – bathing, dressing, toileting, transferring, continence, and feeding. The functional review assesses the Insured's current ability to perform each of these activities with a focus on the nature of assistance that might be required to complete the activity. The assessor renders a judgment about the individual's capabilities by either requesting that the person demonstrate how the activity is performed and making observations on this performance, or by relying on self-reported information as well as an analysis of the level of assistance received by insured, if services are already in place.

For example, to assess the Transferring ADL, a field clinician may begin with a demonstration request: "Please stand up and sit back down for me," and documents his or her observations of the Insured's demonstration. The clinician follows up with a set of questions asking for an Insured self-report or a caregiver report about any assistance to complete each of the component parts of the activity of transferring:

If the Insured responds with a "yes" to either component the clinician may then ask the insured to describe the type of assistance, who provides the assistance, frequency of assistance, start date, and any equipment used. The assessor then integrates direct observation with self-reports and/or caregiver information to determine what type of assistance (if any) is most often required to complete the activity (e.g., no physical assistance, standby assistance, hands-on assistance, or verbal queuing).

Results of Benefit Eligibility Process

Clearly, while not all companies approach the benefit eligibility and assessment process in exactly the same way, there is a great deal of similarity in approach. The policies and practices of every company comply with HIPAA tax qualification regulations as evidenced by a review of contract language, the approval of such policies by state insurance departments, and the way benefit eligibility triggers are administered by companies.[i] Some degree of variation in how benefit triggers are applied is to be expected given the broad definitions in the law and regulations as well as expected differences in risk management approaches across companies.

"Do you receive assistance from another person when transferring?" Including:

(a) Getting in and out of bed ☐No ☐Yes

(b) Getting in and out of a chair ☐No ☐Yes

[i] Additional considerations for implementing benefit eligibility triggers under the CLASS Plan Design and Implementation are presented in The SCAN Foundation's CLASS Technical Assistance Series Brief #3: ("Understanding Long-Term Care Benefit Triggers: Contract and Implementation").

"...insurers have successfully operationalized these benefit eligibility triggers and in conjunction with professional third party vendors, have established an efficient and equitable way to measure them through the in-person assessment process."

The key question is whether such variation leads to adverse outcomes for consumers and companies. The empirical evidence is clear on this point: claim denials are relatively low across the industry, consumer satisfaction with the adjudication process is very high, and decisions appear to be consistent with policy language which is in turn consistent with the Health Insurance Portability and Accountability Act (HIPAA) and the National Association of Insurance Commissioners (NAIC) Model LTC Insurance Regulation. More specifically, empirical data derived from an independent review of 1,200 claims decisions made by seven of the largest LTC companies in the U.S. show that auditors only disagreed with 3% of approval decisions and 1% of denial decisions.[4] This suggests that the assessment and benefit eligibility process is enabling claims adjudicators to accurately determine eligibility in line with contract language, which is in conformance with HIPAA eligibility criteria.

Moreover, across the industry, the overwhelming majority of individuals who apply for long-term care benefits meet clinical benefit eligibility triggers and are approved for claim. In fact, on a national level only 4% of claims are initially denied because the Insured does not meet benefit eligibility triggers, which means that 96% are approved.[5] Within a 12 month period, half of the individuals who are initially denied for benefits begin receiving them. Regarding explicit consumer satisfaction with the process, a longitudinal study of a cohort of policyholders who were at the very beginning of the claims process found that 94% either did not have a disagreement with the company or had a disagreement that was resolved satisfactorily; this includes individuals who had their claim approved as well as those whose claim was denied.[6]

Thus, it would appear that the process results in outcomes that are in line with the expectations of consumers themselves regarding benefit eligibility and with HIPAA triggers and NAIC regulations. Finally, the most common reasons why companies seek rate increases relate to assumptions about lapse and interest rates. On an industry wide basis, actual to expected losses (claims) are running slightly below 100%, thus indicating that industry-wide claims experience is somewhat better than what was originally priced into policies.[7] The implication is that insurers have successfully operationalized these benefit eligibility triggers and in conjunction with professional third party vendors, have established an efficient and equitable way to measure them through the in-person assessment process. This helps ensure that actuaries can both price for and adequately measure the underlying risk. This should clearly encourage those charged with implementing similar triggers in the context of the CLASS Plan.

Considerations for CLASS Plan Design and Implementation

The Community Living Assistance Services and Supports (CLASS) provision

"The experience of private insurers in applying the HIPAA eligibility criteria in LTC contracts is clearly instructive for policymakers charged with implementing the CLASS Plan."

in the Affordable Care Act requires that an assessment process be developed to determine whether benefits are payable, the degree of impairment that exists, and the amount of benefit that will be paid. The experience of private insurers in applying the HIPAA eligibility criteria in LTC contracts is clearly instructive for policymakers charged with implementing the CLASS Plan. Benefit eligibility triggers in LTC policies have evolved over the past two decades and in a manner that ensures greater consistency and transparency for policyholders. Both the definitions of eligibility triggers as well as the processes used to verify that the triggers have been met have become more precise and enable carriers to more effectively manage the underlying risk that is being insured. Consumers also have a better understanding of the conditions under which they will receive benefits if and when they become disabled.

A key component in support of a fair and efficient claims adjudication process is the in-person assessment conducted by a licensed health care practitioner, typically a nurse. The assessment tools and training that these individuals receive must be carefully crafted and monitored to ensure that the information that is being collected is clinically accurate, complete, and enables carriers to render decisions that are in line with the underlying policy language related to benefit eligibility.

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CLASS Technical Assistance Brief Series

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Elements of a Functional Assessment for Medicaid Personal Care Services

By Marshall E. Kelley and Susan M. Tucker

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief discusses the results of the identification and analysis of the assessment instruments and data elements states use for determining medical conditions, activities of daily living and cognitive functional ability within Medicaid-funded personal care services programs. It identifies the elements states use for an assessment of a person's physical and cognitive limitations and need and compares these elements to the requirements of the CLASS Plan.

Introduction and Overview of the Elements of a Functional Assessment for Medicaid Personal Care Services

State Medicaid programs provide long-term services and supports for eligible individuals who have been assessed and determined to be in need of these services. Medicaid beneficiaries must meet financial as well as medical/functional eligibility criteria. Included in the array of long-term services and supports are personal care services (PCS), which provide assistance to individuals with their activities of daily living (ADLs), such as bathing, eating, and dressing, as well as assistance with their instrumental activities of daily living (IADLs) such as shopping, preparing meals, and housecleaning.

Medicaid is the primary source of funding for personal care services, also known as personal assistance services and attendant care. States may offer personal care services as an optional benefit under their Medicaid state plans (as authorized in accordance with a service plan),[1] or through a home and community-based waiver program. For example, section 1915(c) of the Social Security Act provides authorization so that a state may offer home and community-based services, including personal care services, to state-specified target group(s) of Medicaid beneficiaries.[2]

The states have many years of experience in conducting functional assessments that should inform and provide a variety of choices for the development of regulations for CLASS.[3]

WHY ARE MEDICAID FUNCTIONAL ASSESSMENT ELEMENTS RELEVANT TO CLASS?

CLASS, as it is written in the legislation, will provide benefits to individuals enrolled in the CLASS Plan who have paid required premiums and who are

determined eligible to receive program benefits. While CLASS is not part of the Medicaid program, it requires regulations to be developed that will address many of the same functional assessment elements as covered by Medicaid state plan personal care services (PCS) and home and community-based services (HCBS) waivers. These include the definition and establishment of a medical condition, disability or chronic illness expected to last for at least 90 days, establishment of physical functional limitations and the need for supervision of services due to a cognitive impairment. CLASS mandates a "benefit trigger" that will require the tasks of defining the data elements for functional eligibility. The practical lessons learned by states resulting in their current assessment instruments are relevant and may be instructive for the development of the CLASS regulations. States' long-standing experience in Medicaid community-based PCS can provide valuable lessons for CLASS rule-makers to draw upon.

In order to learn how states determine functional eligibility, a review was conducted of the fifty states and the District of Columbia's Medicaid programs to capture information on PCS offered through the state plan or through a HCBS waiver. This review yielded a basic understanding of the size and design of each state's program. It was primarily conducted through internet-based research, which captured high-level information on the number of enrollees, expenditures, type of personal care programs offered, policies, instruments used, functional eligibility criteria, prior authorization criteria, and related data on consumer involvement and direction of services.

Based on the review, ten states, representing a cross section of the various program design characteristics, were selected for further examination. The ten states selected for study were: Arkansas,[4-5] California,[6-9] Florida,[10-13] Georgia,[14-15] Maine,[16-17] Maryland,[18-20] Massachusetts,[21-23] Michigan,[24-26] Nebraska,[27-28] and Oregon.[29-31] For these states, the policy manuals, forms and assessment instruments were obtained to identify the data elements used for a functional assessment. Follow-up interviews were held with Medicaid staff in these ten states in order to verify the documents and processes found and to solicit any additional comments or insight.

The initial review of 50 states and the District of Columbia revealed important details specific to elements of functional assessment.

- Every state has tailored their assessment instruments for determining functional eligibility specific to their programs.
- Only a few states use the same assessment instrument for their state plan personal care program and for their HCBS waiver programs.
- At least six states use or are considering the use of the interRAI© Home Care assessment instrument (sometimes referred to as the MDS-HC), as the basis for their assessment instrument.

Functional Eligibility Assessment Instrument

The assessment instruments and forms provide a focused way to view the common elements and variations that the states use to determine functional eligibility for state plan PCS or services through HCBS waivers.

The functional eligibility assessment instruments used by the states represent different models aimed at gaining an understanding of an individual's physical and cognitive limitations, detailed ADL, IADL deficits and services required, the time per service as well as the daily, weekly, weekend, and monthly frequency of the need for services.

The length of these instruments vary depending upon how much guidance and policy is presented on the form itself (instead of separate manuals or other documents), and how comprehensive the form is with respect to specified ADLs, IADLs, clinical conditions, and other areas covered. The assessment instruments that were reviewed range from succinct two-page versions capturing the necessary information for a care plan and functional eligibility meeting state's policy requirements to instruments that are much more comprehensive with respect to the array of physical, cognitive, and clinical conditions covered.

All states' functional assessment instruments contain sections for gathering information about ADL, IADL, and cognitive functioning. Some states use separate forms for a certification of medical and clinical conditions, while others include this information on the same instrument used for functional status. Most states include the frequency and hour of service need on the assessment instrument. In a few cases, this information is supplied by automated systems.

The functional assessment instruments have multiple functions depending on the state. Below is a list of the common uses of these assessments.

- Identify the ADLs or IADLs for which a person requires assistance;
- Determine a score or level of need for the ADLs and IADLs;
- Determine how many hours, occurrence per day, or week that assistance is need;
- Document the existence of a Medical condition;
- Document cognitive status;
- Serve as an input document to an automated system;
- Serve to completely establish functional eligibility;
- Serve to establish a level of care determination; and/or
- Serve as a care plan.

CLASS FUNCTIONAL ELGIBILITY REQUIREMENTS

The basic functional eligibility requirements for receipt of CLASS benefits include:

"Functional assessment of physical limitations related to ADLs represents the most extensive section of the state assessment instruments."

- Conditions causing a functional limitation that is expected to last for a continuous 90 day period (a qualified health care practitioner must certify the functional limitation);
- Physical functional limitations for a number of ADLs yet to be defined (which may be 2 or 3);
- Cognitive impairment requiring the supervision of services to protect an individual's health and safety; and
- Functional limitations similar to those described above (physical limitations and cognitive impairment).

However, these are only broad requirements. Before CLASS can be implemented, the Secretary of Health and Human Services must develop specific regulations. These regulations will specify uniform data elements to be included, the forms needed and assessment instruments employed in sufficient detail to determine an individual's functional eligibility.

States offer a variety of approaches relevant to the eligibility requirements for CLASS, as the examples below will demonstrate.

1. Medical Conditions Expected to Last for 90 Days

CLASS will require the documentation of a condition causing a functional limitation that is expected to last for ninety days. The state Medicaid programs capture the documentation of a medical condition, disability, or chronic illness and need for PCS by a health care provider in several ways; most of these, however, do not include a 90 day requirement.

Some states were found to use a separate form for a health care provider's signature indicating the existence of a medical condition, while other states capture a statement or information of the medical condition on the functional assessment form itself. These elements range from the acknowledgement of a medical condition requiring assistance for ADLs signed by a health care provider to more information captured on forms that may include a medical diagnosis, diagnosis code, list of medications, or a list of clinical conditions for which the assessor checks yes or no. For example, one state requires that the physician sign a statement indicating that the applicant has been seen in the past 60 days and has a need for PCS. Another state requires a physician or nurse practitioner to certify that the individual has a long-term, chronic disability requiring physical assistance with two or more activities of daily living.

2. Physical Functional Limitations of ADLs

CLASS will require as a benefit trigger for which "the individual is determined to be unable to perform at least the minimum number (which may be 2 or 3) of activities of daily living as are required under the plan for the provision of benefits without substantial assistance (as defined by the Secretary) from another individual."[32] Definitions of the ADLs for CLASS will need to be developed. A review of the ADL definitions used by state Medicaid programs will be very informative.

State requirements regarding PCS services are found in state statutes, administrative rules, and policy manuals and include a

list and definitions of ADLs and IADLs. In some states, definitions from the policy rules or handbook may also be repeated on the assessment instrument itself, and in other cases the definition may be found only in regulations, policy manuals, or programmed on laptops or electronic systems to assist the assessor.

The assessment instruments also capture the extent of functional limitations and the extent of the services required to support an individual with specified ADL or IADL impairments. These instruments provide several options – some provide for a check box containing a description of pre-defined conditions for each functional measure that applies to that individual, while other instruments allow for the assessor to fill in a blank on the form with their own description or notes. Additional elements on the instruments are collected to determine the extent to which each individual may require assistance with each physical deficit noted for each ADL or IADL. Functional assessment of physical limitations related to ADLs represents the most extensive section of the state assessment instruments.

While states have a broad range of ADLs and IADLs, which are captured as elements for assessment, CLASS has a standard list of ADLs. The CLASS list of ADLs mirrors the list from the Internal Revenue Code of 1986.[33] They are:

- Eating
- Toileting
- Transferring
- Bathing
- Dressing
- Continence

A comparison of each of the above ADLs with the elements used by states present a variety of alternatives for development of the CLASS regulations. Keep in mind that states have had the opportunity to revise their lists of ADLs and policy since those developed in 1986. In addition, states may include IADLs or other functions as part of the definition of an ADL.

- **Eating.** While "eating" is one of the more consistently defined elements used by the states, several states use the term "nutrition" or "feeding." The simple definitions of "eating" focus on the mechanical acts of putting foods and liquids into the digestive system. More complex definitions include activities such as the ability to shop for food, prepare food, cut foods, use utensils, and cleaning the individual, if needed. Additionally, some states use elements to measure nutrition and complicating factors such as medications or substance abuse that may be relevant to nutrition. The requirements for a special diet or tube feeding are elements used by a few states. Assessment instruments vary from those with a simple check box for requiring assistance with eating to others that include numerous questions on nutritional status and functional abilities.
- **Toileting.** States are mixed with respect to the terminology used for this ADL. Many states use "toileting" and others describe this function under "bowel and bladder." The shorter and simpler

definitions found discuss assistance on and off the toilet and associated cleaning. Other states expand to specifically include use of bedpans, catheter care, ostomy care, and diaper care. The ADL definition focuses more on what assistance a person needs regardless of method of managing bowel and bladder elimination. As a more comprehensive name "bowel and bladder care," this ADL is used frequently to include functions related to "continence" which is listed as a separate ADL in CLASS.

- **Transferring.** The function of "transferring" is often more broadly termed as "mobility," which usually includes assistance with ambulation. The basic functions for "transferring" are assistance with getting in and out of a bed and/or a wheelchair. Getting on and off the toilet is sometimes included in this ADL, while it is sometimes included under "toileting." A few states include repositioning and range of motion exercises in the definition of this ADL.

- **Bathing.** This is the standard name for this ADL, although "hygiene" and "grooming" were also found to be used by states. The descriptions are also in a more narrow range concerning assistance in and out of the shower or tub, assistance with a sponge bath, and associated grooming. Some states include the need for "transferring" to shower or tub under this ADL, while others place this function under the "transferring or mobility" ADL.

- **Dressing.** Most states use the term "dressing," although "grooming" is found in some cases. The basic definitions include putting on and taking off clothing. Some states specifically address braces, prosthetic devices, and the need for "cueing" or standby assistance.

- **Continence.** Most states describe the assistance needed in this area under either "bowel and bladder care" or under "toileting."

3. Functional Limitations Similar to Those Above

The CLASS legislation does not list IADLs or provide more detailed descriptions of the ADLs to be considered in developing regulations. However, the legislation includes in the "Benefit Triggers" section a third trigger which refers to a level of functional limitation similar to the first two triggers – ADL limitations or cognitive impairment. The additional descriptions of ADLs found in state policy and their inclusion of IADL's are relevant to the development of regulations under this section. Using this authority, the final regulations could include some IADLs to satisfy the requirement of "similar" functional limitations as well as offer some of the more detailed definitions in the examples presented above.

As previously mentioned, some states incorporate related IADLs in their definitions of an ADL; however, a review of states' assessment forms found some of the more common IADLs or activities specifically included are:

- Light housework

- Laundry

- Shopping for food
- Meal preparation
- Assistance with medications and with self administration of medications
- Medical appointments
- Respiration and oxygen management
- Personal Hygiene

4. Cognitive Impairment Requiring the Supervision of Services

Individuals may meet the CLASS functional limitation criteria if substantial supervision is required because of a cognitive impairment to protect their health and safety. Again, this is a subject that states include on their assessment instruments. States have several different approaches to defining a cognitive impairment, which may include a certification statement of the status or a more detailed check list of cognitive factors or clinical conditions that may apply to the applicant. Some states also include cognitive functioning with an assessment of behavioral or substance abuse factors.

One example that states may list on the assessment instrument is a set of cognitive/behavioral factors for the assessors' guidance and choice. The factors may include: memory for events, memory and use of information, global confusion, spatial orientation and verbal communication for cognition, and sleep patterns, wandering, behavioral demands on others, danger to self and others, and/or awareness of needs/judgment in the behavior section. Less frequently, states may include factors such as potential alcohol and substance abuse.

An alternative to checking a box representing these cognitive/behavioral factors is a certification of cognitive status that is signed by the assessor or healthcare practitioner. Usually the certification includes the ability and skills to manage "PCA services."

For Medicaid programs using consumer direction as an option, the elements concerning the cognitive/behavioral function become even more useful because a determination must be made of the individual's capacity to direct his or her own services or, alternatively, the need for a surrogate to supervise or direct the services.

Time and Frequency of Services

Some states estimate the frequency of need for each ADL activity and the time per occurrence during the assessment process. This is done for functional eligibility purposes in that a person may be limited to certain eligible hours or expenditures depending on the need; this is also used for their care plan.

"With the national scope of CLASS, a standard certification form or process would require a minimum of training or instruction for health care providers."

Regulations for CLASS will need to be developed that could use some of the same methods to determine the level of the benefit. Again, there is wide variation among the states. One state places an estimated time by each level of need. In looking at mobility as an example, "transfer" has the guidance of 15-30 minutes, depending on minimal or heavy assistance; "devices, turn and positioning" is allocated 5-10 minutes; and "support/lifting" is allocated 5-10 minutes. There are time estimates for each ADL sub-function. Some states just leave a blank space for the assessor to estimate the time, although there may be guidelines and policies in other documents not on the form. Some states that use automated systems have time frames "pre-loaded" into the system. Another method is to place guidance in the description of the ranking itself. For example, definitions may include under each level of assistance a description such as "limited," which indicates a range of times in the past week for which assistance was required.

Considerations for CLASS Plan Design and Implementation

This issue brief reviewed state's functional eligibility assessment instruments and the elements captured, compared these elements to requirements in CLASS, and offers insight for their potential use in the development of specific eligibility requirements and benefit triggers.

While worded slightly differently in each case, the states' forms and instruments provide CLASS with examples for the requirement to certify by a licensed health care practitioner the existence of a functional limitation expected to last for more than 90 days. CLASS could adopt a certification statement consistent with what is used by and familiar to licensed health care practitioners treating Medicaid patients. With the national scope of CLASS, a standard certification form or process would require a minimum of training or instruction for health care providers.

The review found that although states vary in the detail and comprehensiveness of the data collected, their programs include documentation by a physician or a health care provider of these elements:

- The clinical status and need for PCS;
- A detailed description of ADL and IADL deficits;
- The extent and frequency of services required to overcome the deficits;
- Methods automated and manual to determine hours of services to which an individual is entitled; and
- Periodic review of progress, or reauthorization of services.

As part of the CLASS Plan, elements for the required eligibility assessment system with corresponding benefit levels will need to be defined such that they comply with the benefit triggers described in the legislation. The elements that states use, as described above, are very informative for the development of this system.

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Determining Need for Medicaid Personal Care Services

By Susan M. Tucker and Marshall E. Kelley

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief focuses on the ranking and scoring criteria and mechanisms that state Medicaid programs use to determine functional need and the level of services provided for Medicaid-funded personal care services programs. Because CLASS requires a determination of need and must identify a benefit level for which regulations must be promulgated, this information can be very useful for the development of the CLASS Plan.

Introduction and Overview for Determination of Need for Personal Care Services

Every state Medicaid program has a unique design and utilizes different mechanisms for determining an individual's need for services. For personal care services (PCS) and home and community-based services (HCBS), states will often provide specific criteria to assist the assessor when determining who is eligible for services, what type of services are needed and how much service may be needed. States may use predefined ranking levels, such as high, medium, or low, to indicate the level of frailty or impairment. Additionally, states may define a scoring methodology for which an individual is identified with a numerical score to indicate if services are needed and even what type or level of services are needed.

This is the second of three issue briefs[i] on states' experience with Medicaid personal care and home and community-based services and the relevance of that experience to the development of CLASS.[1]

To evaluate how states determine need for Medicaid PCS, we first conducted a review of the fifty states' and the District of Columbia's Medicaid programs to capture information on PCS offered through the state plan or through an HCBS waiver for the elderly or persons with physical disabilities. This review yielded a basic understanding of the size and design of each state's program so that the authors could select states for a more thorough analysis. It was primarily conducted through internet-based research which captured high level information on the number of enrollees, expenditures, type of PCS programs offered, policies, instruments used, functional eligibility criteria, prior authorization criteria, and related data on consumer involvement and direction of services.

[i] The other two briefs are: The SCAN Foundation's CLASS Technical Assistance Series Brief #5: ("Elements of a Functional Assessment for Medicaid Personal Care Services") and The SCAN Foundation's CLASS Technical Assistance Series Brief # 7: ("Functional Assessment Processes for Medicaid Personal Care Services"). These briefs discuss the actual elements of a functional assessment, instruments used for the assessment and the assessment process states follow.

Based on the review, ten states, representing a cross section of the various program design characteristics, were selected for further examination: Arkansas,[2-3] California,[4-10] Florida,[11-14] Georgia,[15] Maine,[16-17] Maryland,[18-19] Massachusetts,[20-23] Michigan,[24-26] Nebraska,[27-29] and Oregon.[30-34] Further analysis of these states included interviews with state officials who administer the PCS and/or HCBS programs, as well as an examination of policy manuals, forms and assessment instruments to better understand and describe how these states conduct their functional assessments for eligibility determination in their respective personal care services programs. This information was gathered with the express intent of providing information that may support the development of related CLASS regulations.

"Medicaid programs have developed ways to assess an individual by ranking the level of need for certain functional activities."

The initial review of 50 states and the District of Columbia, specific to determining need in Medicaid programs providing personal care services, found that:

- Each state has developed its own unique threshold criteria for determination of functional eligibility, resulting in wide variation and complexity of how states determine need for services in their state Medicaid plan and the HCBS waiver programs.
- Two states have implemented more rigorous level of care thresholds to be eligible for services in a nursing facility as compared to the level of care needed to be eligible for HCBS waiver services.

Methods for Determining Need

CLASS does not specifically define in statute the level of functional ability that an individual will require to be eligible for benefits. Legislation for CLASS states that individuals are eligible if they are unable to perform a minimum number of ADLs; however, it does not further define the level of "inability," such as, "without some assistance" or "without total assistance." Therefore, a review of states' approaches for determining need can provide such details for the CLASS Plan.

Some state Medicaid programs have developed ways to assess an individual by ranking the level of need for certain functional activities (e.g., from "independent" to "totally dependent" with interim functional rankings). Assessment forms with predefined ranking levels provide the assessors a decision-support tool and can produce a more consistent and reliable eligibility determination. During the assessment process, the assessor will indicate the level of need, i.e., rank, for functional or cognitive impairments. States may also incorporate a methodology that scores the ranking levels in which an individual is identified with a numerical score. These ranks and/or scores are used to determine eligibility for services and may assist with the determination of the type, frequency, and time estimates for services to be provided.

"The ranking methods and criteria used by states generally measure the level of ability and assistance needed of the assessed individual to perform specific ADLs or IADLs, but these rankings vary as to how the information is captured."

Ranking

Most states use a ranking system for assessing specified functional areas in order to determine functional eligibility and identify the level of impairment. The ranking methods and criteria used by states generally measure the level of ability and assistance needed of the assessed individual to perform specific ADLs or IADLs, but these rankings vary as to how the information is captured. The examples in Table 1 below illustrate methods that states use.

These are only a few examples of how states provide guidance to determine the need for personal care services. The ranking by ADL and IADL allows the assessor to determine functional levels by area and can help to determine what type of assistance is needed for the individual to remain in the community.

Scoring

In addition to the ranking levels provided in state assessment forms, states have also developed different scoring methodologies that incorporate ranking information to develop a numerical score for each potential beneficiary. These scores are then used to determine eligibility for services (i.e., meeting a minimum threshold) and may also be used to identify the type and/or frequency of services needed. These methodologies may involve an algorithm that assigns a point value to the ranking levels and weights rankings by type of impairment.

A specific state example of how sensitive the issue of scoring thresholds can be is California. A 1-5 ranking (Example #3 from Table 1) is used for each ADL and IADL, but it is a highly individualized ranking. Each rank has an ADL/IADL-

TABLE 1 Examples of Ranking Criteria for Medicaid PCS programs

Example #1	Yes or no responses to very specific and focused questions for need and level of support.
Example #2	Five-Point Ranking: independent, supervision, limited assistance, extensive assistance, and total dependence, with each rank including a standard definition or description.
Example #3	A 1-5 General Ranking System: independent, verbal assistance, some human assistance, much human assistance, dependent.
Example #4	Three-Level Ranking: independent, physical assistance required, dependent.
Example #5	Six-Level Ranking: independent, verbal assistance, some human help, a lot of human help, dependent and paramedical (activities requiring judgment based on training given by a licensed health care professional).

specific definition used to assist the assessor. An individual is ranked in ADL- or IADL-related functions which then produce a numerical Functional Index Score (FIS), ranging from 1 to 5. As a result of the 2009-2010 budget, the state planned to eliminate services for beneficiaries with a FIS less than or equal to 1.99 and eliminate domestic and related services for beneficiaries ranked at 1, 2, or 3. However, due to legal actions, a temporary restraining order prevents the state from implementing the changes.[4-5] A key argument in this case was that the scores were inadequate to measure the impairment or risk of institutionalization and would result in the arbitrary withdrawal of services. Some of these same cuts that have been proposed in the 2011-2012 budget proposal are currently being considered.

"A pre-screening process, conducted by telephone, can be useful in reducing the number of face-to-face assessments for individuals who are not functionally eligible for PCS or waiver services."

Another state's assessment tool includes assessment of functional limitations based on ranking, and provides a mechanism for scoring the limitations to produce eligibility determination for specific services and levels of services. For example, the scoring of certain limitations can identify eligibility for a certain service such as "day health" or "home based care" at a specified level.

One state's HCBS waiver program prioritizes individuals based on 18 levels of service need. The 18 defined levels are related to the level of need for certain ADLs and IADLs. For example, level 1 represents the need for full assistance with mobility, eating, elimination, and cognitive deficits whereas level 18 represents a level of independent functioning. Currently the waiver is serving individuals with a prioritization level of 1-13.

Pre-Screening

A pre-screening process, conducted by telephone, can be useful in reducing the number of face-to-face assessments for individuals who are not functionally eligible for PCS or waiver services. However, most states that were reviewed do not have a pre-screening process in place. There was one state where a pre-screening process is performed via a telephone screening assessment to determine a referral's potential eligibility for the HCBS waiver program; the result of this pre-screening process is used to establish priority for a face-to-face assessment for the initial care plan. The screening process includes:

- Discussing eligibility criteria with applicants;
- Using a form to determine functional eligibility (to be eligible, an applicant must obtain a specified level of impairment score and have an unmet need for care);
- Determining if the applicant likely meets the level of care;
- Assessing financial eligibility; and
- Advising applicants of all available community resources that may meet their needs.

Many states have a waiting list for their HCBS waiver programs. The waiting list, depending on how it is managed, can result in a level of "pre-screening" for HCBS waiver services. For example, one HCBS waiver program conducts an

assessment of elderly individuals seeking services that results in a prioritization score (1-5, with 5 indicating the highest need for services). This score is used for prioritization on the waiting list, not determination of program eligibility. Individuals with the highest scores will be prioritized for assessment to determine level of care before individuals with a lower score.

Threshold Requirements

Each state must have criteria for authorizing PCS through a state Medicaid plan or through a HCBS waiver program and sets unique threshold levels for determining functional eligibility. The determinations of need and authorization procedures generally include:

- A threshold level for the number of ADL and IADL deficits and the extent of assistance needed to meet ADL or IADL deficits;
- Authorization by a physician (required for Medicaid state plan PCS); and
- Other factors established by the state.

The criteria and threshold requirements for determining need for individuals to be served in an HCBS waiver differ from Medicaid state plan PCS because a "level of care" determination is required to be eligible or waiver services. HCBS waivers provide services to support persons in home and community-based settings as an alternative to care in a nursing home, intermediate care facility for the mentally retarded (ICF/MR), or hospital. Waivers that target persons who would otherwise reside in a nursing home require that a person be determined as needing nursing home-level services within a short period of time absent access to HCBS waiver services. This requirement is generally referred to as meeting a nursing home level of care, which each state individually defines along with functional eligibility for their HCBS waiver(s). As a result, there are variations from state to state, with no common definition used.

In general, states require that a person need nursing care or supervision to meet the Medicaid-defined nursing home level of care and may include the requirement that the individual need assistance with a certain number of ADLs. For example, one state that was reviewed requires daily skilled nursing need, extensive assistance need in three ADLs, or a combination of some assistance in at least one ADL and nursing, cognitive, or behavioral need. Most states have prescribed methods for making this determination requiring completion of specific assessment instruments while others require certification by a physician and review by a state entity for "medical necessity" purposes. Table 2 below provides examples of state threshold levels to meet the functional eligibility for HCBS waiver programs and state plan PCS.

There are clear differences in the threshold requirements states use to determine eligibility for Medicaid-funded PCS. Some states may only require needed assistance in at least one ADL and a medical certification, while other states require extensive assistance with specified ADLs.

TABLE 2 Examples of State Threshold Levels for Functional Eligibility

Example #1	Need help with at least 1 ADL.
Example #2	Must have some need for assistance which results in a specified score.
Example #3	Direct physical assistance with 2 or more ADLs.
Example #4	Identified need based on nine different specifically defined levels of care designations.
Example #5	At least some human assistance with certain identified ADLs or IADLs.
Example #6	Needs PCS to live in the community identified by a personal service need in categories: grooming, nutrition, mobility, toileting, medications, special procedures, or supportive services.
Example #7	Need intermediate or skilled level of nursing home care.
Example #8	A medical condition and one of either a cognitive impairment or ADL need.
Example #9	Daily skilled nursing or therapy need or assistance with at least 3 ADLs or nursing services based on list of 6 ADLs and 8 nursing services.
Example #10	Daily skilled nursing need, extensive assistance need in 3 ADLs, or combination of some assistance in at least 1 ADL and nursing, cognitive or behavioral need.
Example #11	At least limited assistance in one or more of 7 identified domains: ADLs, cognitive, physician involvement, physical conditions, skilled rehab needs, behavioral, or service dependency.

"States generally determine the need for services by identifying necessary assistance with both ADLs and IADLs, and may also include needs resulting from behavioral or cognitive limitations."

States generally determine the need for services by identifying necessary assistance with both ADLs and IADLs, and may also include needs resulting from behavioral or cognitive limitations. An important distinction is the identification of a need for assistance as opposed to only the identification of functional impairments.

Some states have targeted persons at lower "levels of care" (intermediate or custodial care) for transition out of nursing homes but only a few states have imposed more rigorous requirements for nursing home level of care. Although not included in the specific state research, two states have implemented more rigorous requirements that trigger the need for nursing home care. One state has replaced the institutional level of care criteria used in most HCBS waiver programs with a needs-based level of care based upon three levels: highest, high, or preventive need for services. Services in a nursing facility and a full array of home and community-based services are available to those individuals with an assessed need at the highest level. A limited set of home and community based services is available to those identified at the preventive needs level.[34]

Considerations for CLASS Plan Design and Implementation

A separate issue brief describes elements and definitions of ADLs, IADLs, and cognitive functioning,[ii] while this issue brief expands on how states use those data elements to determine eligibility. Each state has developed its own assessment methodology to capture necessary functional elements with specific threshold criteria for determining eligibility and necessary level of services, which may also include ranking and scoring mechanisms. These rankings may be generically applied to all functional elements assessed or specific to the condition being assessed. A score may be produced from the rankings which then trigger the identification of services and service levels.

"Each state has developed its own assessment methodology to capture necessary functional elements with specific threshold criteria for determining eligibility and necessary level of services, which may also include ranking and scoring mechanisms."

While the CLASS Plan provides some specification as to what functional limitations will trigger access to benefits, there is great variability as to how those limitations can be defined and how they will be measured for the determination of need for services. Additionally, the CLASS Plan will scale the benefit amount to functional ability. Thus the degree and type of functional limitations will factor into the determination that an eligible enrollee may be entitled to receive. State Medicaid programs offer many examples of how a state assesses and measures the need for personal care services. Approaches that states use include:

- A pre-defined ranking system to assist assessors in the determination of an individual's level of ability to perform and assistance needed with ADLs and IADLs;
- A methodology to score the ranked functional criteria in order to determine if the individual has functional limitations that would trigger the need for benefits in the CLASS Plan; and
- A methodology to score the ranked functional criteria in order to determine the level of need so that the benefit amount is scaled to the individual's functional ability.

No one state provides a definitive model that can be applied to CLASS, but the design of the CLASS eligibility assessment system can clearly benefit from states' approaches in order to provide a more consistent and standardized method of determining need.

[ii] See The SCAN Foundation's CLASS Technical Assistance Series Brief #7: ("Elements of a Functional Assessment for Medicaid Personal Care Services") that discusses the actual elements of a functional assessment, and instruments used for the assessment.

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CLASS Technical Assistance Brief Series

Spring 2011 • No. 7

Functional Assessment Processes for Medicaid Personal Care Services

By Susan M. Tucker and Marshall E. Kelley

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief focuses on components of states' Medicaid functional assessment processes with an eye toward how these processes could potentially inform the development of regulations for CLASS. We explore how states handle the assessment process and determine who performs the assessment and where it is performed. Each of these components is important to the design of CLASS so that those determined eligible can receive appropriate benefits.

Introduction and Overview of State Medicaid Functional Assessment Processes

Each state develops its own unique set of criteria, policies, infrastructure and procedures specific to its Medicaid program, including detailed processes for State plan personal care services and/or home and community-based waiver programs. Understanding how functional assessments are performed is critical to appropriately determining the need for and level of personal care services (PCS) and home- and community-based services (HCBS) for Medicaid-eligible individuals. Clearer insight into all these facets of a state's process can potentially inform the development of CLASS regulations.[1]

This is the third of three issue briefs[i] on states' experience with Medicaid personal care services and the relevance of that experience to the development of CLASS.

To set the background for the evaluation of functional assessment processes in Medicaid programs across the states, we conducted a review of the fifty states' and the District of Columbia's Medicaid programs to capture information on personal care services offered through the Medicaid state plan PCS program or through a HCBS waiver for older adults or persons with physical disabilities. The purpose of this review was to gain a basic understanding of the size and design of each state's program and then identify states for a more thorough review. This review was primarily conducted through internet-based research that captured high level information on the number of enrollees, expenditures, type of personal care programs offered, policies, instruments used, functional eligibility

[i] The other two briefs are: The SCAN Foundation's CLASS Technical Assistance Series Brief #5: ("Elements of a Functional Assessment for Medicaid Personal Care Services") and The SCAN Foundation's CLASS Technical Assistance Series Brief # 6: ("Determining Need for Medicaid Personal Care Services"). These discuss the actual elements of a functional assessment, instruments used for the assessment and scoring, ranking and thresholds that states use in their Medicaid personal care services programs.

criteria, prior authorization criteria and related data on consumer involvement and direction of services.

Based on the review, we selected for further examination ten states that represented a cross section of the various program design characteristics. The ten states selected for study were: Arkansas,[2] California,[3-6] Florida,[7-9] Georgia,[10] Maine,[11] Maryland,[12-13] Massachusetts,[14-15] Michigan,[16-17] Nebraska,[18] and Oregon.[19-20] To better understand these states' processes, policy manuals, forms and assessment instruments were reviewed and interviews were conducted with state officials who administer the programs.

The initial review of 50 states and the District of Columbia found, specific to functional assessment processes for Medicaid personal care services:

- States have developed policy manuals and defined processes; almost 90 percent of states have identified a specific instrument for assessment and determination of functional eligibility whether provided as part of the state plan or through a home and community-based waiver.
- Approximately half of the states use their own staff for the assessment and level of care determination process while other states contract with counties, area agencies on aging or vendors.
- Approximately two-thirds of the states that offer personal care services require some form of prior authorization for the personal care benefit, once the individual has been determined functionally eligible.
- Most states offer beneficiaries the option to direct their own care, i.e., hiring, firing, and supervising personal care workers.
- Some states provide personal care services through a managed care delivery system. These states have varying degrees of participation by the managed care entities in the assessment process.

"In all of the states selected for further review, a face-to-face assessment of functional needs with the individual applying for services was standard."

Collection of Assessment Data

The assessment process includes activities to determine if an individual is functionally eligible for Medicaid personal care services. Assessments compile the necessary information about an individual to evaluate the individuals' need for services based upon their ability to function independently.

The process for evaluating the individual to determine functional eligibility for HCBS waiver services requires that the individual meet a standard known as institutional level of care. PCS provided through the Medicaid state plan do not require an individual to meet this standard; however, all states have processes to evaluate an applicant's functional eligibility and need for PCS regardless of whether the service is provided through the Medicaid state plan or an HCBS waiver.

In all of the states selected for further review, a face-to-face assessment of functional needs with the individual applying for services was standard. While face-to-face assessment for

gathering information is more costly, it allows the assessor to review the physical environment and abilities of the individual on a first-hand basis. Not only will assessors meet with individuals in their residence, but family members and their caregivers are included in the assessment process. The state officials who were interviewed discussed the importance of including the individual's preferences in the assessment process, but some also pointed out the importance for assessors to be able to distinguish between an individual's needs and desires.

"State employees are most commonly responsible for conducting functional assessments."

The process can be further complicated by conflict of interest for the select group of states where assessment is performed by the same entity that provides case management and related services. If the same entity that performs an assessment for functional eligibility also provides the services, there may be less incentive for the assessment to be performed objectively; benefits, then, may be provided to individuals who do not truly meet minimum eligibility requirements.

In states that allow consumer direction, there are varying approaches by which an assessor determines if an individual is capable of directing their own care. Most states rely on the judgment of the assessor and training provided to the beneficiary. While all of the states reviewed consider the individuals' cognitive ability, a more formal determination process is used in some states to assess individuals' cognitive ability to direct their own care.

Assessor Entities

The review found that the functional assessment process may be conducted by a variety of entities:

- State governmental workers;
- County workers;
- Local health department workers;
- Area Agencies on Aging (AAAs); and/or
- Contracted vendors.

The type of entity conducting the assessment in a state can be based upon the program, the population assessed or the setting of the individual being assessed. One state that was reviewed uses both state workers and contracted entities to perform assessments depending on the individual (an older adult or an individual with physical disabilities) and the residence (nursing facility or community). Another state contracts with AAAs to conduct assessments for the older population and with another not-for-profit organization to perform assessments for adults with physical disabilities. One of the states reviewed contracts with a vendor to perform the entire process of functional assessment, eligibility determination, care plan development and authorization for covered services. State employees are most commonly responsible for conducting functional assessments.

Assessor Qualifications

The level of education, experience, and training for workers who perform functional assessments varies across the states. The assessors' required qualifications range from workers without a bachelor's degree, such as case managers with some training, to registered nurses with geriatric experience. One state, with a county-based system, uses county social workers to conduct assessments and relies on the counties to set criteria for the social workers' qualifications. There are counties that require workers performing assessments to hold a Master's degree in social work, while other counties (typically rural ones) require workers to have only training from the county. However, most of the states that were reviewed require assessors to be either a registered nurse or a case manager with a bachelor's degree (preferably in a human services field).

Most of the states reviewed provide some level of training for the assessors. Striving for more consistency in the assessment, California legally requires uniform training for the social workers in the state PCS program. The training materials and curriculum were developed through a partnership of the California Department of Social Services, California Welfare Directors' Association, and California State University; these materials are available online through the California Department of Social Services website.[4] Other states require initial training on the assessment process and on the assessment tool, which is provided by the state or by area agencies on aging.

"All states reviewed require a re-evaluation of PCS (whether provided through an HCBS waiver or the state Medicaid plan) at least annually."

Re-evaluation

States are required as part of their HCBS waiver programs to conduct a re-evaluation of "level of care" at least annually or more frequently if the beneficiaries' condition changes. One state that was reviewed recently changed the re-evaluation requirement from semi-annually to annually in their HCBS waiver program. The state decided that it was not necessary to perform more frequently than the HCBS waiver requirement. Two other states require an initial re-assessment before the end of twelve months of services, then annually thereafter.

Federal regulation does not require re-evaluation of a beneficiary's continued need for state plan personal care services; however, all of the states selected for review do require that beneficiaries be re-evaluated. Of the states selected for further review, only one state requires reassessment of the state plan PCS beneficiaries more frequently than once per year. Reassessment is required in this state every six months or more often if a beneficiary's condition changes. Another state allows an extension to the annual re-evaluation requirement of up to six months for the PCS provided through the State Medicaid plan, as decided on a case-by-case basis. All states reviewed require a re-evaluation of PCS (whether provided through an HCBS waiver or the state Medicaid plan) at least annually. All of the states reviewed conduct a reassessment more frequently if the beneficiary's condition changes as identified by the beneficiary or the case manager.

"The states' experiences suggest that automated systems can help reduce errors and duplication, provide accessible data, support consistency and can provide decision support tools for assessors."

Most states use the same entity and process to conduct the assessment and the reassessment. One exception was found in a state with a managed long-term care program. The initial assessment is conducted by state staff and the managed care organizations conduct reassessments.

Use of Technology

Most of the states reviewed have an electronic system tailored to their states' program(s) to capture the information gathered during the assessment process. The information is either gathered through paper forms or on laptops, then is uploaded into an electronic system. Only one state reviewed does not use an electronic system and relies solely on paper forms. Most of the states' systems compile information specific to the program and are not a central repository for all the beneficiaries' information. This fragmented approach causes duplication of effort and redundant information stored by multiple state systems.

Four of the ten states have systems that go much further than just capturing assessment information. These more comprehensive systems can perform at least one of the following functions:

- Calculate scores related to functional ability;
- Process billing;
- Calculate the number of service hours needed; and/or
- Determine level of care.

One such state system has programmed algorithms which calculate an individual's priority for receiving services based upon the degree of assistance an applicant requires with specific activities of daily living. Another state's electronic system is used to track case information and processes payments for the program that provides state plan PCS. It also interfaces with other county, state and federal agencies. Another state's system produces the level of care determination and the number of hours allowed for the service plan.

One state reviewed has designed a comprehensive electronic system that encompasses the majority of human services programs administered by the state. It is used for the eligibility, assessment, authorization, notifications, and payment for personal care services. However, an early study of this system did caution that too much automation can be counterproductive; in at least one state's experience, such automation restricts flexibility and increases data input time.

The states' experiences suggest that automated systems can help reduce errors and duplication, provide accessible data, support consistency, and can provide decision support tools for assessors. While states recognize the value of technology to automate their assessment processes and indicate the desire for more automation, they are constrained by limited budgets.

Functional Eligibility Determination

The final step in the functional assessment eligibility process is the

"Judgment by an individual assessor or interdisciplinary team is the predominant method by which an individual is determined eligible for PCS."

actual determination of eligibility to receive personal care services. Again, there is range among states in how this step is completed. Judgment by an individual assessor or interdisciplinary team is the predominant method by which an individual is determined eligible for PCS. The determinations may be handled by state staff, through contracts with AAAs, other vendors or county workers. Some states use an electronic system to produce the eligibility determination based on input from the assessment.

Considerations for CLASS Plan Design and Implementation

This review of state functional assessment processes for Medicaid-funded PCS was performed within the context of its applicability to the implementation of the CLASS Plan. These findings help illustrate the variation of processes implemented to determine functional eligibility for PCS and HCBS waiver programs across states. Even though states varied in the different components of the assessment process, one common component is that the states consistently require that the assessments be performed face-to-face. This is considered important to accurately capture information about the individual's condition and physical environment at the time of application. All of the states reviewed also required a reassessment if the beneficiary's condition changes; these reassessments are conducted at least annually, if not more frequently, and generally in the same manner as the initial assessment.

Some variation among the states was found when it comes to who performs the assessment, both in terms of the qualifications and training of the individual assessor, the type of entity responsible for the assessment process, and the level of technology used in the process. Regardless, states need assessors to have a level of expertise (through education, experience and/or training) to have sound professional judgment to accurately assess the needs of an individual seeking Medicaid-funded PCS. Additionally, states appear to be moving toward more automated systems to help provide consistency and accessibility of data for the assessment process.

In summary, the aspects of the states' processes that may be applied to the design of the CLASS Plan include:

- Face-to-face assessment by an entity independent of the service delivery and case management functions;
- Determination of need by trained professionals;
- Re-evaluation of the beneficiary's condition at least annually or more frequently if conditions change; and
- Use of an electronic system to compile beneficiaries' assessment information that includes a methodology for the determination of the need for and level of benefits applicable.

Lessons learned from the states described in this brief should be useful to policymakers in designing the most efficient and effective system possible for the CLASS Plan.

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THE SCAN FOUNDATION.

CLASS Technical Assistance Brief Series

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How Did Cash and Counseling Participants Spend Their Budgets, and Why Does That Matter for CLASS?

By Lori Simon-Rusinowitz, Dawn Loughlin, and Kevin Mahoney

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief addresses some similarities between the Cash and Counseling (C&C) model and CLASS, including participant control over a cash benefit, the ability to develop an individualized spending plan, the ability to hire family members as workers, and the availability of a range of programmatic supports to help participants manage their responsibilities. This brief describes how C&C participants have used their cash allowance, and suggests how these findings can inform CLASS implementation.

Introduction and Overview of Cash and Counseling

Cash and Counseling (C&C) is one of the most flexible models of participant-direction (also called consumer-direction or self-direction) in personal assistance services (e.g., help with daily living activities such as dressing, eating, using the toilet, etc.). The model offers participants who have disabilities and are eligible for publicly-funded supports the authority to manage a personal assistance budget. Flexible spending accounts, which are integral to the C&C model, provide an individualized budget comparable in amount to what the individual would have received through state Medicaid services (less administrative costs). C&C participants develop a spending plan for administering the budget. Participants can hire, supervise, and dismiss their own workers, set the schedule to meet their own daily rhythms (including evenings or weekends), and pay their worker more or less wages depending on the circumstances. Participants can also use their funds to buy goods or services that support their independence (e.g., transportation, home modifications, and assistive devices). The litmus test of an appropriate spending plan is that it meets personal assistance needs and helps the participant to stay independent in the community. Counselors (also called support brokers or consultants) provide advice and program information, quality monitoring of services, and informal training in budgeting, planning, and recruiting and hiring workers. Some participants need more contact with counselors, while others have no difficulty independently managing their workers or their budgets. A participant who feels unable or unwilling to manage all tasks can appoint a representative such as a trusted family member, who acts as an advocate, decision maker, and spending plan manager when needed.

Over 5,500 elderly and adult Medicaid consumers in Arkansas, Florida, and New Jersey participated in the original Cash and Counseling Demonstration and Evaluation (CCDE) – a real world

"Over time, the C&C model has been shown to generate program cost savings by reducing institutional care."

test of this model in which participants manage their own budgets (there were also about 1,000 children with developmental disabilities enrolled in Florida's program; however, they are not included in this discussion as children are not eligible to participate in CLASS). Half were randomly assigned to manage their own budgets (C&C participants), while the remainder used traditional agency-directed services. Use of representatives by C&C participants ranged from 47% to 70%. Almost all participants chose to use agencies to handle financial management and payroll. C&C participants were highly satisfied, and 85-98% said they would recommend the program to others.[1] Compared with those who received traditional agency services, C&C participants reported more flexibility, control, and greater satisfaction with overall quality of life and experienced no greater adverse health events.[2] Over time, the C&C model has been shown to generate program cost savings by reducing institutional care.[3] Reports also suggest that this model of service is successful for individuals with diverse disabilities, including those with physical disabilities as well as those with dementia[4] and other mental health diagnoses.[5]

Why is C&C Experience Relevant for CLASS?

When designing and implementing C&C, program designers were faced with many of the same challenges that face CLASS. For example, program designers asked the following questions: What service design features would make the program most attractive and useful for potential participants? What would participants want to purchase with their benefit, or what purchases are appropriate? What mechanisms would expedite these purchases? Who could participants hire as workers, and how would these hires be accomplished? What support services were needed and what might these services look like? How are employment and payroll obligations met? Currently there are approximately 17,500 C&C participants in 15 states who are managing individual budgets. C&C programs offer a rich source of information for CLASS designers and implementers. One of the major lessons to emerge from C&C data collection and experience is the importance of a broad and flexible definition of personal assistance spending. Participants have shown amazing creativity in using their budgets to meet their specific needs. Our experience is with a low income population; however, the lessons are transferrable to a broader audience – especially lessons pertaining to the various ways participants used their resources.

How C&C Participants Spent Their Budgets

Due to substantial cross-state differences in the services covered, maximum hours of service allowed, and area wage rates, the median monthly budget for C&C participants varied widely across the three original CCDE states (Arkansas: $313; Florida: $829; New Jersey: $1,097). All three programs verified worker time sheets and requests for checks against spending plans before disbursing funds. In general, invoices for expenditures had to be submitted; however, up to 10% of

the budget in Arkansas and New Jersey and up to 20% in Florida could be used by the participant for incidental expenses (such as taxi fare) for which invoicing was impractical.[6] When surveyed at nine months, between 32% and 59% of participants reported that they had used cash for incidentals in the previous month (depending on the state and age group).[1]

"When spending plans were reviewed in the eighth month of participation, in general, about 85% of those participants who were receiving an allowance had hired a personal assistance worker."

Bulk of Budget to Hire Workers

Participants' spending plans were sometimes influenced by state program participation, design features, and rules. When spending plans were reviewed in the eighth month of participation, in general, about 85% of those participants who were receiving an allowance had hired a personal assistance worker. A lower figure (63%) for hiring by non-elderly adult C&C participants in Florida reflects the inclusion of Florida's developmental disability waiver programs, which offered a range of support services in addition to personal assistance. Some Florida participants had service plans that included only supplies, equipment, or therapy. In most programs, payment of workers represented about 75% of participants' budgets (43% for non-elderly adults in Florida).[1] Fringe benefits, including health insurance, life insurance, disability insurance, paid sick leave, paid holidays, paid vacation, free housing, reduced rent, free meals, or free use of the client's car, were negotiated individually between C&C participants and their directly-hired workers. Workers' compensation insurance or other liability insurance is an important benefit as it can protect participants from liability should any worker injuries occur.[7] Approximately 30% of the agency workers reported that they received some fringe benefits during the CCDE. Directly-hired workers were much less likely than agency workers to receive fringe benefits (ranging from 6% to 18% depending on the type of worker and state).[8]

Florida and New Jersey allowed participants to hire legally liable family members (such as spouses) as workers, but Arkansas did not, partly out of concern that it would be politically controversial. In all three states however, participants could hire other relatives. More than half of the C&C participants chose to hire relatives to address unmet personal assistance needs, while only a small percentage of participants (about 5.5%) hired workers who were not previously known friends or family.[9] Due to worker shortages in many areas, it is possible that some participants may have hired relatives due to a lack of other options. However, focus group and interview data have told us that many participants preferred hiring relatives because they found them reliable and sensitive to their physical and emotional needs.[10] In turn, related workers were generally satisfied that the small amounts of pay they received enabled them to devote time to care for their loved ones. As a result, C&C participants were more likely than agency clients to get paid help with housekeeping and with routine health care, including help with medications, blood pressure checks, and physical exercise.[2] C&C participants reported higher levels of satisfaction with the job done by their hired workers, who were more likely to arrive on time and complete their work. They were more

likely to receive paid service at crucial times such as evenings and on weekends. Benjamin et al. suggest that once related workers enter the labor force, effective retention practices may help them stay in the field permanently after their initial work with their loved ones is over.[11]

Creative Purchases Enhance Participant Independence

C&C participants have exhibited a great deal of creativity in using program funds to purchase goods and services to meet their needs. Equipment, goods, and services are logical complements to human assistance, and in some cases can serve to substitute for that assistance. It is also worth noting that the budget option allows personal assistance services to be "unbundled" or customized to support the strengths and preferences of both the participant and their workers. For example, some participants and workers may prefer to use a laundry service, while others may include laundry in a worker's assigned tasks.

Participants' use of their budget allowances to purchase goods and services varied across age groups, states, and types of purchases. For example, program records at eight months indicate that about half of Arkansas participants purchased personal care supplies (such as incontinence supplies), compared with between 15% of Florida participants and only about 1% of New Jersey participants. Of non-elderly adult participants in Florida (mostly adults with developmental disabilities who were least likely to have hired a personal assistance worker), 32% used their allowance to purchase community services such as day care or housecleaning. However, rates of purchase for these community services ranged from only 3% to 19% for the other state/age groups, who were more likely to have hired a personal assistance worker.

We examined fiscal records for 556 New Jersey participants (mean length of program participation was 14.9 months) to better understand purchasing patterns.[12] The financial management agency in New Jersey had recorded at least one assignment of funds for a good or service that was other than employment of a personal assistance worker, for 84% of these participants. Entries recorded over 325 different descriptive purchase labels (e.g., cleaning, laundry), and we grouped these purchases into 25 categories. Categories most often purchased were transportation (46%), laundry service (37%), and insurance (36%). CCDE program staff advised that insurance was usually purchased to protect against liability for in-home workers, although in some cases participants may have been insuring purchases like automobiles or computers. No other category of goods or services was purchased by more than 10% of participants, indicating the wide variation in the purchases participants make to meet their needs

Other items (or categories of items) purchased by approximately 5-10% of participants include:

- small kitchen appliances (e.g., toasters, microwaves, blenders)
- other small appliances (e.g., clocks, watches)
- durable medical equipment (e.g., braces, wheelchairs, scooters)

"Many participants viewed the flexibility to choose how they wanted to spend their money as a key program feature, and they provided their own examples that demonstrated the enormous value they derived from their creative uses of the flexible spending plan."

- pharmaceutical items (e.g., diapers, pads, creams)
- prepared food
- large appliances (e.g., dishwashers, refrigerators)
- help with shopping or errands
- home modifications and furniture (e.g., mattresses, chairs, ramps, grab bars)
- miscellaneous personal assistance or companion service.

Items that were purchased by less than 5% of participants were:

- grooming equipment and services
- housecleaning
- telephone or telephone service
- postal or office supplies
- advertising
- outside chore services
- moving expenses
- vehicles or vehicle modifications
- computers and computer equipment
- massage therapy
- exercise equipment
- personal alarm systems
- miscellaneous self-help equipment (e.g., shoehorns).

Participants View Flexible Spending as an Important Program Feature

Interviews with counselors in Vermont (one of the 12 C&C replication states) provided many examples of clients' creative uses of flexible spending plans. For example, one participant paid for a service dog that provided assistance with mobility along with cognitive and psychological support. Another participant regained access to the community once he was able to repair his retrofitted van. Another participant bought home exercise equipment to maintain a consistent exercise regime, as it had been hard for him to attend physical therapy sessions during the winter months.[13] New Jersey counselors provided examples as well: "I have a client who used some of the money to redo her bathroom… they redesigned the bathroom…so she can wheel herself right into the shower. They raised the toilet, they put in bars… … she needed a lift so she can get in the wheelchair by herself."[12]

Many participants viewed the flexibility to choose how they wanted to spend their money as a key program feature, and they provided their own examples that demonstrated the enormous value they derived from their creative uses of the flexible spending plan. They reported increased safety, comfort, mobility, independence, and ability to perform tasks. In addition, they often spoke of being able to get more for their money by comparison shopping, and by purchasing some items used. For example, one Vermont client reported that after she purchased an air conditioner, her ability to breathe more easily had significantly reduced her visits to the emergency room. Arkansas focus group participants were similarly forthcoming and mentioned a variety of modifications, equipment, goods and services, including help with appropriate grooming. "[With]…the money she gets, she gets her hair done, her toiletries"; "Yes, my daughter takes my mother to church and I give her money for gas"; I purchased a used washing machine and dryer"; "I had rails (installed) beside

my tub and my commode." Participants described the control over their own spending as empowering in the face of coping with functional limitations. This theme of personal individuality was repeatedly part of the focus group discussions as participants reinforced their program experiences with examples of unique purchases that had special personal relevance.

Flexible spending plans not only improved physical health and enhanced emotional well-being for participants, but they also had strong implications for state health care expenditures. In addition, flexible spending plans enabled participants to purchase goods at lower prices than the agency had paid in the past.

"Flexible spending plans not only improved physical health and enhanced emotional well-being for participants, but they also had strong implications for state health care expenditures."

Demographics Influence Purchases

In a review of purchases in both Arkansas and New Jersey, the groups who were least likely to report purchasing equipment for personal activities prior to enrollment in C&C (males 65 and older in both states and females under 65 in Arkansas), showed the largest increases in the percentage of participants reporting these purchases during the first nine months of enrollment. The impact of the budget option for purchasing goods and services appears to have been greatest on what may have been the most underserved groups.

In our in-depth review of New Jersey individual spending plans, we found no significant differences by race or ethnicity for having made any purchase of goods or services (versus no purchase) with CCDE funds. However, there were some significant differences in the types of items purchased. White participants were more likely to have purchased shopping and errands, housecleaning, computer equipment and supplies and massage or therapy, but less likely to have purchased laundry service. Black participants were more likely to have purchased laundry service, large appliances, and exercise equipment. Asian participants were more likely to have purchased outside chore services. Hispanic participants were more likely than Non-Hispanic participants to have purchased transportation and laundry service, although less likely to have purchased pharmaceutical supplies, home modifications, agency worker services, vehicle modifications, computer equipment and supplies, and therapy or massage.[12] Differences in the types of items purchased by participants of different racial or ethnic backgrounds most likely reflect a variety of social factors such as different rates of home and vehicle ownership, different cultural patterns of family connectedness, and different household traditions and priorities.

Savings

CCDE participants explained in focus groups that the ability to save funds was important.[12] All programs allowed for saving funds from month to month for a specified planned large purchase. To help participants make large purchases, New Mexico allowed participants to "borrow" money from their future budget allocation rather than accumulate money over time. While this approach helped participants with purchases, the state had difficulty if participants left the program before accumulating spent funds (i.e., repaying the "loan").

The issue of saving funds for unspecified reasons, however, was more complicated. Program administrators tended to view unbudgeted funds as unneeded, while participants felt more comfortable having "rainy day" funds to cover unexpected expenses. New Jersey was the first to develop a specific policy stating that at the end of the year, any funds which were not earmarked for a specific purpose were returned to the state's general fund. Under this policy New Jersey recouped $3 million by 2005.[8] Accumulation of unexpended funds is a sensitive issue, and programs need to reach a balance between encouraging thrift and economy (as well as acknowledging that participants may have unanticipated needs), versus allowing participants to accumulate unbudgeted funds left over from months when their personal care needs were met without these funds.

Participants' Concerns about Program Procedures

In consumer focus groups during the CCDE, the majority of participants expressed overall approval of the program and appreciation of the difference their purchases had made in their lives. However, participants' concerns about some program procedures are instructive. Arkansas participants felt that the record keeping and state oversight was more burdensome than necessary. Participants offered such comments as: "You have to write down and make a log of every dime we spend of the cash allowance. Before, we didn't have to do that. … I'm not that educated and I'm not that crazy about writing," or, "…They are asking for more records, receipts, bookkeeping. I appreciate what I'm getting, but I don't think it's anyone's business how I spend it."[12] While participant accountability is an important issue, budget option programs need to limit the record keeping burden imposed on participants. Additional training for participants may be useful as well.

New Jersey participants had a related concern about a lack of information about "their" funds. They suggested, "Make the consultants more aware of how to explain what is available to you," or, "We don't know what the balance is at the end of the month so we can't utilize it." It is important to have clear accounting and reporting for participants.

Finally, some participants and counselors were concerned about a lack of clarity regarding the decision process and rules for approving purchases. It is a difficult task to keep a program flexible enough to meet the needs of individuals and to allow for creativity in meeting those needs, while at the same time giving participants enough sense of program boundaries and limits. States have responded to these concerns by simplifying processes where possible, as well as by providing a variety of online and printed informational materials for participants and counselors, which include examples and scenarios of possible purchases.

Considerations for CLASS Plan Design and Implementation

In summary, extensive research and experience from 15 C&C states provide valuable lessons to inform CLASS design and implementation. We offer the following lessons and recommendations:

Individuals with Disabilities Possess the Capacity to Manage Resources. C&C research and experience indicates that participants of all ages with diverse disabilities – including intellectual disabilities – can be successful in this participant directed budget model.

Supports (Counseling and Financial Management Services) are Important to Successful Participant Experience. Participant supports, including counselors, financial services, and the ability to assign representatives, are essential for program success. Almost all participants used financial management services. These supports provide "checks and balances" regarding participant health and safety outcomes and appropriate use of public funds. Within the limits of the administrative cost cap, CLASS design should include funds for technical assistance in developing these services as well as training and supporting personnel who will offer them.

The Ability to Hire Relatives is Important to Participants. Most CCDE participants hired relatives as paid workers (including legally liable relatives when allowed). This is guaranteed in CLASS legislation. Health and satisfaction outcomes for participants who were given the option to hire relatives were positive, and concerns about fraud and abuse unfounded. Clearly, the ability to hire relatives is an important program feature.

Program Features That Enhance Worker Recruitment and Retention are Critical. Features such as the ability to offer fringe benefits can attract workers and help them stay satisfied with direct service positions. Within the limits of the administrative cost cap, CLASS designers would be wise to help participants offer fringe benefits on a large group basis and to encourage the creation of worker registries to help participants needing to locate workers.

A Flexible Budget Including Purchasing Goods and Services is Key. While C&C participants spent the bulk of their funds on personal assistance workers, the ability to buy a wide variety of goods and services was essential to their enhanced independence. Some types of purchases may substitute for human assistance, while others are intended to maximize the value or increase the retention of human assistance. Many purchases clearly benefit both the participant and workers (e.g., air conditioning, pest control) as both parties inhabit the same environment. Additionally, any purchase that helps the worker to be more efficient (e.g., a dishwasher) or to avoid burnout (e.g., respite, fringe benefits) ultimately benefits the participant. Participants used their budgets creatively, and their purchases of goods and services varied by type of disability, culture, and age. CLASS designers should maintain this flexibility to purchase a wide range of goods and

services (i.e., not just durable medical equipment and ramps but microwaves, refrigerators, air conditioners, etc.) so participants can reap the important benefits of this program feature.

Savings are Desirable to Participants.
C&C participants thought it was important to be able to save or accumulate "rainy day" funds, and they strongly preferred minimal record keeping. The CLASS legislation mandates record-keeping and implies that records would be audited periodically, such as when the individual comes up for a reauthorization of continued eligibility for benefits. However, the legislation does not say how detailed the record keeping has to be. Participants also wanted a system that allows them to easily monitor their budget expenses and remaining balance. CLASS designers can incorporate this information about participants' views regarding thrift and simplicity.

The extensive evaluation data and program experience gleaned from 15 state programs is a valuable resource to guide CLASS designers as they meet upcoming challenges. In particular, C&C participants clearly reported that the ability to purchase a variety of goods and services provided flexibility needed to help them maintain their independence in their communities.

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Debit Card Fundamentals and Their Use in Government Programs

By Cathy Corby Parker, James Wironen, Mollie G. Murphy, and Kevin J. Mahoney

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief describes the history and operation of debit cards and provides examples of their use in government programs to inform the use of debit cards to access CLASS Plan benefits.

Introduction and a History of Debit Cards

A little over 50 years ago, banks introduced credit cards. The utility of these early credit cards was limited as a payment card and would only work if both the merchant and consumer used the same bank. To address this issue, major banks formed franchises so that one bank's card could be accepted at another bank's merchant. These franchises became known as "associations." Today, Visa® and MasterCard® are the largest card associations and their product offers have expanded beyond credit cards.

Card associations play an important role in establishing the rules that govern use of payment cards by consumers and businesses. To protect the safety and integrity of the card-based payment system, all payment cards must be issued or guaranteed by a financial institution, and each merchant must be sponsored into the association by a financial institution.

Debit cards were introduced in the 1980's in the form of Automated Teller Machine (ATM) cards that provided consumers with 24-hour access to cash in their bank, checking, and savings accounts. A "debit card" is a plastic payment card that resembles a credit card but it is linked to the card owner's deposit account at a bank. When the card is used, it accesses funds the card owner has in his or her bank account. A Personal Identification Number (PIN) is associated with each debit card to protect against unauthorized use. To increase convenience for consumers, banks formed networks and allowed their customers to use ATMs owned by any bank in the network. A network logo was added to the card for consumers to easily identify the ATMs that were in the network. To extend the value of their ATM cards, networks encouraged merchants to install PIN-pads at their cash registers so consumers could make purchases with ATM cards. Over time, ATM cards came to be known as "debit cards."

In the 1990's, Visa and MasterCard launched their own version of debit

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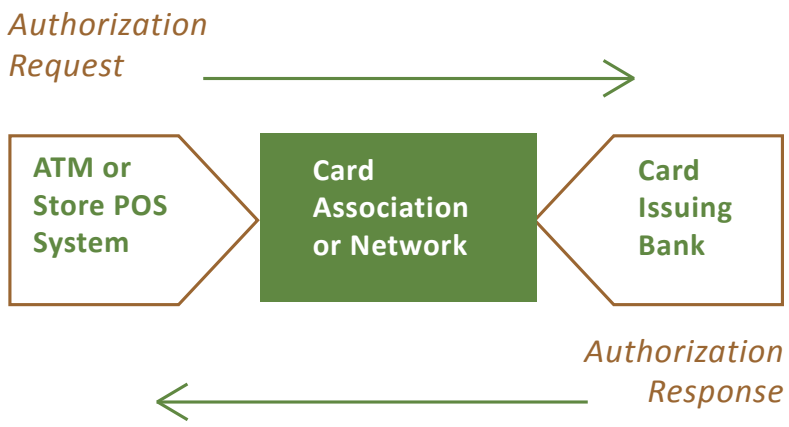
cards that did not require use of a PIN for purchases. Instead, the consumer signed the back of the debit card and this signature could be matched with the consumer's signature on the receipt to validate the cardholder. Today, most debit cards operate in both modes, carrying one or more network brands and an association brand, allowing purchases to be authorized either with a PIN or the cardholder's signature.

Originally, debit cards were linked to one or more bank accounts owned by the cardholder. Around the year 2000, a new form of debit card called a "prepaid debit card" was launched. The funds on prepaid cards were still kept at a bank, but in a pooled account where the balance was held in trust for cardholders. Behind the scenes, balances on each card were tracked in real time so that any one cardholder only had access to the funds in the trust account associated with his or her prepaid debit card.

How Debit Cards Work

When a consumer uses a debit card to get cash from an ATM or make a purchase, the ATM or merchant Point of Sale (POS) system sends an electronic request to the association or network linked to the card. The association passes the authorization request to the bank that provided the debit card to the consumer. The bank validates that the card has not expired or been reported lost or stolen and that there are sufficient funds available to cover the amount of the transaction. If a PIN is entered for identification, the PIN is also validated. The bank then sends the approval or denial transaction back to the association or network, who delivers it to the ATM or POS where the cardholder presented the card. (See Figure below.)

FIGURE Authorization Processing Transaction Flow



All of this happens nearly instantaneously – sometimes in less than one second of time. And, throughout the authorization process transactions are monitored to look for patterns of fraud.

"The newer debit card processing platforms associated with prepaid debit cards were designed to handle more complex authorization procedures. This could include limiting use of the card to certain categories of merchants or particular merchant locations. It could also include restricting use of the card to purchase of particular products or services if the merchant is able to send information about the items being purchased."

The newer debit card processing platforms associated with prepaid debit cards were designed to handle more complex authorization procedures. This could include limiting use of the card to certain categories of merchants or particular merchant locations. It could also include restricting use of the card to purchase of particular products or services if the merchant is able to send information about the items being purchased. Prepaid debit cards can also have multiple "purses" associated with a single card. For example, a prepaid debit card could have a general spending purse and a savings purse.

Debit Card Characteristics

There are a wide variety of debit card products in the market. Underlying this variation are five debit card characteristics that define the capabilities and uses for a debit card. These are:

- **Open Loop vs. Closed Loop** — "Open loop" means that the debit card is connected to an association or network and the card can be used at any merchant in the association or network. "Closed loop" is the term used for debit cards that are issued by a particular retailer and can only be used for purchases at that particular retailer. The most common closed loop cards are store gift cards. Some debit cards are hybrids of open loop and closed loop, in that they have a network or association brand, but they do not work at all merchants where that brand is accepted.
- **Reloadable vs. Non-Reloadable** — Reloadable prepaid cards operate very much like a bank account and the card issuer must validate the identity of the cardholder in essentially the same process as if the consumer was opening a bank account. Money can be loaded onto a reloadable card via direct deposit of pay or government benefits (the same as if the employer or government agency was depositing funds to a bank account). Consumers can also load money onto their cards at retail locations that participate in a reload network (such as GreenDot® or MoneyGram®) by giving cash to the retail store clerk to load onto the card. Non-reloadable prepaid cards are not associated with an individual. Because of their anonymous nature, there are strict limits on the dollar amount of funds that can be loaded onto a non-reloadable card.
- **PIN and/or Signature** — Debit cards can be issued with PIN and signature cardholder authentication, just PIN, or just signature. When a PIN is used, the card is processed over a network and the transaction is considered final at the time the authorization is approved. When a signature is used, the authorization is routed through an association, but the merchant must send an end-of-day electronic file to the association with all of the day's authorized transactions before the movement of money will occur. Cards that allow ATM access must have a

"Debit cards can be issued with PIN and signature cardholder authentication, just PIN, or just signature. When a PIN is used, the card is processed over a network and the transaction is considered final at the time the authorization is approved. When a signature is used, the authorization is routed through an association, but the merchant must send an end-of-day electronic file to the association with all of the day's authorized transactions before the movement of money will occur."

PIN. Many retailers allow customers to obtain cash back with purchases when a PIN is used. Cards that only use PINs are not able to be used for e-commerce purchases or bill payments at merchant web sites.

- **Registered or Anonymous** — All reloadable cards must be registered to a particular individual. Consumers with non-reloadable cards can register the card or use it anonymously. The advantage of registering a non-reloadable card is that it can then be used to make e-commerce or telephone purchases. Many online merchants will not accept unregistered cards because of the high risk of fraud.
- **Primary or Companion Card** — Both bank account-based and prepaid debit cards can have more than one card linked to a specific account. Two cards can both access the same funds or each card can have its own balance. Bank account-based debit cards have one balance shared by the primary and companion cards. Prepaid debit cards can operate similarly, but they can also be set-up to allow the primary cardholder to transfer funds to the companion card. In that case, each consumer has access only to the funds on his or her card, not the combined balance.

Common Debit Card Products

By varying the combinations of these five card characteristics, debit card providers have created dozens of different debit card products to meet specialized market needs. However, the most widely used debit cards fall into seven categories, each of which is highlighted below.

- **Bank-Account Based Debit Cards** — Today, virtually every checking account comes with a debit card. Most bank-based debit cards have both a signature and PIN. The number on the bank debit card is linked to one or more bank accounts. A purchase or withdrawal using a bank account-based debit card may be approved if there are not sufficient funds in the account, based upon the bank's overdraft policies. Funds in the account associated with the bank debit card are insured by the Federal Deposit Insurance Corporation (FDIC).
- **Government Benefit Cards** — State and local government agencies spend millions of dollars annually printing and mailing checks to benefit recipients for programs such as Social Security, unemployment, and court ordered payments. To reduce costs and increase convenience for recipients, government agencies have encouraged direct deposit of benefits to recipients' bank accounts. But, the FDIC estimates that in the U.S. 17 million people reside in households without bank accounts and another 21 million people have a bank account but conduct most of their financial business with cash and money orders.[1] This segment of the population uses check cashing services, where they can receive their funds in cash immediately without any hold period, as may be the case with a bank. To drive costs out of delivery of government payments to unbanked and underbanked consumers, many agencies have distributed reloadable prepaid debit cards to recipients who do not specify a bank account for direct deposit. These debit cards allow benefit recipients to withdraw their funds at an ATM or bank teller, and to make purchases in

stores and online. Government agencies work with the debit card providers to ensure that costs for the recipient are low. Recipients are usually allowed one free withdrawal after each deposit of benefits, and government benefit cards participate in at least one "surcharge-free" ATM network. "Surcharge-free" ATM networks allow cardholders to withdraw funds at an ATM without any fee from the owner of the ATM. While fraud does occur with government debit cards, as discussed later in this paper, the incidence and customer impact of debit card fraud is substantially lower than with check-based distribution of benefits. While comparable statistics are not available, paper checks are subject to being lost, stolen, or altered; there is no real-time authorization for paper checks, as with debit cards; and there are no consumer protections associated with use of checks.

- **Employee Payroll Debit Cards** — Employers for decades have promoted direct deposit of pay to bank accounts in order to save the expense of producing and distributing paychecks. Many employers now provide reloadable prepaid debit cards to employees who do not specify a bank account for direct deposit of their pay. These payroll debit cards have evolved into "checkless checking" accounts. Employees can deposit pay from multiple employers to these cards or even keep their cards when they change jobs. In many states, employers can mandate use of a payroll debit card for employees who do not specify a bank account for direct deposit, but they must provide the cards free, with no monthly fees and at least one free withdrawal after each payroll deposit. Employers have no ability to see card balance or transaction information on payroll debit cards.
- **General Purpose Reloadable (GPR) Cards** — As their name suggests, GPR cards are reloadable prepaid debit cards that can be purchased by consumers for a variety of uses. Consumers who don't have a credit card or bank debit card often use GPR cards to make purchases in stores and pay bills more conveniently than using cash or money orders, as well as for making purchases and paying bills online. Some consumers have their pay deposited to the GPR card – in essence, the GPR card becomes their bank account. Fees for GPR cards vary widely and can include a fee to purchase the card, a monthly maintenance fee and reload, ATM, and purchase transaction fees.
- **Flexible Spending Account (FSA) Cards** — Open loop prepaid cards linked to flexible spending accounts allow in-store and online purchases directly from the funds in the FSA – consumers do not have to file claims for reimbursement. FSA cards use signatures for authentication and do not have PINs or ATM access. Use of FSA funds is restricted to purchases of approved medical and healthcare products and services. Funds in the FSA cards are legally the property of the plan administrator and can only be loaded to the card by the plan administrator. FSA's operate on a "plan year" and at the end of the plan year, FSA administrators zero-out any remaining balances on the FSA card.
- **Health Savings Account (HSA) Cards** — HSA's are savings accounts associated with high deductible

insurance plans. An employee participating in a high-deductible insurance plan can open an HSA account at a bank and either the employee or employer deposits funds to the HSA. These funds earn interest tax-free and the funds can be used for out-of-pocket medical costs. At this time, there is no requirement that HSA account providers substantiate that the funds are used for medical purposes, and employees can withdraw their health savings funds in cash through an ATM or bank teller.

- **Gift Cards** — Gift cards are non-reloadable prepaid cards that can be either open loop or closed loop. The only way funds on a gift card can be accessed is to make purchases. Open loop gift cards can be used anywhere the association brand is accepted. Closed loop gift cards can only be used at stores owned by or affiliated with the retailer who issued the card (for example, a Home Depot® gift card is accepted only at Home Depot stores or the Home Depot web site). Gift cards can have a predetermined fixed balance or they can have variable funding with the card purchaser specifying the amount at the time of purchase. Because gift cards do not require registration, banks place limits on the maximum value that can be loaded onto a card to prevent the use of gift cards in money laundering.

The table on page 7 summarizes the features and characteristics of each of these major categories of debit cards.

Debit Card Providers

There is an "issuing bank" or "issuer" for every open loop bank or prepaid debit card. The bank has a fiduciary responsibility to the associations and networks in the case of fraud or misuse of the card, and is responsible for complying with association and network rules and government regulations. There is not a bank issuer associated with closed loop cards.

"Processors" are companies that process debit card transactions, acting on behalf of issuing banks to manage debit cards and authorize and settle transactions. Open loop card processors accept authorization requests from the associations or networks and approve or deny each transaction. On a daily basis, processors settle with the associations and networks to determine how much money each issuing bank owes each association and network for transactions approved for its cardholders. With closed loop cards, the retailer sends authorization requests directly to its card processing system or provider. There may be settlement involved if a card is purchased in one location of a chain or franchise store and redeemed in another location.

Processors also provide customer service to cardholders, including automated telephone access to account information and balances, an online cardholder web site and telephone agent customer service. Particularly in the case of government benefit programs, the cost of providing agent customer service can be unmanageable if cardholders are not sure how or where to use the card, or if

TABLE Summary of Characteristics of Widely Used Debit Card Products

	Bank Account Based Debit Cards	Payroll Debit Cards	Government Benefit Cards	General Purpose Reloadable Cards	Flexible Spending Cards	Health Savings Account Cards	Gift Cards
Account-Based or Prepaid	Account	Prepaid	Prepaid	Prepaid	Prepaid	Account	Prepaid
Open- or Closed-Loop	Open	Open	Open	Open	Open	Open	Open or Closed
Reloadable	N/A	Yes	Yes	Yes	Yes	N/A	No
ATM Access	Yes	Yes	Yes	Yes	No	Yes	No
Type of Authentication	PIN & Signature	PIN & Signature	PIN & Signature	PIN & Signature	Signature	PIN & Signature	Signature
Registered to Individual	Yes	Yes	Yes	Yes	Yes	Yes	Optional
Bank Identity Validation	Yes	Yes	Yes	Yes	No	Yes	No
Companion Card	Optional	Optional	Optional	Optional	No	No	No
Cardholder FDIC Insurance	Yes	Yes	Yes	Yes	No	Yes	No
Dispute Protection	Government & Association	Government & Association	Government & Association	Association Only	Association Only	Government & Association	Association Only
Funding Source	Consumer	Employer	Government Agency	Consumer	Employer	Employer or Employee	Consumer or Business
Owner of Funds	Cardholder	Cardholder	Cardholder	Cardholder	Employer	Cardholder	Cardholder
Funder Can See Balances/Activity	Yes	No	No	Yes	Yes	No	No
Direct Deposit of Pay	Yes	Yes	No	Yes	No	No	No
Reload Networks	N/A	Optional	No	Yes	No	N/A	No
Surcharge-Free ATM Network	Yes	Yes	Yes	Optional	No	Yes	No
Overdrafts Allowed	Optional	Optional	No	Optional	No	No	No

they are confused about whether their question should be directed to the card provider or the government agency. Clear communication in the collateral accompanying government benefit cards to minimize calls to customer service agents is critical.

"Banks, associations, networks, and processors have created an extensive infrastructure to protect the safety and soundness of the card payment system. There are detailed rules with which every member of an association or network must adhere, as well as government regulations."

Retailers sell prepaid debit cards to consumers either in stores or online. Generally, the cards sold in this way are open loop and closed loop gift cards or general purpose reloadable (GPR) cards. A "card mall" is often used to display an assortment of prepaid cards. Online card malls exist as well. Retailers that sell GPR cards generally also participate in prepaid reload networks and consumers can load funds onto reloadable prepaid debit cards in their stores.

Check cashers, payday lenders and money transfer agents often provide GPR cards to their customers. A portion of funds from cashing a check or loans proceeds can be applied to the GPR card to provide customers with the convenience of paying with plastic and the safety of not carrying around as much cash.

Mitigating the Misuse of Debit Cards

Banks, associations, networks, and processors have created an extensive infrastructure to protect the safety and soundness of the card payment system. There are detailed rules with which every member of an association or network must adhere, as well as government regulations.

PIN numbers have always been treated as highly sensitive by banks and never stored "in the clear" – meaning they were always encrypted when stored or in transit. More recently, the Payment Card Industry (PCI) Data Security Standard was established by the card associations to combat theft of the 16-digit credit and debit card numbers and associated cardholder names and card expiration dates. PCI compliance requires that any company that processes, stores, or transmits personally-identifiable payment information must maintain a secure environment. Issuers and processors are required to have annual third party audits to certify their compliance with PCI standards in order to maintain their memberships in the associations. Some states have adopted laws requiring compliance with data protection rules substantially similar to PCI requirements.

The Treasury Department and the Financial Crimes Enforcement Network developed regulations, as required by Section 326 of the Patriot Act, to maintain "Customer Identification Programs" (CIP) to protect against use of debit cards by terrorists. These regulations require that financial institutions verify the identity of the person opening a bank account and check to make sure that individual is not on the government's list of suspected terrorists.

To combat fraud through identity theft, the Federal Trade Commission (FTC) implemented the "Red Flags Rule" implementing sections 114 and 315 of the Fair and Accurate Credit Transactions Act of 2003. "Red Flags" requires card issuers to diligently protect their

"Friendly fraud occurs when a family member or friend uses the card without the permission or knowledge of the cardholder. Friendly fraud can be especially serious if the cardholder has disclosed his or her PIN to a third party, as that individual can then use the card and PIN at an ATM to withdraw all the money in the account. This type of fraud is more common with government benefit and payroll debit cards, as the recipient population is less likely to have experience with debit cards. It is imperative that messaging to consumers that accompanies debit cards clearly communicates the importance of keeping the card secure and not disclosing the PIN to anybody."

cardholders from identity theft. In the debit card world, the focus is on fraud around address changes. A common scam is for a criminal to acquire a card number and cardholder name (for example, a server in a restaurant who takes the card out of view of the cardholder during the authorization process). Then the criminal calls the bank to change the address on the card and later reports the card lost or stolen. Thus the replacement card, when mailed, is sent to the criminal. Banks and processors now have policies to monitor and validate cardholder address changes. Generally, banks will contact the cardholder to validate the address change or request proof of the change, such as a copy of a utility bill.

Another risk with debit cards is "friendly fraud." Friendly fraud occurs when a family member or friend uses the card without the permission or knowledge of the cardholder. Friendly fraud can be especially serious if the cardholder has disclosed his or her PIN to a third party, as that individual can then use the card and PIN at an ATM to withdraw all the money in the account. This type of fraud is more common with government benefit and payroll debit cards, as the recipient population is less likely to have experience with debit cards. It is imperative that messaging to consumers that accompanies debit cards clearly communicates the importance of keeping the card secure and not disclosing the PIN to anybody.

An additional area of protection against fraud relates to loading of funds on the cards. Banks and processors monitor deposits to debit cards to assure that they are from corporate entities, other banks, government agencies or reload networks, or the cardholder herself/himself in the case of bank debit cards. The assumption is that these entities have performed due diligence on the businesses or individuals from whom they are accepting funds for deposit onto debit cards.

Cardholder rights in the case of disputes between the cardholder and the merchant are governed by association and network rules for open loop cards. Visa and MasterCard offer zero liability to protect cardholders against unauthorized charges as long as the cardholder promptly notifies the issuer.

The Federal Reserve also regulates open loop debit cards through "Regulation E" that limits the cardholder's liability for unauthorized purchases or ATM withdrawals to $50.00, as long as the customer promptly informs the bank.[2] At this time, Regulation E only applies to bank account-based debit cards and prepaid payroll and government benefit cards, although some GPR card providers extend the benefits of Regulation E to their customers. When a cardholder reports a dispute, the amount of the disputed transaction must be immediately credited back to the cardholder. Losses can occur with false filing of disputes if, upon resolution of the dispute in the merchant's favor, there are not sufficient funds to repay the credit that was extended to the cardholder. However, since both government benefit and payroll debit cards have recurring deposits, often the losses are recovered upon the next deposit to the card.

"Processors, associations, and networks continually scan authorization requests to look for patterns that indicate fraudulent activity. These systems are complex neural networks in which the financial services industry has invested billions of dollars. Fraud monitoring takes place at every level in the process, looking for abnormalities in the activity of the card account itself, the bank's card portfolio, the processor, the association or network, the merchant's processor, and the individual merchant."

Regulation E protects cardholders against friendly fraud if the cardholder reports it. However, cardholders are sometimes reluctant to report the fraud as many card issuers require the cardholder to file a police report that would implicate their "friend." Regulation E also requires financial institutions to send cardholders a monthly statement, which can be delivered electronically with the cardholder's consent.

There are no third parties protecting consumer dispute rights with closed loop cards. Any disputes with non-reloadable prepaid cards are resolved directly between the retailer and the cardholder.

Velocity limits associated with each debit card regulate the number and dollar value of activities that can be performed on a debit card. Each issuer establishes its own velocity limits and they vary by type of card program; however, common rules relate to the maximum daily cash withdrawal limit, maximum purchase value limit, and maximum dollar value of a prepaid debit card.

Processors, associations, and networks continually scan authorization requests to look for patterns that indicate fraudulent activity. These systems are complex neural networks in which the financial services industry has invested billions of dollars. Fraud monitoring takes place at every level in the process, looking for abnormalities in the activity of the card account itself, the bank's card portfolio, the processor, the association or network, the merchant's processor, and the individual merchant.

Debit Cards and Government Programs

Below are overviews of some of the major types of government and tax-preferred employee benefits debit card programs in use today.

Social Security Benefits — In 2008, the U.S. Treasury Department introduced Direct Express®, an open loop reloadable prepaid MasterCard. The new card allowed government benefit recipients without bank accounts to receive their benefits by direct deposit to the Direct Express card rather than a paper check. Social Security is the largest government program using Direct Express, but the card is also used for recipients of Supplemental Security Income, Veterans, Railroad Retirement and Office of Personnel Management Benefits. At the time the Treasury Department launched the Direct Express card, there were an estimated 4 million Social Security recipients without bank accounts. The Treasury Department projected savings would exceed $300 million in the first five years alone from depositing benefit payments to Direct Express cards rather than printing and mailing checks.[3] Use of Direct Express is voluntary for benefit recipients. However, in April 2010 the Treasury Department announced that as of March 2011, electronic deposit of benefits (to either a bank account or the Direct Express card) will be required for new benefit recipients and all existing recipients receiving paper checks must convert to electronic deposit by March

2013.[4] The Direct Express card has a fee structure that allows benefit recipients to use the card at little or no cost. The card is delivered to benefit recipients free of charge, has no monthly maintenance fees, no charge for customer service, and allows one free US-based ATM transaction after the monthly deposit of benefits. Additional ATM withdrawals cost recipients 90-cents.[5]

Unemployment Benefits — In the same search for cost reduction and efficiencies that fueled the US Government's introduction of Direct Express, many state governments have launched their own government benefit cards for payment of unemployment insurance and other state benefit programs. In 2009, an estimated $23 billion in unemployment benefits were distributed unto prepaid cards, and by mid-2010 every heavily populated state except for California had either launched or was in the process of introducing an unemployment claims payment card.[6] There are several different providers of these cards, and the particulars of the programs vary from state-to-state. However, the programs have in common that the cards are open loop, reloadable, with fee structures that allow recipients to use the card at little or no cost. While benefit recipients own the card, government agencies typically do not allow cards to be loaded with other than government funds. Recently, a handful of states have changed their positions and are allowing loading of cards with other than government funds; in essence, their benefit cards can serve as a checkless checking account even after the cardholder discontinues receiving benefits.

Court Ordered Payments — States are increasingly adopting open loop reloadable prepaid cards for delivery of court ordered payments. All of the savings associated with movement away from production and delivery of paper unemployment checks applies to checks for court ordered payments. Moreover, since court ordered payments are often delivering child support and/or alimony payments, emotions of the payer and/or recipient can be heated. Using open loop reloadable prepaid cards to deliver court ordered payments increases the transparency around payment and receipt of the funds. While judicial agencies at many levels in state governments administer court ordered payments, some states have adopted one prepaid debit card program for use by all judicial agencies within the state.

Food Stamps — Food Stamps were the first government benefit program to move to paperless benefit delivery, as the fraud associated with paper food stamps was high. By 2009, 36 states had implemented electronic benefit programs for foods stamps and all the rest were in the process of planning implementations.[7] Merchants participating in food stamp programs are required to validate that each item purchased is food stamp eligible. Prepaid debit technology, as we know it today, did not exist when the first EBT programs were launched. As a result, the financial services and merchant community invested in a new technology infrastructure called Electronic Benefit Transfer (EBT). New EBT networks were created, new cards were issued to food stamp recipients, and new terminals were installed at merchant locations to

support the more complex authorization requirements. Because of the costs of the dedicated equipment, merchants may only support EBT in one check-out lane in the store. Thus, food stamp recipients could be inconvenienced and potentially ostracized as the fact that they are paying with food stamp funds would be apparent to other shoppers. Today, many EBT programs are retooling their EBT platforms to "mainstream" acceptance and processing of EBT cards with commercial payment card equipment and processes.

Flexible Spending Accounts — The federal government allows employers to offer Flexible Spending Accounts (FSAs) which let employees set aside pre-tax pay to fund out-of-pocket medical expenses. To prevent consumers from using these tax-advantaged funds for non-medical purchases, the government requires FSA plan administrators to substantiate the eligibility of each purchase. Consumers originally were required to submit a claim for reimbursement. This was inconvenient for consumers and limited the appeal to employees because FSA withholdings reduced net pay, then consumers put forth cash for the purchase and had to wait for reimbursement. In essence, FSA users were paying twice for the purchase before receiving their reimbursement. FSA cards addressed this issue by allowing consumers to access their FSA funds in stores via an FSA debit card. When FSA card issuers receive authorization requests, they must substantiate the medical nature of each item purchased. Issuers check the Merchant Category Code (MCC) sent in the authorization request, and deny transactions from non-healthcare merchant categories. Since large supermarket, discount, and drug stores sell both medical and non-medical goods, FSA cards cannot be accepted at these broad-based retailers unless the retailer distinguishes between eligible and ineligible purchases. Most of the large chains in these categories have modified their cash register systems to automatically identify which items are FSA eligible. These retailers maintain an Inventory Approval Information System (IIAS) that lists all the approved items for sale in the store or on an e-commerce site. At check-out, each item is matched against this list and a separate total is created for the FSA eligible and non-FSA eligible items. The consumer is allowed to pay for the qualified purchases from the FSA card and use another form of payment for ineligible items.

Considerations for CLASS Plan Design and Implementation

The Community Living Assistance Services and Supports (CLASS) provision in the Affordable Care Act requires that procedures be developed to allow use of debit cards to access cash benefits to be deposited into Life Independence Accounts.[8] This primer describes the history and operation of debit cards and provides examples of their use in government programs.[i]

[i] Additional considerations for integrating debit cards into CLASS Plan Design and Implementation are presented in The SCAN Foundation's CLASS Technical Assistance Series Brief #10: ("Financial Management Services in Participant Direction Programs"), Brief #11: ("Options for Getting Purchasing Power into the Hands of Participants: Lessons from Participant Direction Programs"), and Brief #12: ("Considerations for Debit Card and Cash Purchasing Mechanisms in the CLASS Plan").

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Financial Management Services in Participant Direction Programs

By Mollie G. Murphy, Isaac Selkow, and Kevin J. Mahoney

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief seeks to inform the design and implementation of the CLASS Plan using experience from the provision of Financial Management Services (FMS) in participant direction. Highlighting why FMS are used in participant direction and their challenges, we seek to present strategies for maximizing their benefit in the CLASS Plan.

Introduction and Why Participant Direction Programs Use Financial Management Services

Participant direction programs offer participants choice of and control over their long-term services and supports. As choice and control increase, so too do certain fiduciary responsibilities, including those associated with being an employer, managing funds for services, and handling payroll and employer-related taxes and insurance. To date, existing participant direction programs have often used a Financial Management Services (FMS) function to support employment-related tax and insurance compliance for participants as well as for program fiscal accountability. FMS have also been used to reduce the employer-related task burden for participants, allowing them to focus on managing other aspects of their long-term services and supports. Similar to participant direction programs, designers of the CLASS Plan must grapple with administrators' role in supporting beneficiaries to maintain compliance with tax and labor law when they directly hire workers, as well as how to ensure beneficiary purchases meet CLASS Plan rules.

Employment Regulation Compliance

In participant direction programs, many participants choose to use their program funds to purchase labor services, such as personal assistance services, chore help, and companionship services.[i]

When services are procured, they are sometimes provided by a home health care agency or other organization that employs workers to perform these services. In other instances, participants hire the individuals of their choice, such

[i] For additional information, see The SCAN Foundation's CLASS Technical Assistance Series Brief #8: ("How did Cash and Counseling Participants Spend Their Budgets, and Why Does That Matter for CLASS?").

as family members, friends, or others they have determined are qualified to provide the needed services. The Internal Revenue Service (IRS) has determined that, in general, when individuals directly hire workers to perform these types of services (i.e., the individual does not contract with a company to provide these services), the workers are considered employees of the individuals who supervise and manage the work.[1] Specifically, participants are considered "household employers" and their workers "household employees." Many participant direction programs offer participants the use of a "representative." The representative is usually someone the participant knows well and trusts and who can support the participant to manage his or her program services. When a participant has a representative, the representative will often serve as the employer of the participant's workers and, with the participant's input, will supervise, schedule, and manage the workers.[2]

"In Medicaid-supported participant direction programs, when all program payments are routed through the FMS, the program can assure that publicly funded workers are not being paid "under the table."

When employers pay employees, they generally must do the following:[3]

- Withhold federal income tax from employee pay (optional for household employees)
- Withhold Social Security and Medicare taxes from employee pay
- File and deposit with the IRS withheld employee federal income, Social Security and Medicare taxes and the employer portions of Social Security and Medicare taxes
- File and deposit federal unemployment taxes
- File and deposit state unemployment taxes
- Maintain compliance with any employee state or local income or disability tax rules, including withholding from employee pay as well as filing and depositing with state and local tax agencies, as applicable[3]
- Provide employees with year-end information returns, such as Forms W-2
- Maintain compliance with state workers' compensation statutes
- Verify that employees are authorized to work in the United States
- Maintain compliance with other state rules, such as state pay day requirements
- Maintain compliance with the Federal Fair Labor Standards Act[4]

Like other employers, participants who directly hire their own workers must maintain compliance with employment rules and regulations to avoid penalties. In participant direction programs where state and federal funds are used for participant services, program administrators also have incentives to ensure compliance with state and federal rules and regulations is maintained. In the 1990s, some participant-directed Medicaid programs were found to be out of compliance with IRS rules regarding payment of participant hired workers and the programs were fined.[5]

Participant direction programs have used FMS providers to make payments to participants' workers and to other nonemployee providers of goods and services. When an FMS provider (which can be a contracted vendor or government entity, see *Models of Financial Management Services* below) pays a participant's employees, the provider is responsible for maintaining

"Since FMS providers make payments on a participant's behalf and usually collect information on what is being purchased, they have rich program data that can be useful to program administrators and researchers."

compliance with all federal, state, and local tax and labor rules and regulations, including managing employer tax deposits and returns.[2] In Medicaid-supported participant direction programs, when all program payments are routed through the FMS, the program can assure that publicly funded workers are not being paid "under the table."

Participant Budget Management, Fiscal Accountability & Reporting

Participant direction programs have also used FMS to improve program oversight, including for purposes of supporting participant budget management, for program fiscal accountability, and increasing program access to relevant spending and service data. FMS providers are often tasked with ensuring participant expenditures are within authorized funding allotments or that funds are used in accordance with the plan of care or spending plan.[6] FMS providers also ensure that payments are not made for prohibited goods or services or under prohibited circumstances.

Since FMS providers make payments on a participant's behalf and usually collect information on what is being purchased, they have rich program data that can be useful to program administrators and researchers. In addition to submitting various reports to program administrators and providing data as requested, FMS providers usually provide participants with at least monthly reports, similar to a bank statement, about how participants are using their program funds.

Participant Preference for Payment, Recordkeeping and Compliance Support

In the Cash and Counseling program, one of the most flexible models of participant direction, early program designers sought to maximize participant choice and control over services.[7] Designers intended for program participants to fully manage even the financial aspects of their program, including making payments to workers and for other goods and services and managing all employer tax, insurance and recordkeeping responsibilities. However, early program preference studies revealed that a majority of participants preferred a professional service provider to perform financial and administrative services.[7] Empirically, when given the choice, Cash and Counseling participants chose a Financial Management Services provider to manage all employer-related payroll, tax and insurance responsibilities.[ii]

[ii] For additional information, see The SCAN Foundation's CLASS Technical Assistance Series Brief #11: ("Options for Getting Purchasing Power into the Hands of Participants: Lessons from Participant-Directed Programs").

Benefits and Limitations of Financial Management Services in Participant Direction

In existing publicly-funded participant direction programs, most programs (approximately 97% based on preliminary data results) utilize FMS.[8] Some of the benefits and limitations of FMS, as used in participant direction, are compared below. (See Table 1).

TABLE 1 Benefits and Limitations of FMS

Benefits of FMS	Limitations of FMS
• Ensures program funds are only used for authorized services, except when cash is disbursed directly to participants. • Ensures employees are paid in compliance with tax and labor laws. • Supports timely and accurate payment of employees. • Supports participants to hire only those workers who are authorized to work in the United States. • Data on how participants use program funds are recorded by professional organizations; getting data on how funds are spent is straightforward. • Reduces participant employer burden; allows participants to focus on managing their long-term services and supports. • Supports participants to manage their program funds. • Supports program fiscal accountability. • Can help detect and prevent program fraud and abuse.	• Having an FMS make payments for services is significantly less effective when participants must make purchases with limited notice or must use cash for the purchase • Using an FMS does not alleviate a participant from all employer responsibility. While an FMS provides significant support, participants are still ultimately the employers of their staff. • Even with FMS in place, it is still possible for fraud and abuse to occur. • Participants may perceive that the use of an FMS restricts their control of their services and supports.

Financial Management Services and Counseling: A Partnership

Most participant direction programs offer participants counseling (some programs use terms such as "support brokerage," "consulting," "advising," or "flexible case management"). The primary function of counseling is to help participants develop the skills necessary to manage their long-term services and supports.[9] FMS and counseling are both supports intended to help participants maximize their program benefits, but each plays a different and complementary role. While FMS focuses on administrative and "back-office" support related primarily to service payments, employment compliance, and fiscal accountability, counseling focuses on empowering participants with the skills to successfully manage their budgets and workers to meet individual support needs. Ideally, these functions work in harmony, with participants ultimately directing their services.

Table 2 below outlines some common supports often provided by the two functions.[10]

TABLE 2 Common Duties of the Counseling Function and Financial Management Services Function

Common Duties of the Counseling Function	Common Duties of the Financial Management Services Function
• Provide the participant with information about the concepts of participant direction and participant rights and responsibilities. • Assist the participant in identifying his/her own goals and needs using a participant-centered-planning process. • Assist the participant in developing his/her spending plan. • Provide clarification and explanation about allowable program expenditures and documentation/record keeping. • Assist the participant in developing a back-up plan for when planned services may not be available. • Provide training and assistance to participants/ representatives on recruiting, hiring, training, managing, evaluating, and dismissing participant-directed workers. • Assist the participant in obtaining services included in spending plan. • Instruct and assist participant in problem solving, decision-making, and recognizing and reporting critical events. • Coordinate activity among support entities, participants/representatives, and state program. • Help participant make changes to spending plan as needed.	• Provide information to assist the participant in monitoring expenditures under his/her spending plan. • Provide the participant with information to support revising his/her spending plan. • Establish the participant (or participant's representative) as an employer with Federal, State and Local tax agencies. • Procure workers' compensation insurance coverage for participant's employees. • Provide and review employee paperwork for new hires. Perform background checks on workers, as requested. • Process payroll for directly hired workers in accordance with federal, state, and local tax, labor, and workers' compensation laws for domestic service employees. • Process and make all payments for goods and services in accordance with rules, regulations and participant's spending plan. • Issue easily understood reports of budget balances to participants/ representatives and counselors periodically and upon request. • Issue programmatic and financial reports to government program agency periodically and upon request.

"FMS and counseling are both supports intended to help participants maximize their program benefits, but each plays a different and complementary role. While FMS focuses on administrative and "back-office" support related primarily to service payments, employment compliance and fiscal accountability, counseling focuses on empowering participants with the skills to successfully manage their budgets and workers to meet individual support needs."

Models of Financial Management Services

FMS are provided in participant direction programs using one of three primary models. (See Table 3).

- **Fiscal/Employer Agent (F/EA)** — In the F/EA model, the participant or his/her representative is the common law employer of workers hired, trained, and managed by the participant or representative.[11] The F/EA serves as the employer's agent under a specific section of the Internal Revenue Code[12] and takes on joint federal tax liability with the employer. The F/EA pays workers and vendors on the participant's behalf and manages all federal, state, and local employer tax responsibilities, including withholding, filing, and paying those taxes. Two models of F/EA exist: Government Fiscal/Employer Agent and Vendor Fiscal/Employer Agent. The F/EA model generally affords the participant ample authority with his or her workers, services, and supports.
- **Agency with Choice** — This is a co-employment model of service delivery.[13] In this model, an agency is the primary employer of workers who provide service to the participant. The program participant or representative serves as the "managing employer" of workers and refers workers to the agency for hire, participates in worker training, may have a role in setting the worker's schedule and supervising the worker's activities, and can stop receiving services from the worker by notifying the agency that the participant no longer wishes for the worker to visit. As the primary employer, the agency performs all human resource, payroll, and insurance duties. In the Agency with Choice model, the participant may not exercise the level of management control over his or her workers that he or she can with the F/EA model because ultimately the Agency is the employer of the worker.
- **Fiscal Conduit** — With a Fiscal Conduit model, a government entity or vendor disburses public funds via cash or vouchers to participants or representatives. If the participant chooses to directly hire workers and serve as a common law employer, the participant is responsible for managing all payroll-related duties, including paying wages, tax withholding, calculating, depositing, and filing and for doing so in compliance with Federal, State, and Local tax, wage, and hour rules and regulations. In some Fiscal Conduit models, a vendor or government agency may periodically review participants' records to ensure workers are being paid in compliance with rules and regulations and that taxes and insurances are properly paid and managed.[14] In this model, a participant has ample choice and control over services, including hiring, managing, and discharging workers. However, this model also puts the most administrative burden on participants and requires that participants maintain compliance with federal, state, and local employment regulations themselves.

Table 3 below presents important components of each model.*

TABLE 3 Models of Financial Management Services

	Fiscal/Employer Agent	Agency with Choice	Fiscal Conduit
Employer of Workers	Participant	Co-employment shared between Agency and Participant	Participant
Payroll Duties Performed By	Fiscal/Employer Agent	Agency	Participant
Compliance with Employment Rules Maintained By	Fiscal/Employer Agent	Agency	Participant
Sets Worker Rate of Pay	Participant	Agency (participant may have input)	Participant
Sets Worker Schedule	Participant	Agency (participant may have input)	Participant
Pays Nonemployee Goods/Services Providers	Fiscal/Employer Agent or Participant**	Agency or Participant***	Participant

* Individual programs may customize the roles performed by FMS providers and participants. For example, even with a Fiscal/Employer Agent model, the program may not allow the participant to set the rate of pay for a worker or may have a range within which a rate of pay can be set. This chart is a general guideline.

** The Fiscal/Employer Agent can pay nonemployee providers of goods and services or the participant may use a debit card or cash for these purchases

*** The Agency with Choice can pay nonemployee providers of goods and services or the participant may use a debit card or cash for these purchases.

Section 3210.b(A) of the CLASS Act calls upon states to assess their existing infrastructure related to entities that can serve as fiscal agents in the CLASS Plan. See appendix for information on models of Financial Management Services by state.

Cost of Financial Management Services

In participant direction programs, FMS providers may charge for their services via a variety of methods. The most common is the "per member, per month" (PMPM) approach, where the FMS charges a fixed fee for each participant every month regardless of work the FMS does for an individual participant.

Other models exist, but for purposes of comparison, this paper examines costs using the PMPM method. The cost of FMS ranges from approximately $40 PMPM to upwards of $175 PMPM. Based on preliminary data, the average cost is $95 PMPM.[8] Many factors influence the cost of FMS (see Table 4 below).

Fiscal/Employer Agent and Agency with Choice models tend to have similar costs, while the Fiscal Conduit model is generally less expensive because the provider performs much fewer and less complex services. Due to significant fixed costs, generally the more participants an FMS provider serves, the lower the cost per participant.

TABLE 4 Factors Influencing the Cost of FMS

Factors Influencing the Cost of FMS
Model of FMS: F/EA, Agency with Choice or Fiscal Conduit *Responsibilities of the FMS provider in the Fiscal Conduit model are generally fewer than with F/EA or Agency with Choice, so costs for this model are usually lower.*
Volume and type of Customer Service provided by FMS
Volume of participants served *Economies of scale are an important cost determinant in FMS.*
Complexity of payment rules that FMS must enforce
Working capital requirements *Does the FMS use its own funds to pay participants' workers and vendors prior to being reimbursed by the program?*
Data exchange requirements and reporting requirements
Requirements for FMS provider to have a physical presence in the planned service area(s)

Procuring Financial Management Services

In participant direction, program administration agencies have overwhelmingly taken the approach of procuring FMS services for participants, rather than having participants procure the services themselves.[2] Program administration agencies generally enter into a contract or provider agreement with one or many FMS providers that provide services to participants enrolled in the program. The agencies monitor the services, and if quality falters, may develop corrective action plans with providers or terminate the contract. Participant direction programs have generally provided FMS program-by-program, with each program administration agency going through its own procurement process, entering into its own agreement with the provider, and monitoring the quality of FMS separately from other programs or program administration agencies. This means that each program has incurred the procurement and monitoring costs individually. Programs most often procure services using Request for Proposal, Invitation to Bid, or Request for Qualifications processes, with most procurement processes lasting at least several months.

Considerations for CLASS Plan Design and Implementation

A Financial Management Services function has been employed in most participant direction programs to:

- Support participants, while assuring compliance with tax and labor laws, especially because public funds are used to employ workers.
- Ensure fiscal accountability and collection of participant expenditure data.

Like participant direction program designers, CLASS Plan designers may determine that utilizing professional FMS providers is an efficient method of ensuring workers who provide services to participants are paid in compliance with federal, state, and local tax and labor law, while balancing the administrative burden placed on participants.

CLASS Plan designers must balance the benefits of making FMS available to or required for program participants with the expense to procure and provide such services, while ensuring quality of those services. Unlike participant direction programs, CLASS will serve a national population in a single program. The cost of administration of CLASS cannot exceed 3% of all premiums paid during the year.[15] CLASS Plan designers may consider the following approach to providing FMS to maintain tax and labor compliance, while supporting a quality, cost-effective provision of services.

Third Party FMS Certification and Beneficiary Choice of Provider

Using an FMS procurement process like those used in participant direction is likely not efficient or cost-effective for the CLASS Plan. CLASS Plan designers may consider using a "Certified Provider" approach to providing FMS.

The CLASS Plan administration agency may develop or contract with a third party FMS certification entity. This entity would be responsible for developing a set of FMS provider certification standards. Based on the model of FMS, these would include, at minimum, standards for compliance with applicable tax and labor law, data security, reporting, and customer service. FMS providers interested in becoming CLASS-certified would pay a certification review fee to the FMS certification agency to initiate a review. The fee should be developed to cover the cost of certification and ongoing administration of the certification agency. Those FMS providers that are deemed by the entity to be "CLASS-Certified" would then be available for CLASS beneficiaries to choose to provide FMS. On some periodicity (e.g., every two years), FMS providers would be required to be re-certified to continue providing services through the CLASS Plan. FMS providers would pay a re-certification fee to the FMS certification entity and a re-certification would be performed. For those entities that do not pass a re-certification, CLASS beneficiaries using that entity would have some time period to use that provider while they choose a new provider and before the uncertified provider services are terminated. Certain providers may choose to serve certain geographic areas, while others may operate nationally. Participants could choose any FMS provider that serves their geographic area. FMS providers would have to pass certification for state and local requirements for any geographic area in which they will provide services.

Unlike participant direction program approaches to procuring and monitoring FMS, this approach transfers the expense of those important functions from the program administration agency to the FMS providers themselves. CLASS Plan designers must determine, however, if FMS (at least to pay beneficiaries' employees) will be a program requirement or option (e.g., if a beneficiary directly hires a worker, the beneficiary must use the services of an FMS). Additionally, program designers must determine if FMS providers would be paid for their services out of beneficiaries' CLASS benefits or via CLASS administration funds.

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APPENDIX Models of Financial Management Services by State

The information presented below has been collected as part of an ongoing effort of the National Resource Center for Participant-Directed Services (NRCPDS) at Boston College to assemble information about participant direction programs.[8] NRCPDS has collected and continues to amass extensive data on participant direction programs throughout the United States.

The data presented in this appendix is that collected by NRCPDS through February 28, 2011. This data may not represent every participant-directed program in the U.S. NRCPDS continues to collect additional, and refine existing, data.

In the table below, "State" refers to the U.S. state of which participants in the program are residents. "Programs" are generally designated by a distinct funding source and/or population served. In order to be included in this data, the program must offer participants an option to individually manage and direct their own services. Two distinct authorities have been identified by which to manage services: 1) employer authority (a participant has the ability to select/hire and manage individual workers); and 2) budget authority (a participant has the ability to purchase permissible goods and services through the use of an individual budget). A program having either or both authorities is considered participant-directed for the purposes of this data. "Individuals Participant Directing in State" is the sum of individuals in the state who choose a participant direction option. "Model(s) of FMS in State" are those models of Financial Management Services currently being utilized in one or more programs in the state. Some programs may use just one model even if multiple models are active in the state.

State	No. of Programs in State with Participant Direction	Individuals Participant Directing in State	Model (s) of FMS in State
Alabama	4	89	• Vendor Fiscal/Employer Agent
Alaska	1	3,688	• Agency with Choice
Arizona	2	2,140	• Government Fiscal/Employer Agent using a Vendor Sub-Agent • Agency with Choice
Arkansas	4	4,928	• Vendor Fiscal/Employer Agent
California	1	480,000	• Public Authority operating as Statutory Employer
Colorado	6	19,550	• Agency with Choice
Connecticut	8	2,429	• Vendor Fiscal/Employer Agent • Agency with Choice
Delaware	1	35	• Agency with Choice moving to Vendor Fiscal/Employer Agent
District of Columbia	1	1	• Vendor Fiscal/Employer Agent
Florida	8	1,984	• Government Fiscal/Employer Agent using a Vendor Sub-Agent • Billing Agent

Georgia	7	2,849	• Vendor Fiscal/Employer Agent • Agency with Choice • Billing Agent
Hawaii	2	2,271	• Vendor Fiscal/Employer Agent • Agency with Choice
Idaho	4	1,178	• Vendor Fiscal/Employer Agent • Agency with Choice
Illinois	7	8,327	• Vendor Fiscal/Employer Agent
Indiana	3	905	• Vendor Fiscal/Employer Agent • Agency with Choice
Iowa	6	3,095	• Vendor Fiscal/Employer Agent
Kansas	7	3,416	• Vendor Fiscal/Employer Agent • Agency with Choice
Kentucky	3	4,332	• Vendor Fiscal/Employer Agent • Government Fiscal/Employer Agent (performed by quasi-governmental agencies)
Louisiana	6	2,235	• Vendor Fiscal/Employer Agent • Agency with Choice
Maine	8	930	• Vendor Fiscal/Employer Agent • Agency with Choice
Maryland	5	7,175	• Vendor Fiscal/Employer Agent • Agency with Choice
Massachusetts	6	19,460	• Vendor Fiscal/Employer Agent using a Reporting Agent • Vendor Fiscal/Employer Agent • Agency with Choice
Michigan	4	9,355	• Vendor Fiscal/Employer Agent • Agency with Choice
Minnesota	10	5,736	• Vendor Fiscal/Employer Agent • Agency with Choice • Fiscal Conduit
Mississippi	2	3,750	• Agency with Choice
Missouri	5	15,270	• Vendor Fiscal/Employer Agent
Montana	4	4,832	• Agency with Choice
Nebraska	3	2,346	• Government Fiscal/Employer Agent
Nevada	4	1,238	• Vendor Fiscal/Employer Agent • Government Fiscal/Employer Agent • Agency with Choice
New Hampshire	4	1,770	• Agency with Choice
New Jersey	6	2,587	• Vendor Fiscal/Employer Agent

New Mexico	2	4,400	• Vendor Fiscal/Employer Agent • Stipend Program without FMS
New York	3	10,252	• Agency with Choice
North Carolina	3	70	• Vendor Fiscal/Employer Agent (new program currently under development) • Agency with Choice
North Dakota	3	432	• Vendor Fiscal/Employer Agent
Ohio	5	1,082	• Vendor Fiscal/Employer Agent • Vendor Fiscal/Employer Agent using a Reporting Agent • Agency with Choice
Oklahoma	4	953	• Vendor Fiscal/Employer Agent • Government Fiscal/Employer Agent using a Sub-Agent • Agency with Choice
Oregon	10	23,512	• Public Authority operating as Statutory Employer • Fiscal Conduit
Pennsylvania	5	19,157	• Vendor Fiscal/Employer Agent • Government Fiscal/Employer Agent using a Sub-Agent • Agency with Choice
Rhode Island	3	1,642	• Vendor Fiscal/Employer Agent • Agency with Choice
South Carolina	5	1,786	• Vendor Fiscal/Employer Agent • Government Fiscal/Employer Agent
South Dakota	2	1,036	• Agency with Choice
Tennessee	2	1,186	• Vendor Fiscal/Employer Agent
Texas	15	7,964	• Vendor Fiscal/Employer Agent • Agency with Choice
Utah	4	2,875	• Vendor Fiscal/Employer Agent
Vermont	5	4,310	• Government Statutory Employer with Reporting Agent
Virginia	6	7,809	• Vendor Fiscal/Employer Agent
Washington	6	22,585	• Government Statutory Employer with Vendor Payment Agent(s)
West Virginia	2	690	• Government Fiscal/Employer Agent with Sub-Agent • Stipend Program
Wisconsin	5	9,563	• Vendor Fiscal/Employer Agent • Agency with Choice
Wyoming	2	506	• Vendor Fiscal/Employer Agent
Totals	**233**	**739,488**	

CLASS Technical Assistance Brief Series

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Options for Getting Purchasing Power into the Hands of Participants: Lessons from Participant Direction Programs

By Mollie G. Murphy, Lori Simon-Rusinowitz, Dawn Loughlin, Kevin J. Mahoney, and Isaac Selkow

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief describes the use of cash, debit cards and third party payers in various participant-directed programs and suggests how these findings can inform the design and implementation of the CLASS Plan.

Introduction and an Overview of Participant Direction

Individuals receiving benefits through the CLASS Plan will have a Life Independence Account, which will hold their authorized monthly benefit amount. This account can be accessed by the individual to purchase non-medical goods and services that support the person's independence at home or in another community-based residential setting. While specific rules and regulations have not determined how beneficiaries will access their Life Independence Account, the law states that they will have the option to use a debit card connected to their Life Independence Account.[1]

Parallels exist between the CLASS Plan and participant-directed home and community-based services offered to public program beneficiaries under the Cash and Counseling budget authority system.[i] Participant direction (also called self direction or consumer direction) empowers public program participants and their families by expanding their degree of choice and control over the long-term services and supports that they need to live at home. Participant direction programs have a rich history of program participants utilizing an authorized benefit amount to hire personal care assistants and select and purchase goods and non-employee services. These programs have grappled with identifying the best methods to support such purchases, including providing program participants with cash, issuing payments through a neutral third party, and providing a debit card for purchases. While these mechanisms tend to be used with low-income populations, the instruction is transferable beyond this demographic, including to the one served by CLASS. Experiences with payment mechanisms from public participant-directed programs can help inform implementation of CLASS.

[i] For additional information, see The SCAN Foundation's CLASS Technical Assistance Series Brief #8: ("How did Cash and Counseling Participants Spend Their Budgets, and Why Does That Matter for CLASS?").

Cash: The Cash and Counseling Experience

"The 2006 evaluation of the ICP found high satisfaction levels across participants, caregivers, and case managers, including improved quality of life and increased health and wellness for participants. Participants did report difficulty with the tax and recordkeeping requirements and the evaluation recommendations reported that many participants would prefer not to be responsible for those requirements."

Cash and Counseling is one of the most flexible existing models of participant-direction, and offers participants budget authority with an individualized budget comparable in amount to what the individual would otherwise receive through state Medicaid services. Program participants develop a spending plan for administering the budget, and can use it to hire workers to provide personal assistance and/or to purchase other non-employee goods and services. This model was tested in three state Medicaid programs (Arkansas, Florida, and New Jersey) in the Cash and Counseling Demonstration and Evaluation (CCDE).[2]

During development of the Cash and Counseling program and throughout the program's pilot period, program designers sought to structure the program to provide meaningful choice and control to program participants, ensure service quality, provide program participants with ample support to maximize the program benefit, and monitor use of funds to avoid fraud and abuse. Early research on program participant preferences shaped the initial and ongoing development of the program. University of Maryland Center on Aging researchers conducted a three-part "preference study," and findings showed that 43% of prospective participants across age and disability levels wanted increased control over and choice of services that a "cashed out" benefit might offer.[3] "Cashed out" refers to converting a public program participant's need-based service authorization from a number of units of a particular type of care to the actual dollar value of those units. The participant can then determine, within parameters, how that dollar value is used to support the participant's independence.

When prospective program participants were asked if they wanted help or training with key fiscal and employer tasks, including issuing payments, managing worker payroll, deciding worker pay, and performing worker background checks, the vast majority of participants (76%) across all age and disability groups wanted assistance.[3] Once the program was operational and participants had to decide if they wanted the support of a Financial Management Services (FMS) provider, over 95% chose to use the FMS provider.[4]

To aid Cash and Counseling demonstration participants in using a cash benefit and assure that they were equipped to manage the requisite responsibilities, program designers offered two options: 1) neutral, third party, professional FMS, or 2) a training curriculum and readiness test for individuals who wanted to manage their own cash benefit. In concept, those interested in managing their cashed–out benefit would complete a user-friendly curriculum and take an open book "test" to show that they were prepared to maintain compliance with labor laws and appropriately manage tax requirements. If participants passed, they would proceed to manage their cashed out program benefit.[6] This approach yielded unintended results in that participants overwhelmingly chose the third party FMS and very few took the readiness test.[4] Ultimately, participants almost

never handled cash advanced from their individual budgets, yet participants maintained choice of and control over their services. As there were so few people interested in managing their own cash benefit, states discontinued the first option. The curriculum originally designed for participants was adapted for organizations interested in providing third party FMS for the programs.

"Of the 19,000 program participants in 2010, less than 1% chose to perform the payroll and employer administrative responsibilities themselves."

The Oregon Independent Choices program (ICP), which started as a Robert Wood Johnson Foundation supported pilot program under a Medicaid 1115 waiver, pays the entirety of the cash allowance benefit directly to enrolled participants. The ICP cash payments are electronically direct-deposited into program participants' own dedicated bank accounts, which are solely for ICP funds. Every six months each participant's case manager conducts a financial review separate from the regularly scheduled, annual needs assessment/reassessment. The case manager asks to see receipts, check registers for evidence of worker paychecks, and documentation that applicable payroll taxes were filed. Program participants may handle all of their own financial transactions, including paying applicable taxes for workers or they can access their cash benefits to pay for private accounting or tax preparation services. The 2006 evaluation of the ICP found high satisfaction levels across participants, caregivers, and case managers, including improved quality of life and increased health and wellness for participants. Participants did report difficulty with the tax and recordkeeping requirements and the evaluation recommendations reported that many participants would prefer not to be responsible for those requirements.[5]

In Massachusetts, the Executive Office of Elder Affairs administers a participant-directed Personal Care Attendant program for Medicaid state plan eligible elders to directly hire their own attendants. Operational for over a decade, this program offers program participants the option of using the services of an FMS to support payroll processing and employer administrative responsibilities or performing such responsibilities themselves. Those participants that choose to manage administrative responsibilities themselves must provide records for review quarterly. Of the 19,000 program participants in 2010, less than 1% chose to perform the payroll and employer administrative responsibilities themselves.[7]

Participant Use of the Individual Budget

Over 5,500 elderly and adult Medicaid individuals in Arkansas, Florida and New Jersey participated in the Cash and Counseling Demonstration and Evaluation (CCDE). Findings suggest that program participants place great value on having flexibility in the purchases they make with their individual budgets.[8] While hiring employees to provide personal assistance services is a common use of budget funds, equipment, goods, and non-employee services are also purchased to both substitute and complement human assistance. In the CCDE, about 25% of participants' budgets were used to purchase non-employee goods and services.[2]

"While hiring employees to provide personal assistance services is a common use of budget funds, equipment, goods, and non-employee services are also purchased to both substitute and complement human assistance."

Participants report getting more for their money when they have control of how their budget is allocated. This is often achieved by comparison shopping and buying used goods. Participants have reported a desire to purchase goods they have found on the internet. Internet shopping facilitates efficient cost comparisons even across geographical areas, while allowing individuals to shop without leaving their homes.[9, ii]

Purchase of Goods and Services under Exceptional Circumstances

While the establishment of parameters of allowed goods and services in a participant direction program is valuable for efficiency, fraud prevention, and clarity, in some cases exceptions can be cost efficient and beneficial for participant quality of life. Unconventional goods have proven to be highly effective purchases under certain circumstances. For example, one individual with intellectual disabilities benefited from being outside at home, but was not safe from wandering into the street near his house. Rather than purchase more Personal Care Attendant time to watch the individual outside, the individual and his circle of support elected to utilize his budget to install a fence around the yard, thereby allowing outdoor activity and minimizing the risk of the individual wandering into the street. This purchase was only possible due to the program's adaptability on a case-by-case basis. Home improvements of this nature are generally not permitted in the program; however, by allowing an exception in this instance it proved to be life-changing and cost effective.[10]

Financial Management Services: Processes, Successes, and Limitations

In participant-directed programs, an FMS is almost always used to support financial accountability of participants' budget use and to aid in employment and payment issues, including hiring workers and payroll.[iii] FMS providers are responsible for monitoring participants' budgets to ensure that only approved items are paid for and in the amount approved. The FMS provider may perform a variety of administrative tasks to allow the participant to focus on his or her services and supports, while assuring compliance with recordkeeping, tax, and employment rules and regulations.

The use of FMS impacts the process used by participants to procure non-employee goods and services in participant-directed programs. The procedure most often carried out is a Requisition Process, outlined below:

[ii] For additional information, see The SCAN Foundation's CLASS Technical Assistance Series Brief #8: ("How did Cash and Counseling Participants Spend Their Budgets, and Why Does That Matter for CLASS?").

[iii] For additional information, see The SCAN Foundation's CLASS Technical Assistance Series Brief #10: ("Financial Management Services in Participant Direction Programs").

Requisition Process

1. Good or service is listed in participant's approved spending plan
2. Participant identifies desired good or service, including location from which to procure good or service
3. Participant submits a request to FMS to purchase desired, identified good or service
4. FMS verifies that participant's spending plan approves the good or service and that the budget includes sufficient funds to cover it
5. FMS issues check to seller of good or service
    a. FMS may mail check to participant and participant takes check to seller to pay for and obtain good or service
    b. FMS may mail check to seller of good or service directly

While the Requisition Process has worked well for many participant goods and services purchases, it is decidedly limited. One of the most prevalent issues with this process is retailers' inability to accept a check from a third party.[11] This is a routine occurrence when participants identify goods at large, corporate retailers, such as Wal-Mart©, The Home Depot© and Walgreens©. For participants in some geographic areas, such "Big Box" stores are the only non-internet or mail order options for buying certain goods. Additionally, prohibition of purchase from certain stores constrains participants' ability to effectively comparison shop.

Another frequently reported issue with the Requisition Process is that it generally prohibits participants from making internet purchases. A participant may find a great price on bulk incontinence supplies on eBay©, but eBay© cannot be paid by check from the FMS provider. This example suggests another issue with the Requisition Process: on-demand purchases (purchases that require fast access to funds) generally cannot be made. The time required for the participant to request the funds from the FMS and the FMS to verify that the request should be fulfilled and then write and mail the check can be prohibitive. In the eBay© example, after the time has passed to accommodate the Requisition Process, the bargain price on bulk products such as Depends© may not be available. Transportation issues are especially detrimental under the Requisition Process because transportation is regularly required without much notice, or provided in such a way that it is difficult to predict the final cost and request a check in an amount to cover that cost in advance (e.g., taxi fare).

In the CCDE, 10% of the budget in Arkansas and New Jersey and up to 20% in Florida could be used by the participant for on-demand expenses and would be reimbursed via the Reimbursement Process.[12] Nine months into the program, between 32% and 59% of participants reported making an on-demand purchase in the previous month.[2]

Cash disbursements to program participants to make purchases are less frequent. This is largely due to Medicaid

rules for most waivers prohibiting cash disbursement and, in non-Medicaid programs, general policy concerns about monitoring participant purchases when advancements of cash occur. When cash is used, it most often takes the form of a participant being reimbursed. This is called the Reimbursement Process, and is outlined below.

Reimbursement Process

1. Good or service is listed in participant's approved spending plan
2. Participant identifies desired good or service, including location from which to procure it
3. Participant uses own money to purchase good or service
4. Participant submits receipt for good or service to FMS for reimbursement
5. FMS verifies that participant's spending plan approves such good or service and that budget includes sufficient funds to cover it.
6. FMS issues check to participant as reimbursement

The Reimbursement Process is nearly as imperfect as the Requisition Process. First, it relies on the participant having the money to purchase the good or service, and to be able to be without that money until the FMS provides reimbursement. For many program participants, this is impossible because their financial resources are such that they do not have funds to purchase items and wait for reimbursement. Second, the participant is at risk of making the purchase and not being reimbursed; since the purchase may be made without the FMS verifying that funds exist in the participant's budget to cover the good or service, if funds do not exist to cover the good or service, the participant will not be reimbursed.

Debit Cards and Participant Direction

Program administrators hypothesize that many of the challenges described above could be alleviated by a properly implemented debit card arrangement. Over the past 5 years, in an effort to reduce these complications, participant direction programs have explored the use of debit cards for participant goods and services purchases.

In Kent County, England's "Direct Payments" program (a program similar to the Cash and Counseling program, but providing less support to participants for financial management and less oversight on how funds are used), a debit card procedure has been implemented called The Kent Card.[13] With The Kent Card, participants' monthly benefit amounts (in part or in whole) are directly loaded onto a Visa debit card. Kent County provides a list of home care agency and non-medical goods and services vendors that are capable of processing program payments with The Kent Card. Program participants, however, are not limited to using those vendors but rather can use any vendor that can process Visa card payments. The Kent Card has been adopted enthusiastically by Direct Payments program participants. One

"With The Kent Card, participants' monthly benefit amounts (in part or in whole) are directly loaded onto a Visa debit card. Kent County provides a list of home care agency and non-medical goods and services vendors that are capable of processing program payments with The Kent Card."

important design feature of The Kent Card approach is that it does not have any proactive controls to manage purchases made. That is, The Kent Card can be used anywhere Visa is accepted, and the card does not prevent any types of purchases (e.g., those at liquor stores, casinos). Kent Card users must track their expenditures and make them available for program administrator review with presumably a penalty for improper expenditures. The key point, however, is that improper expenditures are not *prevented* by The Kent Card.

"'Transition funds' can be loaded to a debit card to be used for security deposits, utility connections, and household items. The debit card is never permitted to be used by the program participant, but rather is used by his or her care manager at the program participant's direction."

Debit cards have also been used in Illinois' Division of Mental Health Permanent Supportive Housing Bridge Subsidy Initiative, a program that supports individuals to establish decent, safe, and affordable permanent rental housing of their choice in the community. In this program, "transition funds" can be loaded to a debit card to be used for security deposits, utility connections, and household items. The debit card is never permitted to be used by the program participant, but rather is used by his or her care manager at the program participant's direction. Prior to using the debit card, a requisition must be submitted (see the above description of the Requisition Process) to the program administrator for approval. Following purchase with the debit card, the care manager must submit the receipt to the program administrator. Like Kent County, system controls do not exist on the debit card to prevent improper use of the card at the point of sale, and the process to monitor what is purchased with the card is through administrative review.

Given these challenges above, debit card use has not gained meaningful acceptance in participant direction programs.[14] However, significant interest in using debit cards remains; participant direction programs across the nation have explored using debit cards, but ultimately few have implemented them. At a 2009 conference on FMS in participant direction, a session on debit cards was one of the most highly attended of the conference. In the Veteran-Directed Home and Community Based Services program, a program for veterans modeled after Cash and Counseling, sites must pass a "Readiness Review" prior to serving veterans. Most sites report an interest in using debit cards for veteran non-medical purchases, but lack information on how to implement a debit card structure with requisite controls on allowed purchases.[15]

Considerations for CLASS Plan Design and Implementation

In developing the CLASS program, mechanisms used in participant direction programs can inform the use of debit cards, cash, and third party payers to maximize benefits while minimizing drawbacks. We recommend that program designers consider the following:

- Allow beneficiaries to access limited cash from their Life Independence Account using a debit card and an ATM machine.
  - The debit card could be programmed to prohibit a withdrawal of more than the standard allowed amount per month.

- Participants could use cash for on-demand and incidental purchases and be required to keep receipts, but to minimize administrative burden, receipts would not be submitted to an FMS provider. In the case of an audit, a beneficiary may be asked to make receipts for cash purchases available for review.

- Develop an infrastructure similar to that used with Flexible Spending Accounts (FSA) for debit card use.[iv]
  - Beneficiaries could access their Life Independence Account at the Point of Sale using their debit cards.
  - At the Point of Sale, the card issuer will receive an authorization request and will compare the request to the Merchant Category Code to substantiate that the items purchased contain a code permitted for purchase in the CLASS program. Any items requested for purchase that do not hold a Merchant Category Code approved for purchase in CLASS will be denied at the point of sale.
- An FMS provider manages the participant's total spending plan and makes the majority of payments to employees.
  - An FMS provider ensures that the participant's spending plan, including that planned to be purchased by debit card, through an FMS payment or through some other payment mechanism, is adhered to.[v]
  - An FMS provider makes all payments to beneficiaries' employees to ensure that labor laws are adhered to, and to manage all payroll, tax and insurance withholding, filing and payment requirements on beneficiaries' behalves.
- Using either a Requisition Process or Reimbursement Process, an FMS provider substantiates purchases and makes payments for purchases made from sellers without a debit card capacity.
- Using either a Requisition Process or a Reimbursement Process, an FMS provider substantiates purchases and makes payments for those items that would be denied per their Merchant Category Code because the item is an unusual purchase (e.g., a fence around the yard allows the person to stay at home because it prevents him or her from wandering into the street).
  - These purchases may be denied at the point of sale with a CLASS debit card, but could be made with prior approval through the FMS provider. The FMS provider would purchase the item on the participant's behalf using his or her Life Independence Account funds, or the FMS provider would issue a check for the good or service payable to the seller, or the FMS provider would reimburse the beneficiary for the purchase.

[iv] For additional information, see The SCAN Foundation's CLASS Technical Assistance Series Brief #9: ("Debit Card Fundamentals and Their Use in Government Programs").

[v] For additional information, see The SCAN Foundation's CLASS Technical Assistance Series Brief #10: ("Financial Management Services in Participant Direction Programs").

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CLASS Technical Assistance Brief Series

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Considerations for Debit Card and Cash Purchasing Mechanisms in the CLASS Plan

By Mollie G. Murphy, Cathy Corby Parker, Isaac Selkow, and Kevin J. Mahoney

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief describes the benefits and challenges of using debit cards and cash in CLASS and how they could be implemented and integrated into a Financial Management Services structure.

Introduction

Individuals receiving benefits through the CLASS Plan will have a Life Independence Account that will hold their authorized monthly benefit amount. This account can be accessed by the individual to purchase non-medical goods and services that support the person's independence at home or in another community-based residential setting. While specific rules and regulations have not decided how beneficiaries will have access to their Life Independence Account, the law states that they will have the option to use a debit card connected to their Life Independence Account.[1] Using lessons from participant direction programs, CLASS Plan administrators can consider how debit cards and cash may influence participant use of their benefit and program fiscal accountability.

Debit Cards in the CLASS Plan

Benefits of Debit Cards in the CLASS Plan

Using a debit card to access resources in a Life Independence Account could prove efficient and cost effective in the CLASS Plan. Some benefits of using debit cards for CLASS beneficiaries to purchase goods and services that increase their independence include:

- Unlike cash, with a properly implemented debit card infrastructure, beneficiaries could only purchase categories of items permitted in the CLASS Plan.
- Beneficiaries can make purchases on-demand; they need not submit a request to a third party and wait to receive payment from that third party to make the purchase. Participants carry their purchasing power with them in the form of a debit card that accesses their Life Independence Account.

"Unlike cash, with a properly implemented debit card infrastructure, beneficiaries could only purchase categories of items permitted in the CLASS Plan."

- Beneficiaries can purchase items online, from catalogs and from other sellers that may not accept cash or checks.
- Beneficiaries are prohibited from making a purchase with a third party check (such as from a Financial Management Service), returning the item and receiving cash, a possibly fraudulent scenario.
- Beneficiaries can make purchases from retailers that do not accept checks from third parties.

If strategically implemented, debit cards could drive efficiency in payment processing, increase beneficiary choice and control over services and supports, and improve internal controls both preventing and detecting improper use of public funds.

Challenges of Debit Cards in the CLASS Plan

Using debit cards in the CLASS Plan also presents some challenges, outlined below:

- Debit cards alone cannot be used to pay employees of beneficiaries, while properly withholding employee taxes and meeting employer requirements, such as filing and paying required taxes and insurances.[i]
- Debit cards are not accepted everywhere a beneficiary may wish to purchase goods and services (e.g., a private independent contractor may install a ramp in the beneficiary's home, but that contractor may only be payable by cash or check, not debit card).
- For beneficiaries to get the most of their debit card, they will require training on the use of the card in the program and will need access to ongoing customer service support. Potential support, as described below, would come at a cost:
  - Training on how to use the debit card and for what purchases it can be used;
  - Training on what to do if one's card is declined at the point of sale;
  - Understanding how to allocate one's spending plan across sources of purchasing power, including the debit card.
- Spending from different sources (debit cards, cash and through the FMS provider) must be communicated, managed, and coordinated with a single Life Independence Account. This puts an administrative burden on the beneficiary and the FMS provider.
- Debit cards could be stolen and misused. While controls are in place to prevent use of the card by someone other than the cardholder at the point of sale, they are not foolproof.

Implementation of Debit Cards in the CLASS Plan

A signature debit CLASS prepaid card would allow beneficiaries to make purchases in stores and online.[ii] Use of the CLASS cards could be limited to purchases within specific merchant categories. Permitted merchant categories should reflect those allowed supports outlined in Section 3205.c.1.B of the CLASS Act. As an alternative or

[i] For additional information, see The SCAN Foundation's CLASS Technical Assistance Series Brief #11: ("Options for Getting Purchasing Power into the Hands of Participants: Lessons from Participant Direction Programs").

[ii] For additional information, see The SCAN Foundation's CLASS Technical Assistance Series Brief #9: ("Debit Card Fundamentals and Their Use in Government Programs").

"If strategically implemented, debit cards could drive efficiency in payment processing, increase beneficiary choice and control over services and supports, and improve internal controls both preventing and detecting improper use of public funds."

supplement to permitting purchases by merchant category, the CLASS prepaid card could be used only for purchase of eligible items at major retailers. Retailer support would be required to extend the infrastructure retailers have established for approval of specific healthcare-related products for Flexible Spending Account (FSA) cards. Purchases outside of approved categories could be denied at the Point of Sale with a signature debit prepaid card.

If CLASS Plan designers determine that beneficiaries should access their Life Independence Accounts through ATMs to obtain cash for requisite purchases, the CLASS debit card could have a separate cash purse, or a companion card with a PIN for cash access.[iii] Prepaid debit cards can have multiple "purses" associated with a single card. For example, a prepaid debit card could have a general spending purse and a cash access purse. Any withdrawal or balance inquiry from an ATM would only consider the balance in the cash access purse. Purchase transactions would be authorized solely against the funds in the general spend purse. Each purse would have a separate balance. Prepaid debit cards can also have more than one card linked to a specific account. Two cards can both access the same pool of funds, or each card can have its own independent funds balance. The card owner can move funds between the primary and companion cards. Separate purses or companion cards would allow the FMS provider to limit the portion of monthly funds that is accessible in cash. To the extent that ATM usage is permitted, the cost structure for the card provider would change and nominal fees may be required.

Integration of Debit Cards with a Financial Management Services Provider Structure

Financial Management Services (FMS) providers may be used in the CLASS Plan to manage overall spending in beneficiaries' Life Independence Accounts and to support beneficiaries when they directly hire their own employees, thereby serving as employers.[iv] Beneficiary employers may designate payroll, tax withholding, payment and filing and other employer administrative tasks to FMS providers that will be the beneficiary employers' agents. Providers may also make payments on beneficiaries' behalves for goods and non-employee services purchases that cannot be made with a debit card (e.g., paying a small business contractor to install a ramp).

For FMS providers to ensure CLASS beneficiary total spending does not exceed the amount authorized in each Life Independence Account, the providers must manage and coordinate beneficiary spending across sources, including the debit card, payroll payments to beneficiaries' employees and other non-employee payments made on a beneficiary's behalf

[iii] For additional information, see The SCAN Foundation's CLASS Technical Assistance Series Brief #9: ("Debit Card Fundamentals and Their Use in Government Programs").

[iv] For additional information, see The SCAN Foundation's CLASS Technical Assistance Series Brief #11: ("Options for Getting Purchasing Power into the Hands of Participants: Lessons from Participant Direction Programs").

"If CLASS Plan designers determine that beneficiaries should access their Life Independence Accounts through ATMs to obtain cash for requisite purchases, the CLASS debit card could have a separate cash purse, or a companion card with a PIN for cash access."

(e.g., payments to vendors that cannot take debit cards). To ensure beneficiary spending does not exceed the Life Independence Account, the beneficiary must create a spending plan that authorizes fund amounts across spending mechanisms and the provider must then assure spending occurs as planned.

The funds on the CLASS card could be managed by an FMS provider and remain accessible to the beneficiary. This will support the month-to-month carry forward of benefits and reclamation of funds unspent during the Plan year. It will also allow the provider to review a beneficiary's purchase and transaction history without violating any privacy laws. Online access to view this information should be available to providers so that they can reconcile debit card spending with beneficiary total Life Independence Account spending, including paying employees of beneficiaries. Providers should provide real-time, online information to beneficiaries with their complete Life Independence Account balance information.

Cash in the CLASS Plan

Benefits of Cash in CLASS

Accessing cash from a Life Independence Account affords CLASS participants maximum flexibility and control over their CLASS resources. By allowing participants to obtain the full value of the CLASS benefit in cash, participants can purchase, on demand, those services and supports that they determine they need. Participants can determine the best mix of goods and services for themselves and are not restricted in any way from obtaining goods or services that they determine will support their independence. With cash, if a participant identifies that a certain purchase, even one that may seem unusual to a CLASS Plan administrator, would support their independence, nothing restricts the participant from making that purchase and thereby supporting their independence.

Second, allowing participants unrestricted control over their cash could reduce the oversight and administration required of the program. At least in the short run, this could reduce the total administrative cost of the CLASS Plan.

Challenges of Cash in the CLASS Plan

Full access to CLASS resources in cash does present certain complications. Some of these challenges are outlined below.

- Proactive controls on what CLASS participants can purchase do not exist with cash. While CLASS Plan rules may stipulate purchases that are not permitted, nothing restricts a CLASS Plan participant from using cash to purchase impermissible items (e.g., alcohol, gambling).
- Obtaining information about whether completed purchases are permissible is administratively burdensome. With cash purchases, to audit whether the benefit amount was used appropriately, CLASS participants may be required to save and submit receipts.
  - Some entity must audit those receipts. If it is determined that an unallowable purchase was made, it is unclear what recourse (and how expensive that

"With cash, if a participant identifies that a certain purchase, even one that may seem unusual to a CLASS Plan administrator, would support their independence, nothing restricts the participant from making that purchase and thereby supporting their independence."

recourse may be) the CLASS Plan has to obtain those misused funds from the participant.

- Obtaining information about how CLASS benefit funds are used, for purposes of evaluation or research purposes, is administratively burdensome.
  - Participants must provide reports on or receipts for purchases and that data must be aggregated for evaluation purposes.
  - Other purchasing mechanisms, such as FMS purchases and some debit card use, make obtaining retroactive purchase data significantly less administratively burdensome and costly.
- Permitting use of unrestricted cash access to the Life Independence Account may make it more difficult for program administrators to detect and prevent fraud. Without any proactive controls on how CLASS benefits are used, it may be easier for participants (or perhaps more likely, other individuals who are aware of the CLASS benefit) to misuse benefit funds.
- Cash is not an acceptable purchasing mechanism for all purchases. To make purchases online, usually a credit card or bank account from which electronic purchases can be made is required.
  - If cash is the only method for accessing CLASS benefits, participants may need to use their own credit or debit cards or checking accounts to make certain purchases.
- Paying workers who are employees of participants with cash is complex and potentially burdensome for CLASS participants. The vast majority of workers who are directly hired by participants will be considered employees of those participants by the Internal Revenue Service and Department of Labor.
  - Participants must ensure that employment taxes and insurances are appropriately calculated, withheld, paid, and filed to state and federal tax and insurance agencies.
  - Without additional support, maintaining compliance with employment regulations, especially for withholding, calculating and paying taxes and insurances, may be overly burdensome for certain CLASS participants and may lead to CLASS participants paying workers without being in compliance with relevant rules and regulations.
- The method by which participants obtain cash from their Life Independence Accounts can impact cost. If participants will withdraw cash from their Life Independence Accounts using a debit card and ATM, the cost of doing so must be recognized.[v]

Integration of Cash with a Financial Management Services Provider Infrastructure

If an FMS provider is used to make certain payments on a CLASS participant's behalf (e.g., paying directly hired workers and managing all tax and insurance calculation, withholding, payment and filing responsibilities) and participants have unrestricted access to their Life

[v] For additional information, see The SCAN Foundation's CLASS Technical Assistance Series Brief #9: ("Debit Card Fundamentals and Their Use in Government Programs").

Independence Accounts to obtain cash, coordination between the Financial Management Services provider and the participant will be required. In general, the participant will need to ensure that sufficient funds exist in the Life Independence Account for the FMS provider to pay the participant's directly hired workers and account for all employer tax and insurance costs. One approach to this collaboration may be for participants to dedicate a monthly portion of the Life Independence Account to paying directly hired workers and for that amount to be restricted from being withdrawn in cash until the month is over. That approach would ensure that the participant does not direct a worker to provide service, and simultaneously use all cash in the Life Independence Account before the worker is paid and corresponding taxes and insurances are paid.

Considerations for CLASS Plan Design and Implementation

Using debit cards for beneficiary goods and non-employee services purchases in the CLASS Plan could drive efficiency in payment processing, increase beneficiary choice and control over services and supports and improve internal controls, both preventing and detecting improper use of public funds. However, not all purchases a beneficiary might make could be made using a debit card, resulting in some administrative burden on the individual beneficiary and program administrator, such as a Financial Management Services provider. Additionally, when directly hired workers are used by a beneficiary, employment rules and regulations must be complied with, including those related to tax and labor laws. Regardless of the mechanism for receiving CLASS resources, debit cards or cash alone do not solve meeting requirements for tax withholding, deposits and filings or other requirements that must be met for tax and labor regulations.[vi]

To maximize the benefit of debit cards in conjunction with other CLASS Plan requirements, we recommend consideration of the following:

- Implement a prepaid debit card with Point of Sale controls similar to those used in Flexible Spending Accounts.
- If cash can be obtained from Life Independence Accounts by beneficiaries at ATMs, have a separate card purse or companion card that can only be used for obtaining cash.
- The funds on the CLASS card should be managed by a Financial Management Services provider but be accessible by the beneficiary to support the month-to-month carry forward of benefits and reclamation of funds unspent during the Plan year and to allow the Financial Management Service provider to manage overall spending, including spending for employee services or other purchases not made with a debit card.

[vi] For additional information, see The SCAN Foundation's CLASS Technical Assistance Series Brief #10: ("Financial Management Services in Participant Direction Programs").

- Recognize that for the efficiency of debit cards to be maximized, ample support and clear communication on using the debit card should be provided to beneficiaries.
- Recognize that for spending to occur from multiple sources (e.g., debit card purchases and payments from a Financial Management Service provider), administrative and communication burdens exist.

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CLASS Technical Assistance Brief Series

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The *Own Your Future* Long-Term Care Awareness Campaign: Implications for CLASS

By Eileen J. Tell

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief describes lessons learned from the *Own Your Future* Campaign in regard to the best means and messages to encourage long-term care planning and how this information may be useful for communications outreach for the CLASS Plan.

Introduction and Overview of the *Own Your Future* Campaign

While 70% of persons age 65 and over will need long-term care at some point in their lives,[1] most do not plan for this potentially devastating risk. Thus, the United States Department of Health and Human Services (DHHS) launched *Own Your Future*, a consumer awareness campaign designed to encourage Americans to take an active role in planning for long-term care needs. If individuals and families are more aware of this potential need, they are more likely to take steps to prepare for the future. From a public policy perspective, increased planning may increase private financing and may reduce the already excessive burden on public financing.

The Development Phase

An important element in launching a successful communications campaign on long-term care planning is the careful development and design of effective messages for the desired audience. To this end, a comprehensive research agenda was undertaken from 2000 to 2005 to explore why people do not plan, how to best motivate planning, and what factual information and motivational messages people need to feel that planning ahead for long-term care needs is both beneficial to them and feasible.[2]

The campaign used both qualitative and quantitative research methods to determine the best means and messages to encourage planning. Specifically, numerous focus groups, a comprehensive consumer survey, best practice interviews with leading experts in messaging on long-term care, as well as other social marketing topics, and a literature review were conducted in order to inform the best communication strategies and messages to help raise awareness of the need to plan and give consumers the "planning tools" they need.[3] The key component of the *Own Your Future* campaign—the Long-Term Care Planning Guide—was developed based on the research findings and was further fine-tuned through additional focus groups and one-on-one consumer testing.

Lessons Learned from the Development Phase

The research preceding implementation of *Own Your Future* indicated that many people are aware of the possible risks and costs of someday needing long-term care but are overwhelmed at the prospect of how to plan for that need. The research also showed that people's attitudes and knowledge about long-term care have changed dramatically over the last 25 years.[4] Misperceptions, such as the belief that "it won't happen to me" or that "Medicare or my health plan will pay for long-term care" still exist. But overall, awareness about the need to plan has improved.[4] Currently, people lack knowledge about how to plan or may not believe that planning is possible and beneficial. Like "end-of-life" planning, making preparations for a time when one might be functionally or cognitively dependent on others, is something people do not want to think about. Overcoming this denial by making people realize that planning is possible and beneficial was the campaign's first challenge and one that will apply to CLASS as well.

Awareness and education campaigns specific to long-term care are more challenging because they must overcome a natural resistance (in this case denial and discomfort) in order to get the target audience to adopt the behavior being promoted. Other such challenges include:

- **Denial.** People do not believe they may need long-term care and thus underestimate the risk of needing care.[3]
- **Difficulty comprehending the value of planning.** The benefits of planning ahead, such as greater peace of mind and financial and emotional independence, occur far in the future for most people and are difficult to quantify.[5]
- **Disbelief.** Some people may not believe planning can make a difference in an event that is already perceived as a negative[5]
- **Overestimating costs.** People who buy private long-term care insurance while they are still young and healthy can realize lower premiums. However, people consistently overestimate what they believe to be the costs of obtaining such coverage, even among those who have met with an agent or planner.
- **Misperception of financial risk.** Even if they do accept that they may need long-term care, some people mistakenly believe that Medicare, disability insurance, or their private health plan will pay for it.[6]

The consumer research conducted prior to *Own Your Future* provided a critical baseline to assess knowledge of long-term care, factors that would motivate planning, and barriers to planning. Specifically, the focus groups helped inform the most effective "language" of long-term care to use in reaching out to consumers. It highlighted consumers' concerns with "message overload," the importance of a government-sponsored campaign that is clearly identified as such, and the need to differentiate communications that are really meant to "sell" something as opposed to those meant to "educate."[2]

State activities used to reinforce core campaign messages included:

- television spots with introductory messages from the governors;
- distribution of materials through state and local senior organizations;
- a governor's press event;
- briefings for media, state legislators, and other state officials;
- educational activities for private employers;
- a state-specific component included in the kit to identify local resources for learning more about long-term care; and
- print and radio ads.[1]

The Implementation Phase

The campaign implementation phase was conducted in waves from 2005 through 2010, with a total of 24 states and the District of Columbia participating. Key elements in the campaign included an initial mailing from each state's governor and subsequent communication follow-up. Specifically, governors in participating states sent letters to all households with residents between the ages of 45 and 65 (and in some states up to age 70), raising awareness about long-term care risks and costs and encouraging residents to consider their future long-term care needs and order a free Long-Term Care Planning Guide. This mailing reached approximately 20 million households in 24 states and over 1.5 million recipients took the additional step of ordering the free Planning Guide.[2]

(Sample campaign materials can be found at: http://www.longtermcare.gov/LTC/Main_Site/Planning_LTC/Campaign/Kit/index.aspx)

Results of the Implementation Phase

Response rates ranged from 4% to over 20%, greatly exceeding typical direct mail campaign response rates. Factors believed to have influenced the response rates across states include the degree of additional state activity supporting the campaign, including the use of both paid media and public service announcements (PSAs), and the nature and degree of follow-up messages.[2]

Based on a post-Phase I survey, important differences were observed between individuals who requested the Long-Term Care Planning Guide ("responders") and those who did not ("non-responders"). As found in other studies, differences in attitudes are more important than demographics in differentiating those who ordered the Planning Guide and those who did not. Specifically, individuals with the following characteristics were more likely to order the Planning Guide:

- older (specifically, those ages 65 to 69 were most likely to respond);
- male;
- not married;
- greater education;
- retired;
- greater asset wealth;
- having other financial planning vehicles such as an IRA or annuity;
- knowing someone who has needed long-term care;
- a belief in the value of planning;
- a belief in the benefits of planning ahead;
- a belief that long-term care may someday be needed;
- concern about the burden on their family if they needed long-term care;
- concern about how or whether they will get the help they need if they need long-term care; and
- an unwillingness or inability to rely on family or friends to provide care.[5]

The post-campaign consumer survey found that individuals who received the Planning Guide were more likely to take some type of long-term care planning action after the campaign than those who did not.[5] Specifically, they were more likely to:

- review their existing coverage to learn the facts about how it does not cover them for long-term care needs;
- look into a reverse mortgage;
- talk to an agent or financial planner about their future long-term care needs; or
- buy long-term care insurance.

Based on an analysis that took into account multiple variables but also controlled for variables that are related to one another, we are able to identify factors important in motivating individuals to order the Planning Guide in the first place:[2]

- a variable constructed to measure one's "attitudes toward planning" (see Table);
- a variable constructed to measure the "level of campaign exposure" (see Table);
- a belief that someday one may need long-term care;
- age;
- being male;
- being unmarried;
- having a college degree or higher; and
- having taken some action as a result of something they "read, heard, or saw" about long-term care in the media.

But not everyone who received the Planning Guide took some type of long-term care planning action (see Figure). In order to identify the key factors important in moving an individual to the point of doing something to plan ahead for future long-term care needs, another multi-variable analysis was conducted. Significant factors that predict the likelihood of taking some type of long-term care planning action include:[2]

- score on the "attitudes toward planning scale;"
- score on the "level of campaign exposure scale;"
- being between ages 65 and 69;
- being male; and
- having recently "read, heard, or seen" something about long-term care in the media.

These analyses show that attitudes toward planning, campaign exposure, and acknowledgement of the risk of needing long-term care are important factors compelling individuals to learn more about how they can plan ahead. With respect to undertaking planning, exposure to campaign messages is important. This suggests that multiple messages, not just receiving the governor's letter or ordering the kit, are important to compel action. Also, once again a "planning orientation" or a belief that planning is both feasible and leads to more favorable outcomes is a critical variable.

While long-term care is often thought of as a "women's issue," it is surprising to note that women (and married couples) were actually less likely, all else being equal, to order the planning guide. The following are possible reasons:

- They may already be further along with planning on their own and do not feel a need for the guide. Indeed, women and married couples are more likely purchasers of long-term care insurance.
- Women may not feel that they need the guide because they are already more familiar with long-term care than are males and may have already done some long-term care planning.
- Married people may have less interest in the guide because they may feel that they have other resources for planning available to them, such as each other, adult children, or a personal financial planner or insurance agent.

FIGURE Planning Actions Taken, by Responder Status

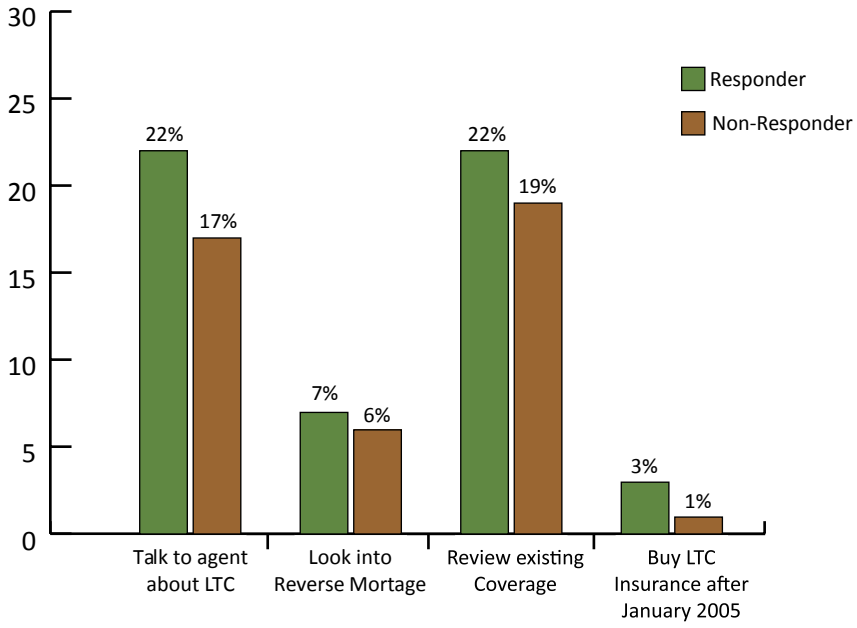

TABLE "Attitudes Toward Planning" and "Level of Campaign Exposure"

Key Questions Used to Derive the "Attitudes Toward Planning Scale"

A score of 0 through 8, with one point given for each answer that indicated a planning attitude:

- I can take steps now to plan for a time when I may be unable to care for myself;
- If I am ill or unable to take care of myself, I am confident I could get the help I need;
- By planning now, I am more likely to have control over the type of care I receive;
- If I make arrangements now, I can better protect my income and savings;
- Planning ahead will help me stay in my home;
- I worry that the cost of care would burden my family;
- Disagreement with the statement…."I feel confident that family or friends would care for me"; and
- Disagreement with the statement…."I'll deal with it when it happens."

Key Questions Used to Derive the "Level of Campaign Exposure" Scale

A possible score of 0 through 3, with one point for each "YES" answer:

- Recalled receiving Governor's letter
- Recalled seeing TV ad
- Recalled hearing radio ad

Implications for the CLASS Plan

A well-researched education and awareness campaign is critical to building support and enabling consumers to take personal responsibility for their future long-term care needs.

Own Your Future was a successful social marketing campaign in terms of both its favorable response rates and evidence that campaign exposure helped move consumers along the "planning continuum" and take a variety of long-term care planning steps including purchasing insurance. It will be important for the CLASS Plan to develop and test key messages and use research to identify appropriate market segments for whom those messages best resonate.

Own Your Future showed that key messages also need to include incentives for planning and illustrates how the CLASS Plan can help provide those elements, such as:

- greater independence and choice of care setting when care is needed;
- the peace of mind of not having to rely on or burden one's family or friends with caregiving responsibilities;
- financial protection, that is, being able to protect quality of life and lifelong savings and leave an estate to a surviving spouse or heirs; and
- some assurance that one can afford the type and amount of care that is preferred.

From both the development and the implementation phases of *Own Your Future*, a number of "best practices" were identified that should be incorporated into the design of the communications for the CLASS Plan.[3] Critical factors in reaching out to consumers to motivate learning and behavior change with regard to long-term care include the following:

- The best approach is one that is factual and uses personal anecdotes and real stories to illustrate the facts but does not use scare tactics. Some humor can be helpful, but it must accompany key facts and a meaningful "call to action."
- Repeat messaging is important. A complex topic such as long-term care requires more than one "touch." This was also evident in the finding that individuals with greater exposure to the campaign messages were more likely to take planning actions.
- Campaign messages need to be sent through a trusted source. Research for the CLASS Plan needs to identify how best to leverage affinity in reaching out to its target market. This is especially critical where CLASS is offered directly to consumers rather than through a sponsoring employer.
- The education gap needs to be addressed by providing basic facts about risks and costs, but also by providing a solution to any problem that is raised.
- Direct mail is relatively inexpensive and allows for focused and repeat communications.
- Earned media is cost-effective but difficult to obtain. Paid advertising can be an effective supplement to direct mail as well, but it is not generally useful on its own because of the complexity of the message and the cost.
- Materials need to include an easy "call to action" and reinforce the rewards promised by the campaign, such as more care options, empowerment through education, independent living, peace of mind, aging with dignity, and others.

One challenge identified by the campaign was the difficulty of reaching "non-planners," since individuals with a planning orientation were naturally more receptive to the messages being sent.[5] Research is needed to identify what would motivate someone not naturally inclined to "planning" to engage with materials and information on long-term care in general and CLASS in particular. Reaching "non-planners" has proven challenging within the private long-term care insurance market and is likely to be a challenge for CLASS as well.

In general, however, an education and awareness campaign on the basics of long-term care and the need to plan—broadly focused rather than specific to CLASS—is likely to be a useful prelude to a more focused marketing endeavor. Such a campaign can lay the groundwork of interest and help clarify the advantages of planning ahead while overcoming the challenges associated with doing so. In this context, direct marketing communications for CLASS are likely to find a more receptive audience.

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CLASS Technical Assistance Brief Series

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Employer Long-Term Care Insurance Market Participation Rates: Implications for CLASS

By Eileen J. Tell

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief looks at best practices in gaining strong participation rates in employer-sponsored long-term care insurance offerings to help inform strategies for the success of the CLASS Plan.

Introduction and Overview of the Employer Long-Term Care Insurance Market

As of December 2009, almost 25,000 employers offered long-term care insurance to their employees and often also to employees' family members.[1,2] The employer-sponsored long-term care insurance market is a critical one for the industry. It has historically been the market segment with the most aggressive growth, often even during periods of flat growth or sales declines for the industry overall. Despite this consistent growth, this market segment remains small, accounting for just over 35% of the roughly 7.5 million policies in force today.[1]

Employers today have a wider variety of long-term care insurance options from which to select. In addition to the traditional group product approach, employers can sponsor an individual policy offered at the worksite. Individual policies often provide additional discounts (such as a good health or spousal discount) not typical of a true group product and may also provide more customizable plan options. This expansion of the market, including both true group and worksite or multi-life plans, has also meant that employers have more insurers from which to choose when considering whether to offer long-term care coverage.

While most workplace long-term care insurance is offered on a voluntary, employee-pay-all basis, there is a sizable segment of the market with some type of employer subsidy. This may be in the form of an employer contribution to the premium, or the employer may offer a low-cost base plan and allow employees to "buy up" to additional coverage amounts.

Employers of all types and sizes offer long-term care insurance as a voluntary benefit. With less than 1% of all employers currently offering any type of long-term care insurance plan, the

"Participation Rate refers to the number of eligible individuals (employees, spouses, and parents) who enroll in the long-term care plan, divided by the total number of eligible employees."

untapped market potential is significant.[3] While early efforts focused on larger employers, a significant and growing share of the market is among smaller and mid-sized employers. Currently, 66% of firms that offer long-term care insurance have 500 or fewer employees, while only 11% have more than 5,000.[3] While insurers get more "bang for the buck" marketing to large employers (all else being equal), the sheer number of smaller and mid-sized firms makes this an important market segment on which to focus.

This brief reports what is known about current employer behavior regarding participation in the existing long-term care insurance market and offers considerations for marketing the CLASS Plan to employers.

Participation Rates

The number of individuals insured who have obtained coverage through an employer-sponsored plan is approximately 2.7 million.[1] This market penetration is distributed across about 10 insurers focused on the true group employer-sponsored market, and 18 insurers offering worksite or multi-life coverage to employer groups.

Participation levels are a key marketing concern in group long-term care insurance. Enrollment must be sufficient to cover the initial and ongoing marketing expenses and the risks of being selected against by higher-risk applicants and hence exceeding anticipated claim costs. (This is especially important where coverage is offered on a guaranteed issue basis for actively-at-work employees.) For these reasons, many carriers include assumptions about participation levels in their pricing models, and some vary their pricing to different employer groups based on assumed participation levels. Coverage features are also impacted by participation rates; if a carrier anticipates low participation, more limited coverage may be offered to offset the potential for adverse selection. For example, few employer-based plans offer lifetime coverage. Some insurers will offer coverage on a guaranteed issue or limited underwriting basis only if the employer guarantees and can deliver a specified participation rate; if the required number of employees do not sign up, the plan does not go forward.

Virtually all group long-term care carriers struggle with the participation issue, both in terms of determining what participation levels are adequate and in terms of maximizing participation. There are anecdotal reports and sales claims but very little in the way of solid industry data on achieved participation levels by carrier.

Here is what is presently known:

- Average voluntary participation levels are between 3% and 8%, with an overall industry average of 5%. While averages are fairly consistent, participation can vary significantly by employer, from below 3% to over 50%.[4]
- Participation rates vary by industry from a low of 2.5% for education to a high of 14.7% for law.[5] It is possible that employer contribution may have been

a factor in the highest participation rate in this study, since this is a common practice in law firms that offer long-term care insurance.

- An adequately-funded marketing campaign can have a significant impact on participation. For example, spending less than $5 per employee results in 4% participation, while spending $10 or more can yield a 14% participation rate.[6]
- Variations appear to be a function of the nature and characteristics of the employer, employee demographics, the plan design(s) offered, and the marketing activities of the carrier.
- State tax policies also influence market penetration to varying degrees, with state tax credits more successful than tax deductions.[7] The State of Minnesota achieved a 20% participation rate in its 2000 offering of long-term care insurance to state employees, due in part to the prominent reference to the state's $500 tax credit for those who buy tax-qualified long-term care insurance.[8]

While some carriers appear to have participation rates on the higher side of the ranges, none has yet developed an approach that consistently delivers double-digit participation. No one seems to have found the so-called "silver bullet."

The first comprehensive analysis of practices for maximizing enrollment participation in group long-term care insurance was conducted in 2000 in anticipation of designing a successful marketing campaign for the Federal Long-Term Care Insurance Program.

TABLE 1 Factors Critical to Strong Participation Rates[9]

- Active employer support and positive employer-to-employee affinity.
- A favorable employment environment (such as low turnover, no recent benefit "take-aways").
- A sound and affordable plan design, with a limited number of reasonable and easy-to-understand coverage choices.
- A good track record with other voluntary benefits at the workplace.
- Good demographics—a reasonable portion of employees within the desired age, income, and education levels suitable for long-term care insurance.
- A high percentage of employees who are female and/or ages 46-49.
- Marketing expenses of $10 per employee or more.
- A limited number of coverage options including a low-cost plan.
- A strong and varied communications plan.
- Worksite meetings with time off for employees to attend.
- A call to action or deadline for enrollment.

This analysis identified several factors that are critical for strong participations rates, as described in Table 1. These variables interact in a variety of ways that we are just now starting to better understand. More successful group long-term care enrollments are associated with employers that:[6]

- have a favorable take-up of other voluntary benefits they offer;
- enthusiastically support the long-term care insurance program (are willing to "own" the program and be visible in sponsorship, exclusively endorse one long-term care insurance program, and take a visible role in program endorsement and sponsorship);
- recognize the importance of an education and communications campaign and allow multiple touches and varied communications;
- are willing to provide a member database with mailing information and are supportive of the key components of a communications campaign specific to long-term care (such as workplace meetings, direct mail to home, and payroll deduction);
- allow the use of a specified enrollment period (60 to 90 days) with a "call to action" deadline;
- keep the plan design options simple and limited to only a few key choices;
- facilitate opportunities for communicating with employees (payroll stuffer, e-mail, website, direct mail, company newsletters, workplace seminars with administrative time-off, etc.); and
- have a positive management and professional environment (that is, minimal workforce disruption resulting from lay-offs, divestitures, mergers, acquisitions, etc.) and a stable workforce.

Employee characteristics associated with more successful group long-term care enrollments include the following:[6]

- A majority of employees are age 45 to 65, the prime buying ages for long-term care insurance.
- Employees are concentrated in a single geographic area (such as the same state), reducing the need for complex variations in plan design to accommodate different market areas.
- A large number of employees are concentrated in a relatively small number of worksite locations (making enrollment meetings and communications easier).
- A decent proportion of employees have a moderate to high income (e.g., $50,000 or more in annual salary).
- White collar, non-union employees predominate, relative to blue-collar, union workers.
- A decent proportion of employees have education at the college level or beyond.
- Employees have positive and strong feelings of affinity with the employer/sponsor (measurable by participation in other voluntary programs, low staff turnover, and other factors).
- Industries with better participation rates include law, government, higher education, insurance and financial services, biotechnology, pharmaceutical, high technology, and the like.

"Successful Enrollment Strategies[5]

One insurer reports an increase from 60% to 85% when electronic online enrollment was expanded from modest use in 2001 to nearly complete use in 2009.

Employees like to buy long-term care insurance at the workplace because they trust the due diligence of the employer.

Initial enrollment is 18% higher when payroll deduction is offered. First year retention rates are also higher.

'Off-cycle' enrollments are three times as successful as those that coincide with health or other benefit enrollment periods."

Strategies to Maximize Enrollment Results

Success in the group market requires the insurer first to establish and implement processes for an internal review and approval of employer prospects with a focus on those that will be more desirable from a participation perspective. That is not to say that all employers with the desired characteristics will always have good participation, but on average when this knowledge is applied consistently the results will be better than taking a more reactive approach or focusing the same resources on all comers.

In addition, both the plan design and the marketing communications campaign need to work for the specific employer situation. Long-term care insurance is not a one-size-fits-all product. The campaign needs to focus on the messages that will get employees to take action and include the basic principles that have worked in the industry. These include the following:

- **Company support and endorsement** — As noted above, the importance of this factor in a successful enrollment cannot be overstated.
- **Multiple touches** — A high-frequency multiple-touch campaign during the enrollment period is needed. Because of the tendency for denial of the need for the product, frequent contact with and varied messages to employees are critical to "building the need" and overcoming obstacles to purchase.
- **Timing** — Enrollments during "distraction months" (holidays, summer, or the employer's usual health care open enrollment) and in negative corporate environments (such as a period of downsizing) should be avoided.
- **Pre-launch research** — Because long-term care insurance is not one-size-fits-all, it is important to learn about the corporate culture and employee demographics and customize the plan offerings to meet the needs, preferences, and financial resources of the target audience. Also, market research is critical to ensuring that the strongest marketing messages are used: those that best resonate with the motivations and concerns of the employee population.
- **Education** — Sufficient time for building awareness and education should be allowed. Typically, successful campaigns require three months, with the first month for pre-education, a second for the actual enrollment, and a third to process enrollments and conduct underwriting (where relevant).
- **Plan choices** — Complex plan choices should be minimized, but affordable and relevant coverage alternatives need to be assured. Industry data suggest that successful plans need to offer alternatives that most employees perceive as affordable yet meaningful. Too many choices cause employees to become overwhelmed and opt not to purchase.
- **Ease of offering** — Materials should be simple and easy to read, and the enrollment process should be as easy and familiar as possible. Industry experience indicates that ease of enrollment is one of the key factors in successful enrollments. Ease of offering means both supporting the employer with all the materials it

needs to communicate with employees and making it easy for employees to participate (automatic online enrollment and payroll deduction).

Participation in group long-term care insurance is not just a one-time event. Enrollment may grow slowly over time, but only if significant attention is paid to growing an existing group, possibly from year to year by having subsequent highly focused marketing campaigns (such as an annual application period). In addition to the initial enrollments, there are significant opportunities to remarket to an existing group, which can cost-effectively improve participation levels. Historically, many carriers have viewed re-solicitations as opportunities to move existing insured individuals to more up-to-date plans and to meet their legal requirements to offer inflation buy-ups. While this is important, another way to think about re-solicitation is as an opportunity to remarket to a semi-captive group of millions of employees in hundreds of groups, with some people in those groups having already made a positive purchase decision. There are significant opportunities to both increase the number of people and to increase sales to people who are already insured through remarketing to existing employer customers.

Employer Participation

Another key element in the participation equation is engaging the employer in offering a long-term care plan in the first place. While employer awareness of long-term care insurance as a voluntary benefit is high (87% in 2006[10]), even today only about 15% of all employers offer it.[3,1] Employers that have considered long-term care insurance but do not offer it cite a variety of factors: lack of employee interest, concern over the administrative cost and complexity of making the offer, and others. A recent study found that 40% of employers believe that the administrative time and effort needed to support the benefit is similar to that of a long-term disability (LTD) plan, putting it just below health insurance or a 401(k) plan in complexity but above group life insurance.[3] Nearly two-thirds of employers say they do not offer coverage because they perceive a lack of interest in the benefit among employees.[3] This underscores the importance of ensuring employers that best practices in maximizing participation rates will be used.

Employers also lack accurate information about long-term care insurance:

- Only 40% know that coverage is portable.[11]
- Only half know that employer-paid premiums are tax-deductible as a business expense.[11]
- More than half do not know that the costs of offering long-term care insurance at the workplace are minimal or none.[12]
- In one state that offers a straight $500 tax credit to anyone who buys long-term care insurance, 60% of employers surveyed in the state were not aware of this important tax advantage for their employees.[12]

Addressing these gaps in awareness can help improve employer interest. One of the major factors motivating the offer of long-term care insurance at the workplace is personal experience with long-term care by an opinion leader, chief executive, or other key person. The ability to attract and retain employees, the tax advantages for business owners, and employee interest are other compelling reasons to offer long-term care insurance, as shown in Table 2. Employers also need to know the true facts about the coverage they might offer — that it is fully portable, that the costs to the employer can be minimal or none, and that the coverage can help improve employee workplace productivity and morale as employees struggle with juggling work and family caregiving.

TABLE 2 The Top Four Reasons Employers Currently Offer Long-Term Care Insurance[3]

Attraction and retention of key employees (47%)
Tax advantages to the business-owner (43%)
Employee demand (43%)
Personal experience with long-term care (42%)

Considerations for CLASS Plan Design and Implementation

The first important challenge to maximizing enrollment in the CLASS Plan will be to interest employers in offering the program, especially employers that have not yet embraced long-term care insurance. This will require an understanding, based on the research we have discussed in this brief, of the reasons why some employers offer coverage while others have chosen not to. It will be critical for the CLASS Plan to address employer concerns in this regard.

Pre-Launch Research and Education

The CLASS Plan will need to undertake a comprehensive educational campaign in order to gain the attention, interest, and confidence of employers. Currently, while over 87% of employers are aware of long-term care insurance, only 35% are aware of the CLASS Plan.[11] The educational

TABLE 3 Employer Views: Positive Features of CLASS[11]

No tax dollars will be used in the program (74%).
All employees are eligible to enroll—no underwriting (71%).
The cash benefit can be used for a wide variety of long-term care services (70%).
There will be no premium increases for those who are over age 65 and retired and who have paid in for at least 20 years (64%).

campaign should focus on the reasons why it is important to offer long-term care insurance at the workplace and emphasize the advantages of CLASS (as shown in Table 3).

Other important ideas that employer education should convey:

- Employees value long-term care insurance offered through the workplace, and offering it can be done on an employee-pay-all basis.
- There is little if any administrative cost to the employer, and any costs it might incur, including a contribution to premiums should it decide to make one, are tax-deductible to the employer.
- While not required, even a small employer premium contribution can enhance participation.
- Many states offer a tax credit or tax deduction to employees who purchase long-term care insurance. The CLASS Plan should reinforce this message to employers in states that offer such incentives. Market penetration for long-term care insurance is enhanced where there are tax incentives, most notably tax credits.[7] The CLASS Plan should target employers in these states and build on the momentum this provides.

Conducting pre-implementation research among employers and employees is another element critical to success in obtaining both employer engagement and good employee participation. To succeed in penetrating the employer-sponsored market in a meaningful way, CLASS should conduct research to help it answer these questions:

- Which employer market segments have the greatest interest in offering CLASS? How well do the size and nature of this workforce fit with the objectives of CLASS with respect to broad and varied participation? To begin with, CLASS should focus on those industries and employer types found to generate the greatest participation rates when long-term care insurance is offered.
- What information do employers need to motivate an interest in offering CLASS where it may not exist currently?
- How will employers currently offering group and multi-life long-term care insurance feel about modifying their existing plan to accommodate CLASS? Are those currently offering long-term care insurance the better prospects, or is the program likely to find more success with those without a competing plan? One recent survey found that more than half of employers without an existing long-term care benefits would evaluate CLASS and consider participating.[11]
- What support and resources will employers want to help them communicate to employees about the CLASS Plan? A survey conducted in Minnesota among employers not offering long-term care insurance found that they would be significantly more willing to do so if the state provided educational and motivational materials so that human resources personnel did not have to take on that responsibility.[12] This is similar to how many voluntary benefits are offered today, where the employer selects an insurer and provides access to its employees, whereas the insurer is responsible for information, education, and customer service. This is the model that employers will expect when engaging with the CLASS Plan.

Plan Choices

One advantage of the CLASS Plan with respect to favorable participation experience is the simplicity of the offering. As research cited above shows, participation declines with the number of plan choices offered. Keeping it simple enhances participation. Since CLASS does not require employees to review and choose among complex coverage options, the decision becomes a simpler "yes" or "no" consideration.

On the other hand, employers and employees may not react positively to the CLASS Plan design as constructed in the existing law because it does not offer choices to match varying consumer preferences. Indeed, in a recent employer survey, 84% of employers were concerned about the one-size-fits-all coverage of CLASS.[11] Therefore, it will be important for the CLASS Plan to consider the development of more than one coverage plan from which employees can choose. For example, where the CLASS coverage currently contemplated is "long and skinny" in the sense that it provides a relatively low monthly benefit amount but extends coverage for as long as care is needed, an option that provides "short and fat" coverage could be an attractive option and introduce some easy-to-understand choice into the program. This would also allow CLASS to better compete with private plans, which always include at least some choice of coverage amount and/or duration.

Ease of Offering

CLASS can and should also offer employers a choice of roles—those that do not want to offer it as a voluntary benefit can still be encouraged and supported to play an educational role. Under either scenario, the CLASS Plan needs to make implementation as simple as possible for the employer. It needs to basically establish a "turn-key" approach to the offer, providing an implementation kit that includes everything the employer would need to communicate, install, and maintain the benefit. This kit should include detailed educational documents, motivational pieces for consumers, a how-to guide for getting the most participation out of the offer, and all the forms and materials the employer needs to implement and maintain the CLASS Plan. The program should have a dedicated toll-free line specifically for employer support. A recent employer survey found that 57% of employers said that ease of implementation is one of the most important concerns they would have if they were to add long-term care insurance to their existing benefits.[12]

Multiple Touches and Other Best Practices

Once an employer agrees to offer the CLASS Plan, employees must be persuaded to enroll. The research indicates best practices for reaching employees, as discussed above, and these should be followed by the CLASS Plan:

- Marketing materials should clearly educate employees about the need, risk, and cost of long-term care and the value of having insurance to meet that risk. This information can be enhanced when presented in an emotional but non-threatening way. The use of real-life testimonials can be especially persuasive.
- Onsite and workday-based education and enrollment meetings should be

held, with employers either mandating attendance or allowing time off for employees to attend.

- There should be repeat messaging because the more "touches" employees have, the more likely they are to enroll. Also, varying the message and communication vehicles is important. Using a combination of direct mail to employee homes, workplace e-mail and newsletter communication, worksite posters, and other methods is important.
- The CLASS Plan should have a dedicated website with lively and engaging interactive tools, including the ability to enroll on line, to generate improved participation and retention.
- The CLASS Plan is already intending to rely on automatic payroll deduction, another best practice in engaging and retaining participation.
- Offering the CLASS Plan outside the employer's other usual benefit offerings (off-cycle marketing) is also likely to enhance participation, as it allows employees to focus on CLASS without the distraction of other benefit decisions. Having a strong call to action in the form of an enrollment deadline (typically one to three months, shorter for a plan with guaranteed issue) is also vital.
- Maintaining a strong re-enrollment initiative to build participation over time among participating employers is also important. Long-term care insurance is not a "once and done" marketing activity; the CLASS Plan needs to maintain a presence and return for re-enrollments within participating employers.

An additional key question that the CLASS Plan needs to be prepared to address if it wants to get a foot in the door among employers is how it can or will coordinate with private long-term care insurance offerings that the employer may already have in place or choose to add. It is widely acknowledged that the CLASS benefit is meant to "take the edge off" long-term care costs but is not a complete solution for comprehensive coverage including nursing home care, given the anticipated daily cash benefit of $50 to $75. The CLASS Plan will not be the complete solution for many who desire protection. Similarly, the CLASS Plan needs to fit in where employers have decades of experience and satisfaction with a long-term care insurance plan. So an important part of CLASS marketing and education to employers will be to help them understand how the CLASS Plan can complement their existing coverage and how employees with coverage should maximize the best of both options.

Based on the experience of long-term care insurers in penetrating the group market, the CLASS Plan will face substantial challenges in persuading employers to sponsor the program and employees to enroll in it. Drawing on the knowledge gained by the private sector over many years, the CLASS Plan can apply the lessons learned by insurers to maximize both employer and employee participation.

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CLASS Technical Assistance Brief Series

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Long-Term Care Insurance Buyer Profiles: Implications for CLASS

By Eileen J. Tell

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

In ths brief, demographics and key attitudes that differentiate long-term care insurance buyers from those who do not buy are reviewed. This analysis can help the CLASS Plan inform a more cost-effective targeted marketing strategy, reaching out first to those most receptive to the product.

Introduction and Overview of Relevant Research

There is a great deal of information about individuals who buy long-term care insurance and those who consider it but choose not to buy. Key variables explored in the research focus on how buyers and non-buyers differ in terms of:

- demographics,
- long-term care knowledge and attitudes,
- long-term care experiences,
- decision-making processes, and
- other factors.

With over two decades of research findings on this topic, much is known about buyers—who they are, what motivates their decision to purchase coverage, and why they select the specific coverage they choose. One of the most important sources of information is a series of studies conducted by LifePlans, Inc. on behalf of both America's Health Insurance Plans (AHIP) and the U.S. Department of Health and Human Services.[1,2,3,4,5,6,7,8,9] Every five years since 1990, LifePlans has conducted a comprehensive survey of buyers, non-buyers, and the general population age 55 and older. One of the strengths of these surveys is that many of the core questions focusing on attitudes, knowledge, and concerns about long-term care have remained constant over time, which allows us to make comparisons and view trends in long-term care awareness. Each generation of surveys includes questions focused on issues important at that time. The most recent surveys that are currently in the field include questions about the CLASS Plan.

Building a profile of individuals who have the greatest propensity to buy long-term care insurance is important to developing the messages that are likely to be most salient to that audience. For example, buyers are more likely than non-buyers to be concerned about becoming a burden to their family should they need long-term care. Therefore,

marketing messages that emphasize independence, peace of mind for loved ones, and similar concepts will resonate more for those already more likely to consider long-term care insurance. Similarly, understanding non-buyers helps to craft marketing messages that overcome their key objections. For example, many non-buyers say that they are still on the fence about the purchase—while they have chosen not to buy at this time, they are not fully closed off to the concept. Marketing messages that reinforce the advantages of buying at a younger age (and at a lower premium cost) may help address the wait-and-see tendency of many non-buyers.

While it is important to understand key attributes of buyers and non-buyers, it is also important that the information gained be actionable. For example, if research showed that people with smaller families (all else held constant) are more likely to buy, it could be difficult to operationalize this finding in a cost-effective marketing campaign. How would messages be tailored to find and reach this audience? In contrast, knowing the prime ages at which people are likely to buy is an actionable insight, as direct mail marketing and education can be focused on specific age segments.

About Today's Buyers and Non-Buyers

People buying long-term care insurance today differ from buyers of 15 years ago. Most notably, people are buying at younger ages perhaps in part because of the expansion of the workplace as a venue for purchasing coverage, but also as a result of greater affordability due to lower premiums for younger ages (since premiums are based on one's age at the time of purchase). With an average age of 61 (compared to 68 in 1990), almost 70% of buyers today are under age 65 while almost 25% are age 55 and younger.[9] While the gap is narrowing, females still outpace males in the purchase of coverage (57%).[9] This is likely due in part to women's greater awareness of the risks and costs of long-term care as they are more likely to outlive their spouse and thus lack a critical source of support

TABLE 1 Demographic Profile Buyers vs. Non-Buyers[9]

Trait	Buyer	Non-Buyer
Average age	61	64
Married	73%	65%
Income $75,000+	49%	30%
Assets $100,000+	76%	53%
College graduate	61%	53%

should they need care.

Compared to non-buyers, buyers are more likely to be younger and married (see Table 1 on page 2). One hypothesis is that married individuals may have more disposable income and/or be motivated to purchase out of concern for protecting income and assets for their spouses. Buyers also have greater income and assets than non-buyers and are more likely to have higher levels of education. It makes sense that individuals with the financial means to protect their assets are more likely to purchase insurance than those who are less well-off.

More important, however, than these socio-demographic differences are differences in long-term care knowledge, attitudes, and experiences; these key factors seem to shape one's perception of risk and desire to have insurance to preserve independence and protect income and quality of life.

Why People Buy Long-Term Care Insurance

Financial protection against the costs of long-term care is only one of many reasons people buy long-term care insurance. Other important reasons are to avoid relying on others, to help pay for needed care, and to preserve assets and protect one's family's quality of life.[9] There are also non-financial reasons. People often cite the desire to have choice in how they receive care (59% of buyers say this is a very important reason for them to buy), and avoiding reliance on others for meeting care needs is a very strong motivator (cited by over 70% of buyers).[9] And while there is evidence that some people are willing to "take their chances" and use Medicaid as a safety net should they need long-term care, just over 40% of those who buy private long-term care insurance say that avoiding reliance on Medicaid is a very important reason for their purchase.[9] Other very important concerns include not using up savings or income to pay for care (76%) and ensuring adequate income for a spouse (57%)[9]. See Table 2 for what people cite as the most important reason to buy.

TABLE 2 Most Important Reason to Buy Long-Term Care Insurance[9]

Protect assets or leave an estate	36%
Avoid dependence on others	23%
Guarantee affordability of care	18%
Protect living standards	14%
Some other reason	24%

Critical Knowledge and Attitudes

Buyers and non-buyers differ significantly in their perception of the risks and costs of long-term care and how it is financed. Building a baseline of knowledge about the likelihood of needing care and the lack of alternative payment sources is a critical component of any successful marketing campaign.

As shown in Table 3, buyers have a more realistic view of the likelihood that they might need long-term care and understand that, if they did, it would be their own personal responsibility to pay for that care. In contrast, non-buyers are more likely to have incorrect knowledge about the costs of long-term care and how it is paid for; they are more likely to believe that government programs such as Medicare or Medicaid will cover the costs of care. Finally, an important distinction between those who buy long-term care insurance and those who do not is having a planning orientation. Individuals who strongly agree that it is important to plan ahead to best meet long-term care needs are twice as likely to buy long-term care insurance as those who do not share this perception.

The research literature also finds significant differences between buyers and non-buyers in terms of their long-term care experience—whether or not they have had a family member or close friend who has needed long-term care. Those who have had personal experiences with long-term care have been found to be more likely to buy long-term care insurance than those without such experience.[9] This can be explained by the fact that those who have watched a close family member or friend go through needing long-term care have learned the hard way about the harsh realities of long-term care risks and costs and who pays, and their long-term care experience has fostered a buyer mindset.

TABLE 3 Attitude Differences, Buyers vs. Non-Buyers[9]

Attitude	Buyer	Non-Buyer
Perceive risk of needing LTC in nursing home.	64%	53%
Perceive risk of needing LTC at home.	71%	59%
Have correct LTC cost estimate.	26%	17%
Don't know who pays for LTC.	15%	25%
Believe government pays for LTC.	12%	22%
Know LTC paid on one's own.	56%	45%
Believe important to plan ahead.	62%	30%

The Buying Process

A variety of individuals are influential in the process of deciding to buy long-term care insurance, as shown in Table 4. Because long-term care has an impact on multiple family members, it makes sense that spouses are more likely to influence buyers. Adult children, on the other hand, rarely play a role in the decision-making process as they are less likely to know about risks and costs and, many are uncomfortable advising their parents in financial matters such as long-term care insurance. Other important influencers include insurance agents, financial planners, and other friends and relatives. Knowing someone who has bought long-term care insurance increases the likelihood that an individual will buy.

Interestingly, negative media reports on the long-term care insurance market do not seem to have much influence on the buying decision. Non-buyers are no more likely than buyers to have heard about companies that are going out of business or no longer selling long-term care insurance (32% of both groups have).[9] Other important factors motivating the buying decision (shown in Table 5 on page 6) include the company's reputation, an agent recommendation, the company's financial ratings, and policy cost. The policy's benefits do not rank highly as a factor motivating purchase or differentiating between buyers and non-buyers.

Why People Do Not Buy Long-Term Care Insurance

People give different reasons for not buying long-term care insurance. Cost is the most common, as shown in Table 6 on page 6. Other reasons include denial of the financial risk or the need for care, as well as confusion about which coverage features or what type of policy to buy. Some consumers are waiting for better policies, and others are uncertain whether they can trust insurance companies to provide the coverage they promise.

When consumers say that they did not buy coverage because it costs too much, it may mean that they do not perceive the value of coverage relative to the price,

TABLE 4 Who Influences the Decision to Buy Long-Term Care Insurance?[9]

Spouse	40%
Agent	22%
Financial planner	21%
Other relatives or friend	14%
Children	3%

TABLE 5 Factors Important in the Buyer Decision[9]

Factor	Buyers	Non-Buyers
Company reputation	63%	41%
Agent recommendation	62%	48%
Company ratings	46%	33%
Policy cost	44%	32%
Policy benefits	23%	23%

or they are considering coverage options that cost more than they believe they can afford. Once consumers understand the value of long-term care insurance and are given options that match their financial preferences, resistance based on cost is significantly reduced.

It would seem that affordability is in the eye of the beholder, since individuals who say long-term care insurance costs too much do not have significantly lower income and assets than those who do not think it is too costly (although we do not know what other financial obligations individuals may have).[9]

Other reasons that people say are important to their decision not to buy long-term care insurance include the following:[9]

- I was concerned about premiums being increased in the future (55%).
- I don't mind using my own income or savings to pay for care (49%).
- I don't think I'll need long-term care (27%).
- My family will take care of me (20%).
- Medicaid will pay for my long-term care if I need it (19%).

TABLE 6 Most Important Reason NOT to Buy Long-Term Care Insurance[9]

Too costly	53%
Waiting for better policies	19%
Don't believe insurer promises	16%
Hard to choose a policy	14%

Clearly, it is important to help individuals understand that while they may intend to pay on their own, it is very difficult to save the amounts needed to fully pay for long-term care. While "self-insuring" gives people the flexibility to use their savings for other purposes if they never end up needing long-term care, saving enough is extremely difficult. For example, a female who puts aside $100 a month starting at age 30 and who earns 5% return on those funds would still face a significant shortfall between her expected costs of care and her savings by the time she reaches the age when she is likely to need care, as shown in Table 7.

Addressing concerns about rate stability is also important, as is helping people understand the realities of the risk of needing long-term care, its costs, and the burden that relying on family can impose. Another interesting observation is that the vast majority of non-buyers have not fully ruled out the possibility of buying at some point in the future. In fact, only one-third of non-buyers intend never to buy coverage; the majority (56%) are undecided, and 13% say they will purchase at or around the time of retirement but are not ready to do so at present.[9]

Public Sector vs. Private Sector Programs

Relevant to the offer of the CLASS Plan is research comparing buyers and non-buyers in the private and public sectors. A 2004 study found only a few differences between buyers and non-buyers in the private sector (a private employer offering an insurance company policy) in comparison to those in the public sector (a government-offered program such as the federal government's long-term care program or state government programs).[8] (Note that some existing government programs are self-

TABLE 7 Saving on Your Own for Long-Term Care[10]

Begin saving at age 30. Put aside $100 a month and earn 5% annually on investments.
Need long-term care at age 80 for an average amount of time for a female.
Lifetime cost of long-term care: $2.146 million (adjusted for inflation).
Amount saved by age 80: $264,000.
Gap between savings and costs: $1.9 million.

insured like CLASS, while others have an insurance company partner.)

Perhaps the most significant finding is that public program buyers tend to be less affluent than private-sector buyers. Their primary purchase motive, not surprisingly, also differs. While public program buyers are more likely to buy to avoid reliance on family or to assure that affordable care is available when needed, private sector buyers are more motivated by financial concerns — protecting assets and ensuring adequate family resources to pay for care. While for both groups cost remains the primary reason not to buy, public program non-buyers are more likely to cite a belief that the government might pay for care as a reason not to buy. An important similarity between these groups is that a roughly equal proportion of non-buyers within each say that they are planning to buy at a later time. This suggests that opportunities for education on the value of insurance and on concerns about relying on public programs may help boost future participation.[8]

Considerations for CLASS Plan Design and Implementation

With creativity, research, and targeted marketing, CLASS can learn from the private sector experience and identify and reach out to best prospects for enrolling. It is important to understand that in marketing it is not the case that "one approach works for all," and this is especially true for CLASS given the very broad eligible population segments involved. Evaluation, such as the buyer and non-buyer studies outlined here, is also a vital component of marketing success—learning what worked and did not work and identifying obstacles and facilitators to the sale in order to leverage them in future campaigns. Only with this commitment to marketing research can the CLASS Plan understand why it succeeded (and replicate that) or why it failed to meet objectives (and modify that).

Drawing on the research discussed in this brief to understand the demographics and key attitudes that differentiate long-term care insurance buyers from those who do not buy can help the CLASS Plan develop a more cost-effective, targeted, marketing strategy. Considerations on plan features, marketing messages, and marketing focus are outlined below.

Plan Features

According to the cited research, plan features, with the exception of price, do not seem to be a primary factor in the purchase decision (or at least they play a much smaller role than other factors).[9] Existing research does have some plan design implications however, that can help market the CLASS Plan.

- Not being a burden to family and friends is an important motivating factor to purchase. Therefore, it may be important to emphasize how the CLASS cash benefit can be used either to hire relatively low-cost paid providers (removing the caregiving responsibility from family) or to compensate family for real costs they incur for caregiving (such as time off work). Simply discussing the ability to hire family caregivers may not adequately

address the desire not to burden family, since many people would rather not receive hands-on care from family members even if they are compensated. Consequently, emphasizing the alternative ways cash payments can be used to offset family burdens will be helpful.

- Cost is most frequently and consistently cited in the research as a reason for non-purchase. Therefore, designing CLASS to have as competitive and attractive a premium as possible is important. However, price in and of itself is not the key factor — it is the perception of price relative to the value of coverage. It will be important to CLASS Plan design to identify features that can be scaled back to lower the price without compromising the appeal of the program, and research will be needed to guide the program in doing this. At the same time, of course, CLASS needs to be mindful of the legislative mandate and of features of coverage that cannot be modified.
- Research indicates that having confidence in the sponsor and the program is important to the buying decision. Consequently, the CLASS Plan needs to conduct research to identify the nature of affinity and confidence among working individuals, address obstacles or concerns, and reinforce favorable perceptions where they occur. Design features that increase confidence should also be considered; these may include the use of rate stability guidelines in pricing, contractual promises about meaningful options in the case of a rate increase, transparency and clarity with respect to the process of becoming eligible for and receiving benefits, and other provisions. The CLASS Plan should also market test messages that best convey the sponsorship and administration of the program in the most favorable light, engendering greater confidence in a government program where such confidence may be lacking.

The Marketing Message

Research also has implications for how the CLASS Plan should be marketed.

- CLASS needs to focus marketing messages on the value of having coverage and the cost of insurance relative to the cost of going without coverage. Another marketing message that can help provide a needed context for price is the financial value of having coverage in terms of quality of life and access to care options. Also, messages that help reinforce the understanding that self-insuring is neither efficient nor realistic can be effective as long as they are not overly complex. The Savings Cost Calculator found at the National Clearinghouse for Long-Term Care Information (www.longtermcare.gov) provides an excellent illustration of how much an individual would need to save in order to pay for the average amount of care needed in one's lifetime.[11]
- Marketing messages need to focus on the variety of reasons that (according to research) motivate people to buy long-term care insurance. While for some people financial reasons to buy are important, communications need to focus on the many other reasons that motivate purchase such as avoiding reliance on family, quality of life for a loved one, and freedom of choice about

how best to meet care needs.

- Marketing messages should address the most prevalent objections to purchase such as speaking to perceptions of cost relative to value, fostering confidence that the plan will do what it promises to do, and enabling and fostering belief in the probable need for care and the significant advantages of having insurance.
- Likely of greatest importance to the CLASS Plan is the need to foster the key attitudes that research shows are critical to making the decision to buy coverage (see Table 8). Using real-life stories of people who have needed long-term care — both those who have coverage and that who do not — has been shown to be an often effective way to raise awareness of these key attitudes.

TABLE 8 Critical Buyer Attitudes

Individuals are more likely to buy insurance if they:
• Accurately understand the risks and costs of needing long-term care.
• Know that such needs are not currently covered.
• Know that long-term care needs are best met when they are planned for, providing more freedom of choice, independence, and peace of mind as care needs are met.

The Marketing Focus

Yet another important consideration for the CLASS Plan is identification of the best prospects on which to focus initial marketing. Once the plan gains momentum, marketing can be expanded to other segments, but early marketing success will be important to the plan's acceptance both among employers and employees. Based on the research literature, best prospects are likely to be the following:

- People ages 40 to 50.
- Individuals with incomes of $50,000 or more and assets of $75,000 or more.
- Married employees: Given the influence of spouses in the decision-making process, marketing to this group is more cost-effective. Reaching out to married employees could mean enrolling both members of the couple with the same amount of marketing, so marketing to this group is cost-effective. It also provides some protection against adverse selection, since married couples

often have lower service utilization. (Whether this is true in the presence of a cash benefit, however, is not known.)

- Employees of participating employers: The CLASS Plan should probably emphasize working through employers. Employees' affinity with the employer can be leveraged, and CLASS can utilize information on employees (age, gender, marital status, and other voluntary benefits) to identify best prospects for long-term care coverage.
- Individuals with a planning orientation: If the research for the CLASS Plan indicates that it resonates more favorably with individuals who see the value of planning ahead for long-term care needs (as it does for private long-term care insurance), then identifying proxy measures that tend to indicate someone is a planner can be useful in target marketing for CLASS. These measures might include interest in retirement planning (such as participation in retirement seminars at work); contribution to the company's 401K; and owning annuities, IRAs, and other insurance products. For example, one insurance company that sells both long-term care insurance and homeowners insurance identifies customers with umbrella coverage as better prospects for long-term care insurance, and experience has shown that they have a higher purchase rate, all else being equal. It may be possible for CLASS to obtain this type of information through reliable, purchased marketing database lists. The cost of obtaining this type of information for direct marketing efforts may well be justified by the higher propensity to buy among people with this profile.

It would be to the CLASS Plan's advantage to encourage healthy individuals to enroll, to address concerns about adverse selection and the possibility that those in only fair or poor health are more likely to have an interest in enrolling. If feasible, the CLASS Plan design might include features to encourage healthier purchasers, as is done in the private sector. These might include a rebate or brief premium holiday to individuals who remain claim-free for some defined period of time; a good health discount for individuals willing to apply for it based on evidence of good health once they have enrolled on a guaranteed issue basis for the program; and other similar concepts.

Finally, learning more specifically why the undecided have not bought and fashioning messages and approaches to overcome obstacles is a vital but untapped area of research on buyer behavior which could benefit the CLASS Plan. Research to identify what factors are preventing these people from buying today and how to overcome those concerns could be rewarding. These fence-sitters have admitted that they are not closed to the purchase decision but also are not ready to make it. Learning more about what might persuade them to act earlier could be useful.

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Building Infrastructure to Support CLASS: The Potential of Matching Service Registries

By Dorie Seavey and Abby Marquand

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief examines the "service fulfillment" challenges posed by the CLASS Plan. New and improved mechanisms will be needed for connecting consumers of in-home services and supports with the workers who provide them. Outlined in this brief are findings from a recent PHI study of "matching service registries." The potential of these registries for building needed infrastructure is explored and key design issues for their development are identified.

Introduction and Why Infrastructure Matters

To date, virtually all of the attention paid to the recently enacted CLASS Plan has focused on program design and operational issues, including how to assure financial solvency. But another stated purpose of the new program is to "establish an infrastructure that will help address the Nation's community living assistance services and supports needs."[1]

Under the new title establishing CLASS, states are required to ensure "adequate infrastructure for the provision of personal care attendant [PCA] workers." In particular, within two years of the enactment of the Plan, states are directed to: assess the adequacy of their existing infrastructure, and designate or create entities in order to create a sufficient supply of PCAs while not impeding existing self-directed home and community services.

Infrastructure development to accommodate the impending expansion of in-home services and supports must address three interrelated issues: workforce supply, service fulfillment, and quality assurance. In order to meet increased demand for care services, sufficient numbers of workers need to be drawn into personal care jobs. But an adequate supply of PCAs will not be enough—effective and efficient mechanisms are needed for deploying the PCA workforce in millions of consumer homes on a daily basis. Lastly, given the lack of widely accepted standards for the provision of personal care services, it is critical to create supportive resources for both consumers and workers, thereby fostering better quality services and jobs.

The purpose of this brief is to explore the second of these three challenges—the challenge of "service fulfillment." Service fulfillment, a business term, refers to the processes and operational infrastructure that match the supply and demand-sides of a market in economic and efficient ways. We consider traditional mechanisms for connecting

consumers with workers, and the need for augmenting these under the prospect of a fully operational CLASS Plan. In particular, we focus on "matching service registries"—a type of labor market intermediary currently taking root in the context of Medicaid programs which allow "consumer direction." Under these options, consumers may create and direct their own PCA services and employ their preferred caregiver. We examine these registries and explore their potential to help build the infrastructure needed to support service fulfillment for CLASS beneficiaries.

Current Service Fulfillment Systems

There are two basic models for providing in-home services and supports in the U.S. today: an agency model and an independent provider model.

Under the agency model, a home care organization serves as a third-party service provider and is responsible for employing and assigning the worker as well as monitoring the delivery of services in the consumer's residence. In 2009, an estimated 471,000 PCAs were employed across a universe of over 70,000 agency-based establishments that provide services related to home health care and personal assistance.[2]

Under the independent provider (IP) model, the consumer assumes a range of employer responsibilities and is responsible for hiring, scheduling, supervising, and terminating the PCA. The IP model in turn has two broad variants: private and public. The private strand of the IP model, or "grey market," is fairly invisible. It is made up of households that hire PCAs under private arrangements, most of which are thought to be unreported and unregulated. The public strand operates within a plethora of state-based consumer-directed programs funded either by Medicaid, directly by states, or through programs or grants administered by the Centers for Medicare and Medicaid Services (CMS). Nearly all states offer some kind of a consumer-directed option, and about 30 percent of states offer this option in more than one program.[3,4]

In six states, the public IP model is organized under a public authority structure. Public authorities are quasi-governmental entities—sometimes called home care councils or commissions—typically governed by a board made up of consumers and their representatives and advocates as well as state officials. Public authorities generally aim to provide a forum for efforts to recruit new PCAs and to improve quality of services and supports. They usually play a role in setting compensation and other employment terms for PCAs working under specified public programs. In addition, they may also assume responsibility for the payment process and, along with the consumer, can serve as the "employer-of-record" for the workers for purposes of collective bargaining. Finally, they often maintain registries of PCAs and provide referral/matching services for consumers in need of in-home services and supports.

Reliable counts of PCAs employed under public and/or private IP arrangements are not available.[5] However, we do know that there are approximately 535,000 PCAs working in public IP programs across the country covered under collective bargaining agreements.[6] Two-thirds of these PCAs are based in California and the majority are paid family caregivers.

The agency and IP models differ significantly in their structures and functions, and in the responsibilities they place on both consumers and workers. Under the agency model, the home care organization is responsible for service fulfillment: it directly employs a pool of available workers and carries out the matching function of assigning a particular worker to a particular consumer. Under the IP model, there is no inherent fulfillment platform. Usually, as a result, consumers are responsible for recruiting and hiring their PCAs and workers must search for their own consumer-employer. In other words, consumers and workers must fend for themselves in locating each other and determining workable "matches."

Matching Services as Promising Service Fulfillment Platforms

Previously informal and unpaid caregiving arrangements between friends and family members are becoming increasingly formalized in the face of steadily growing demand for in-home supports and services. Evidence suggests that growing numbers of families are compensating relatives who serve as caregivers, either privately or through state Medicaid programs that permit hiring family members or friends.[7,8]

While this reliance on family and friends for the provision of in-home services and supports is feasible and preferable for many individuals, this is not true for all consumers. Moreover, one of the stated purposes of the CLASS Plan is to "alleviate burdens on family caregivers."

Consumers often utilize other informal channels to locate workers, including: word-of-mouth, classified ads, postings at sites in their communities such as places of worship, banks, or supermarkets, and online postings at sites such as Craigslist. However, consumers can encounter difficulties in finding qualified workers through these informal channels, and as a result may experience unmet needs.[9,10,11] Furthermore, even when a consumer has engaged the services of an independent provider, finding back-up workers in last minute or emergency situations, or when workers have planned absences, can be challenging.[12]

One alternative to these informal channels is a type of labor market intermediary that has been emerging in public IP programs, namely, "matching service registries." These entities create a dynamic platform for matching supply and demand by allowing consumers to tap into an up-to-date bank of available workers, while also enabling workers to signal their availability for employment.

What Matching Services Do

Matching service registries typically gather detailed information about both

the consumer's needs and preferences, and the worker's availability, skills, and preferences. Consumers and workers must each initiate their side of the transaction. The gathered information is electronically stored and updated by the registry staff.

When a consumer contacts the registry with a request for a worker, the "matching" is done in one of two ways: either the consumer performs their own electronic searches of the worker database using one or more searchable criteria, or the consumer connects with trained staff who in turn conduct the database searches and report the search results back to the consumer.

Matching services often are structured as just one component of a larger continuum of services that support self-directing consumers and their independent providers. These additional services may include: recruitment and outreach to potential workers, screening and orientation for workers; and training, skills enhancement, and peer mentoring opportunities for both consumers and workers. Matching services may also include program components that assist consumers in need of irregular services such as back-up or emergency support and on-call assistance with an event such as returning from a stay in an acute care or rehabilitation facility.

Note that matching service registries play a very different role from two other kinds of registries that exist in all states: "safety registries" such as criminal background check and abuse registries,[13] and "quality assurance registries" such as nurse aide registries, which list individuals who have satisfactorily completed a state's training requirements to work in nursing homes and other long-term care programs.

Existing Matching Services

Under a project for the Center for Personal Assistance Services (www.pascenter.org), with support from the National Institute on Disability and Rehabilitation Research,[14] PHI has been tracking the development of publicly-funded matching services across the country. A summary of our findings to date follows.

- **Numbers** — Based on a 50-state survey, we have identified 16 state-based matching services. Larger states tend to operate their registries at the county level. In addition, we found 6 regional matching services operating in other states, one of which—the Care Registry of the Wisconsin Quality Home Care Authority—is slated to become statewide in 2011. Two-thirds of states lack any kind of publicly-supported matching service.

PHI Matching Services Map

http://phinational.org/policy/the-phi-matching-services-project/

- **Years of Operation** — The oldest matching services are found in California and date back to the mid-

1990s. However, most matching services have been established just within the past five years.

- **Operational Responsibility** — Of the 16 state-based services, five operate under public authority systems: California, Massachusetts, Michigan, Oregon, and Washington. The registry in Wisconsin also operates under a public authority.

Using a multi-state platform, five state-based matching services are operated by a third-party non-profit corporation called Rewarding Work Resources, Inc. As of March 2010, 5,629 consumers and 16,388 workers were registered across Rewarding Work's matching service registries in Connecticut, Massachusetts, New Jersey, Rhode Island, and Vermont. Florida's Developmental Disabilities Resources registry is operated by Delmarva Foundation, a non-profit Quality Improvement Organization (QIO) in partnership with the State of Florida's Agency for Health Care Administration (AHCA) and the Agency for Persons with Disabilities (APD).

Four more matching services are directly maintained or operated by state agencies in Arkansas, North Dakota, Ohio, and South Carolina. The two remaining state-wide services are operated by Centers for Independent Living (CILs): the Alpha One CIL in Maine, and the Granite State Independent Living Center in New Hampshire. We have also identified five regional matching services of note in five separate states: Idaho, Kansas, Illinois, Pennsylvania, and New York. These regional services are operated by CILs.

- **Eligibility** — Each of the state-based matching services was designed to accommodate consumers of personal care services under specific Medicaid programs. These consumers utilize the registries for no charge. However, the majority of these services also allow private pay consumers to access the registry (13 states). And most of these states offer the service to private pay consumers for free (9 states). At the same time, use of the registries by private-pay consumers appears to be relatively limited.
- **Search Platform** — All of the state-based matching services allow consumers to search for a worker based on geographic location. Most also allow the consumer to search based on worker availability, such as times of day, live-in service, and availability for back-up and emergency services. Some registries offer more expanded search criteria. For example, the Rewarding Works registries collect searchable information regarding the experience, education and training of workers, and also their access to transportation. The Wisconsin Quality Home Care Authority matching service registry includes searchable criteria relating to personality and work/home environment details with the goal of making a better "relationship-match" between the consumer and worker.
- **Additional Functionalities** — A smaller number of matching services offer an expanded continuum of functionalities that allow them to serve as de facto "quality infusion" points. Some provide access to a rich set of training opportunities for both consumers and workers. For example, the Oregon Home Care Commission

operates a matching service registry and also organizes optional training courses for both consumers and workers. Consumers can use the registry to search for a worker based on which training courses the consumer would like his or her worker to have completed.

- **Linkages to Other Public Information and Referral Networks** — Existing matching services, with few exceptions, appear to have weak interconnections with other publicly supported information and referral networks such as those provided by Aging and Disability Resource Centers, Area Agencies on Aging, and Centers for Independent Living. In states with statewide matching services, less than 10 percent of all AAAs and CILs demonstrated any notification or information about the registry on their websites.
- **Funding** — Virtually all of the matching services we identified are publicly funded, most with state dollars. A few receive federal dollars through reimbursement for Medicaid administrative costs. Initial or start-up funding for several of the registries was provided by federal Medicaid Systems Transformation grants. Given the severe fiscal pressures facing many states, it is not surprising that funding streams for matching service registries, along with funding for publicly-administered home- and community-based services more generally, are tenuous. In fact, the matching service registries in California, Washington, and Vermont were each at risk for termination or severe cuts during the prior fiscal year.

Considerations for CLASS Plan Design and Implementation

Implementation of the CLASS Plan will require innovations in the infrastructure for long-term care delivery; matching service registries could be leveraged to help improve this infrastructure. Already across the country, interest in these registries is growing, driven by increasing demand for self-directed home-based services. However, matching services are arguably in their infancy and their scale is limited. Furthermore, virtually no research has been conducted to examine the outcomes of these entities and demonstrate their value. At the same time, the role and potential of matching services are compelling.

As labor market intermediaries, matching services carry out a brokerage function that connects seekers and providers of in-home services. The intermediation offered by these registries has the potential to create genuine value for both sides of the market, especially by overcoming barriers due to lack of information that both consumers and workers can experience. These barriers or "market imperfections" are endemic to service fulfillment in the IP model precisely because it is so decentralized as it strives to yield thebenefits of individualized services and supports in one-on-one consumer/worker relationships.

In addition, matching services may offer value as venues for linking to other services that foster and support higher quality care for consumers and better quality jobs for

workers. This quality infusion role may be particularly important in a highly dispersed system where the services for consumers may be unsupervised and largely unregulated, and the job environment for workers is often unprotected.

In light of the enactment of the CLASS Plan, we offer the following considerations for the future evolution of matching services:

1. *Grounding the design of matching services in the "customer dyad."* Matching services have two main customers—consumers and workers—and the intermediation power of these registries is maximized when the service is designed to serve both. Interestingly, there is likely to be a strong affinity between what consumers and workers want. Both value quick access to up-to-date information, safety and quality, good matches, and access to one-stop type efficiencies and functions as well as to supportive services. Direct input from consumers and workers is needed to determine how best to translate these goals into specific registry operations and functionalities.

2. *Building broad-based, integrated support across care management and referral points*. For matching services to be successful, they need buy-in from all entities with a stake in ensuring that individuals with functional limitations can access the in-home supports they need. Care managers—publicly or privately funded—who help arrange services for their clients are critical referral points that should be connected to matching services. The same is true for existing networks of community organizations that provide information and referral services, such as AAAs, CILs, ADRCs. But an even broader inclusion of referral points is likely to be necessary, one that extends to providers of medical services such as physicians, hospitals, medical homes, and even nursing homes. These entities each have an interest in preventing re-hospitalization and promoting successful transitions to consumers' own homes, especially in light of new Medicare reimbursement regulations.

3. *Serving both public- and private-pay consumers and workers.* Existing registries predominantly serve publicly-supported consumers, although most indicate that private pay consumers can utilize their services as well. The advent of CLASS raises the question of how to accommodate a new group of consumers, some of whom may wish to self-direct their own care. Pricing issues may arise in states with noticeable differences in the wages and benefits paid to PCAs under private versus publicly-funded IP arrangements. These issues need to be addressed for matching services to serve both private and public consumers; otherwise, a segmented labor market may develop wherein the most qualified or desirable PCAs are bid away to the consumers paying higher wages, possibly resulting in labor shortages for some groups of consumers.

4. *Determining the interface with the home care agency network.* One might imagine matching services and agencies as mutually exclusive entities competing for the same consumers. But self-directed services are not for everyone and many consumers (or family members acting on their behalves) prefer to engage a home care agency. Furthermore, in some states, agencies can receive public contracts to operate fiscal management services for state-based consumer-directed programs. In others, IPs under public programs must register with an agency in order to be co-employed by a self-directing consumer, sometimes called an "agency with choice" arrangement. In sum, the possible roles and divisions of labor between agencies and registries are many and will evolve as both the agency and independent provider models of service delivery continue to develop.

5. *Creating robust business models and financing structures to support operations.* The business models employed by existing matching services registries are varied, and research is needed to understand how they could be extended to support a larger scale of operations. The sustainability of these financing structures must be considered. The near exclusive reliance of matching services on public state funding exposes these services to the risk of cut-backs or even elimination during times of state budget deficits. Options for more robust financing include subscription-based fees from private-pay consumers or health care organizations that wish to support the registry's operations. It is also worth noting that the federal government has yet to target specific funding to this area, either through the Medicaid program, the Older Americans Act, or through other federal grant programs. Additionally, this may be an area of interest to private foundations with a focus on improving the country's infrastructure for providing community living supports and alleviating the burden of family caregiving.

6. *Supporting quality assurance for consumers and workers.* The key function that matching services play is to intermediate service fulfillment. But other functions related to quality assurance can and should be built into these models thereby creating additional value for both consumers and workers. Existing registries provide important examples of these added functions, and evaluating their relative utility and ideal mix could be helpful to developing recommendations for a basic "best practice" matching service model.

In conclusion, the strong emphasis on "infrastructure" imbedded in the CLASS legislation reflects a recognition by legislative framers that current systems for delivering "community living assistance services and supports" in the U.S. need to be thoughtfully streamlined and strengthened. The call for examining and improving this infrastructure must be taken seriously if we are to accommodate a new class of beneficiaries with enriched power to purchase in-home services and supports.

Matching service registries have the potential to play an important role in service fulfillment for both privately and publicly funded in-home services and supports, thus helping states meet expanded demand. Brought to scale, these registries are likely to play an important role in reducing the unmet need experienced by some consumers when trying to locate independent providers. Additionally, effective matching service registries offer promise as labor market intermediaries that can help stabilize employment for home care and personal assistance workers as well as provide valuable access points for training and other resources that bolster high quality services.

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