Insights from State Medicaid Innovations to Enhance LTSS Access:

Compendium of Long-Term Services and Supports (LTSS) Related Medicaid Waivers

NOVEMBER 2025

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Research bridging policy and practice

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In alignment with the Governor's Master Plan for Aging, this report was funded by the California Department of Aging's Long-Term Services and Supports (LTSS) Financing and Affordability Initiative as part of the Budget Act of 2022 AB 179 (Ting). This Initiative focuses on data and research of LTSS financing and service options for older adults, people with disabilities, and family caregivers. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, the State of California. For more information, please see the LTSS Financing and Affordability Initiative webpage.

SUGGESTED CITATION

Wickersham, C., Tavares, J., & Cohen, M. (2025). *Insights from State Medicaid Innovations to Enhance LTSS Access: Compendium of Long-Term Services and Supports (LTSS) Related Medicaid Waivers.* LeadingAge Center @UMass Boston. Accessed at https://www.ltsscenter.org/OverlookedMiddle-CA.

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Executive Summary

The Compendium of Long-Term Services and Supports (LTSS) -Related Medicaid Waivers Project provides policymakers and researchers with a national overview of innovative Medicaid programs outside of California that bridge the gap between Medicaid and private pay in covering long-term care services. The Compendium catalogs more than two dozen state models that extend functional eligibility, introduce cost-sharing flexibility, and integrate caregiver supports, demonstrating practical pathways to make LTSS more equitable and sustainable.

This project is part of California's LTSS Financing and Affordability Initiative – a statewide effort to identify scalable strategies that expand access to home- and community-based services (HCBS) for middle-income older adults and people with disabilities who are ineligible for traditional Medi-Cal but cannot afford private long-term care.

To highlight the most transferable approaches, two high-value case studies were presented: Oregon's Project Independence-Medicaid (OPI-M) and Vermont's Choices for Care Moderate Needs Group. These programs illustrate complementary strategies for reaching the "overlooked middle".

The Compendium of Long-Term Services and Supports (LTSS) -Related Medicaid Waivers Project provides policymakers and researchers with a national overview of innovative Medicaid programs outside of California that bridge the gap between Medicaid and private pay in covering long-term care services.

- Oregon Project Independence-Medicaid (OPI-M) extends Medicaid eligibility up to 400% of the Federal Poverty Level (FPL) and offers a broad suite of home- and community-based supports without imposing estate recovery. The program also integrates self-direction and paid caregiver options, giving participants flexibility and protecting family assets.
- Vermont's Choices for Care (Moderate Needs Group) uses a tiered eligibility model that provides homemaker, adult day, and case management services to adults who do not yet meet nursing facility level of care. This preventive approach helps delay institutionalization while maintaining affordability.

Together, these models underscore a growing national movement toward upstream LTSS financing, designed to preserve independence, delay costly institutional care, and protect financial security for aging adults outside of traditional Medicaid boundaries. Lessons from the innovative programs in the Compendium can inform California's ongoing deliberations on how to structure an LTSS financing system that is both equitable and fiscally sustainable.

The Medicaid Compendium: Overview and Purpose

As part of California's **Long-Term Services and Supports (LTSS) Financing and Affordability Initiative**, the research team developed a **Compendium of LTSS-Related Medicaid Waivers** to identify, catalog, and compare innovative Medicaid policy approaches across states that expand LTSS access for the so-called "*Overlooked Middle*." This population includes older adults and people with disabilities whose income or assets place them above traditional Medicaid eligibility thresholds yet who remain unable to afford private long-term care.

Purpose and Scope

The Compendium serves as an Excel-based inventory of Medicaid waiver programs, State Plan Amendments, and demonstration projects outside of California that advance LTSS affordability and accessibility. It provides a systematic framework for examining how states use existing federal authorities such as 1115 demonstrations, 1915(c)/(i)/(k) waivers, and State Plan options to support individuals who do not meet nursing facility level of care requirements but need functional supports to remain in the community.

This resource allows policymakers and researchers to:

- Identify replicable and scalable program models that address middle-income needs.
- Understand the eligibility, benefit structures, and financing mechanisms underpinning innovative state LTSS programs.
- Highlight pathways that bridge Medicaid and non-Medicaid populations through flexible income thresholds, self-directed services, or partial-cost participation.

Development and Analytic Approach

The Compendium was developed through a structured, multi-method process integrating:

1. **Academic and policy literature review** to identify relevant Medicaid innovations nationally;
2. **Desktop research** on waiver documentation, state plans, and CMS approvals; and
3. **Expert interviews** with state and national LTSS policy leaders.

Each program entry in the Compendium includes standardized fields on program type, target population, eligibility criteria, services offered, and program design features, facilitating cross-state comparison. The analytic framework was designed to surface models that demonstrate novel financing structures, expanded functional eligibility, or integrated caregiver supports applicable to California's policy environment. Note that California waivers, state plan, and demonstrations are not included in this analysis.

Key Features

The Compendium includes over two dozen programs representing diverse Medicaid authorities and design strategies, such as:

- **1115 Demonstrations** (e.g., Oregon Project Independence-Medicaid) extending Medicaid eligibility to individuals up to 400% FPL;

- **1915(c) Home- and Community-Based Waivers** that introduce self-direction and caregiver compensation components;
- **1915(i) State Plan Amendments** for adults with functional limitations below nursing facility level of care (e.g., Washington's "At-Risk" programs);
- **Medicaid Buy-In and Reinsurance models** for near-dual and working adults with disabilities (e.g., New York, Maine);
- **Flexible or tiered service structures** that adjust intensity and cost-sharing according to need (e.g., Vermont's Choices for Care Moderate Needs group).

Collectively, these innovations illustrate a growing national movement toward upstream LTSS financing models that preserve independence, delay institutionalization, and protect assets for aging adults outside traditional Medicaid boundaries. The following case studies illustrate two of these high-value models in detail.

High-Value Program Case Studies

In addition to developing the Compendium, another component of the project was to conduct in-depth analyses of two "high-value" programs that exemplify promising, transferable approaches to serving middle-income populations through Medicaid innovation.

These case studies **Oregon Project Independence-Medicaid (OPI-M)** and **Vermont's Choices for Care Moderate Needs Group** were selected for their distinctive design features, including broadened financial eligibility, emphasis on home- and community-based service delivery, and integrated caregiver supports.

By examining these two programs in detail, the project highlights practical strategies that could inform California's policy deliberations on designing sustainable, equitable LTSS solutions for the overlooked middle.

I. Oregon Project Independence - Medicaid (OPI-M)

Oregon OPI-M Features Overview

Category	*Details*
Eligibility	Age 60+ (or 18–59 with disability); income ≤ 400% FPL (~$5,217/month); asset limit $94,523 (single).
Functional Criteria	Requires help with ≥ 1 ADL; no nursing facility (NF) level of care required.
Key Benefits	Adult day care, case management, personal care (up to 40 hrs/biweekly), home modifications (up to $5,000), assistive technology, and meal services.
Caregiver Supports	Education and paid family caregiver options (excluding spouses); self-direction through consumer-employed providers.
Notable Features	No Medicaid Estate Recovery; continuous coverage for 24 months even with income or asset changes.

Program Type

- The Oregon Project Independence-Medicaid (OPI-M) Program is a Section 1115(a) Medicaid Demonstration Waiver.
- The Centers for Medicare & Medicaid Services (CMS) approved the waiver on February 13, 2024, and implementation began on June 1, 2024. It became fully operational in early 2025.
- Initially, a separate program, the Family Caregiver Assistance Program (FCAP), was proposed to support unpaid family caregivers. However, OPI-M and FCAP merged under OPI-M.
- OPI-M is an entitlement program; meeting eligibility requirements equates to immediate receipt of program benefits. In other words, there is no cap on the number of participants.

Description

- Medicaid (OPI-M) is a unique Medicaid-funded program for seniors and physically disabled adults who require assistance with their daily living activities and are at risk of needing long-term services and supports via OR Medicaid (Oregon Health Plan), such as the State Plan Personal Care Program (SPPC) and the Aged & Physically Disabled Waiver (APD Waiver).

General Criteria

- OPI-M is for Oregon residents age 60+, or younger (age 18-59) and physically disabled.
- Program participants can live in their own home or in the home of a loved one. They cannot live in an assisted living residence, residential care facility, or adult foster care home.

Medical Criteria/Functional Need

- Many long-term care programs require an applicant to need a Nursing Facility Level of Care (NFLOC), but the Oregon Project Independence-Medicaid does not.
- For OPI-M, one must require assistance with their Activities of Daily Living (ADLs), including transferring from the bed to a chair, mobility, eating, toileting, bathing, and dressing.
- An applicant's ability to complete Instrumental Activities of Daily Living (i.e., housekeeping, medication management, shopping, laundry) are also assessed.
- The tool used to determine if one meets the functional need is the Client Assessment and Planning System (CAPS).
- Relevant to some persons with Alzheimer's disease or a related dementia, behavioral problems, such as regular attempts to leave the facility or removal of one's clothes, are also considered.
- A diagnosis of dementia does not necessarily mean one will be functionally eligible.
- A service priority level is generated during the assessment process.

- There are 18 levels, ranging from 1 (the highest level of assistance) to 18 (the lowest).
- OPI-M serves individuals with a service priority level ranging from 1 to 18.

Financial Criteria

Income

- The applicant's income limit is equivalent to 400% of the Federal Poverty Level (FPL), which increases annually in January.
- In 2025, an applicant can have up to $5,217 in monthly income.
- When an applicant is married, only the applicant's income is considered; the spouse's income is disregarded.
- While many long-term care Medicaid programs allow a non-applicant spouse a Spousal Income Allowance, also called a Monthly Maintenance Needs Allowance, from their applicant spouse, this is not permitted via OPI-M.

Assets

- Effective July 1, 2024, to June 30, 2025, the individual asset limit is $94,523. This figure is equivalent to six times the monthly Medicaid-funded nursing facility rate in Oregon, which was $518.22 per day in 2025.
- For married couples, with both spouses as applicants, each spouse can have up to $94,523 in assets.
- When only one spouse is an applicant, the assets of both spouses are limited. This is because a married couple's assets are typically held in joint ownership. In this case, the applicant spouse can retain up to $94,523 in assets and the non-applicant spouse is allocated a larger portion of the couple's assets as a Community Spouse Resource Allowance (CSRA).
- The Community Spouse Resource Allowance allows the non-applicant spouse to retain 50% of the couple's assets, up to a maximum of $157,920. If 50% of the couple's assets are less than $31,584, the non-applicant spouse can retain all the couple's assets up to this amount.
- Some assets are excluded from the asset limit.
    - These generally include an applicant's primary home, household furnishings and appliances, personal effects, and a vehicle.
- Assets should not be given away or sold for less than fair market value within 60 months of a long-term care Medicaid application. Medicaid has a Look-Back Rule and violating it results in a Medicaid Penalty Period of ineligibility.
- The Medicaid Estate Recovery Program (MERP) does not apply to OPI-M beneficiaries. Via MERP, following a long-term care Medicaid recipient's death, a state's Medicaid agency attempts reimbursement of long-term care costs for which it paid for that individual.

- Via OPI-M, individuals can receive long-term care without the state reimbursing costs. This means that one's assets are protected for family as inheritance.

Home Ownership

- The home is often the highest-valued asset a Medicaid applicant owns, and many individuals worry that Medicaid will take it.
- For eligibility purposes, OR Medicaid considers the home exempt (non-countable) in the following circumstances.
- The applicant lives in the home or has Intent to Return home, and in 2025, their home equity interest is no greater than $730,000. Home equity is the current value of the home minus any outstanding mortgage. Equity interest is the portion of the home's equity value the applicant owns.

Exclusion Criteria

- Individuals cannot receive OPI-M benefits and be enrolled in other Medicaid-funded long-term services and supports programs, such as the SPPC Program or the APD Waiver, at the same time.
- Persons who qualify for these programs, can instead choose to receive assistance via OPI-M.
- Persons who enroll in OPI-M will have continuous coverage for 24 months, even if their circumstances change, such as an increase in income and assets.

Services Covered[1]

Through OPI-M, a variety of Home and Community-Based Services are available:

- Adult Day Services/Adult Day Care
- Assistive Technology – $5,000 limit
- Assisted Transportation/Escort Services/Non-Medical Transportation
- Caregiver Education/Training
- Case Management/Service Coordination
- Chore Services – i.e., yard work, sidewalk maintenance, heavy housework
- Community Caregiver Support Services – facilitated support groups, group-based activities, paid wellness services
- Evidence-Based Health Promotion – individual or group programs
- Emergency Response Systems
- Home Delivered Meals
- Home Modifications – $5,000 limit
- In-Home Support/Personal Care Services (up to 40 hours every 2 weeks) can include respite care

[1] https://www.medicaidplanningassistance.org/oregon-project-independence/

- Long-Term Care Community Nursing Services – i.e., assessment, monitoring, assigning, teaching
- Options Counseling – counseling to assist persons in making long-term care decisions
- Special Medical Equipment / Supplies
- Supports for Consumer Direction / Advocacy

*The exact benefits one receives is based on an individualized service plan.

**OPI-M does not provide medical benefits (Oregon Health Plan/Medicaid). However, some OPI-M beneficiaries may also be eligible for the Oregon Supplemental Income Program - Medical (OSIPM), the Medicaid program through which seniors and adults with disabilities receive medical care.

Family Caregiver Assistance

- There is also a component for family caregiver assistance.
- Informal (unpaid) caregivers of OPI-M beneficiaries can receive education and training specific to the needs of the care recipient.
- The program participant has the option of receiving personal care assistance through an in-home care agency or self-directing their care through the Consumer-Employed Provider Program.
- With the participant-directed option, the program participant is responsible for finding, hiring, managing, scheduling, and terminating their caregiver, also known as a "homecare worker" (HCW). HCWs must be 18+, capable of performing the required tasks, complete a provider enrollment packet, pass a background check, and attend a homecare worker orientation.
- Friends, relatives, and adult children can be hired as home care workers, but spouses cannot.
- The financial aspects of being an employer, such as tax withholding and issuing caregiver payments, are handled by the state.

Target Population

- Adults aged 60 and over and people with physical disabilities aged 18 to 59.

II. Vermont's Choices for Care Program

Vermont CFC – Moderate Needs Features

Category	*Details*
Eligibility	Age 65+ (or 18+ with disability); income ≤ 300% SSI (~$2,901/mo); asset limit $10,000.
Functional Criteria	Assistance 3+ times/week with ADL or IADL or need for supervision; daily monitoring for chronic condition.
Key Benefits	Homemaker, adult day, case management, respite, assistive devices, home mods.
Caregiver Supports	Case management and respite embedded in service array; coordination with adult day providers.
Notable Features	Not an entitlement; funding limited by appropriations – focus on preventing NF placement.

Program Type: 1115 Demonstration Waiver

Description

- Vermont's model demonstrates how tiered eligibility can extend preventive supports to moderate-need adults not otherwise Medicaid-eligible.
- Vermont's Choices for Care program is divided into two groups: High Needs and Moderate Needs.
- Choices for Care High Needs Group beneficiaries must require a Nursing Facility Level of Care.
- Choices for Care Moderate Needs Group beneficiaries must demonstrate a medical need for the program's services.
- The state will conduct a functional assessment of Choices for Care applicants to determine what level of care they require.
- The assessment will take into consideration an applicant's ability to complete the Activities of Daily Living (mobility, bathing, dressing, eating, and toileting), their need for regular skilled nursing (such as dialysis, tube feedings, and wound care), and their cognitive state.[2]
- The Choices for Care "Moderate Needs" program is an option for individuals who may not require a nursing home level of care but still need some services to help them remain independent in their homes, thereby preventing the need for a more intensive level of service.
- The Moderate Needs option is not an "entitlement" and is limited by available funds.
- Choices for Care provides limited funding for homemaker, adult day, case management, and 'flexible fund' services to people in the "Moderate Needs Group". People in this group do not meet nursing home level of care criteria.

[2] https://www.medicaidlongtermcare.org/eligibility/vermont/#:~:text=Choices%20for%20Care%20High%20Needs%20Group&text=This%20means%20they%20can%20hire,and%20supports%20they%20can%20purchase.

- The intent is to prevent or delay the need for more costly long-term services and supports by providing services.
- People do not need to be Medicaid eligible, however, funding is limited.

General Criteria

- Be a Vermont resident
- Be 65 years of age or older OR 18 years of age or older with a physical disability
- Meet specific clinical criteria
- Meet financial criteria for Vermont Long-Term Care Medicaid.
- Have a functional limitation resulting from a physical condition (including stroke, dementia, traumatic brain injury, and similar conditions) or associated with aging.

Clinical Eligibility

- Individuals who require supervision or any physical assistance three (3) or more times in seven (7) days with any single ADL or IADL, or any combination of ADLs and IADLs.
- Individuals who have impaired judgment or decision-making skills that require daily general supervision.
- Individuals who require at least monthly monitoring for a chronic health condition.
- Individuals whose health condition shall worsen if services are not provided or discontinued.[3]

Financial Criteria

Income

- The income standard for the Moderate Needs group is met if the adjusted monthly income of the individual (and spouse, if any) is less than 300% of the supplemental security income (SSI) payment standard for one person (or couple) in the community after deducting recurring monthly medical expenses (including but not limited to prescriptions, medications, physician bills, hospital bills, health insurance premiums, health insurance co-pays, medical equipment and supplies, and other out of pocket medical expenses.)
- Countable income includes all sources of income, such as Social Security, SSI, retirement, pension, interest, VA benefits, wages, salaries, earnings, and rental income, whether earned or unearned.
- Countable resources include: cash, savings, checking, certificates of deposit, money markets, stocks, bonds, trusts or other liquid assets, excluding primary residence or one car, that an individual (or couple) owns and could easily convert to cash to be used for their support and maintenance, even if the conversion results in the resource having a discounted value. A $10,000 disregard is applied as an adjustment to resource limits.[4]

[3] https://asd.vermont.gov/sites/asd/files/documents/Moderate%20Needs%20Manual%20Merged%205.26.16.pdf

[4] https://asd.vermont.gov/sites/asd/files/documents/Moderate_Needs_Services_At_A_Glance_2.pdf

- Vermont residents must meet an asset and income limit to be financially eligible for home and community-based services through Vermont's Choices for Care program.
- The 2025 income limit for a single applicant for Choices for Care home and community-based services is $2,901 per month.
- The 2025 income limit for the applicant is $2,901 per month, and the non-applicant spouse's income is not included.[5]
- For married applicants with both spouses applying to Choices for Care's Highest Needs Group, the 2025 income limit is $5,802 per month combined.

Assets

- For a single applicant in 2025, the asset limit is $2,000, with two exceptions.
    - Single applicants who own and live in their own home have a $5,000 asset limit.
    - The asset limit for the Choices for Care Moderate Needs Group is $10,000 for both single applicants and couples with one or two spouses.
- The asset limit encompasses nearly all countable assets, including bank accounts, retirement, stocks, bonds, certificates of deposit, cash, and any other assets that can be converted into cash.
- Almost all income is counted, including IRA payments, pension payments, Social Security benefits, property income, alimony, wages, salary, and stock dividends.
- For married applicants with both spouses applying to Choices for Care's Highest Needs Group, the 2025 combined asset limit is $4,000.
- For a married applicant with just one spouse applying for Choices for Care Highest Needs Group, the 2025 asset limit is $2,000 for the applicant spouse and $157,920 for the non-applicant spouse, thanks to the Community Spouse Resource Allowance.

Home Ownership

- An applicant's home does not always count as an asset (see the How Medicaid Treats the Home section below for more details), and there are other non-countable assets, like Irrevocable Funeral Trusts and Medicaid Compliant Annuities.

Exclusion Criteria

- Individuals are not eligible if they require Moderate Needs services that can be effectively met with existing Medicare, Medicaid, VHAP, VA, or private insurance-covered services (e.g. Home Health Agency services, Day Health & Rehab, CRT, TBI waiver, DD waiver, ASP, Essential Person, etc.)

[5] https://www.medicaidlongtermcare.org/eligibility/vermont/#:~:text=Choices%20for%20Care%20High%20Needs%20Group&text=This%20means%20they%20can%20hire,and%20supports%20they%20can%20purchase.

Services Covered[6]

- Medicaid-funded long-term services and supports are provided to individuals who require a nursing home level of care.
- Services are provided in a variety of settings, including a person's own home, Adult Family Care, Enhanced Residential Care and Nursing Facility settings.
- The following services are available to help individuals remain at home:
    - Case Management
    - Intermittent Personal Care
    - Respite or Companion Care
    - Adult Day Services
    - Personal Emergency Response Systems
    - Assistive Devices/Home Modifications
- Adult Family Care (AFC) is a 24-hour, shared living option in the home of another person. Authorized Agencies (AAs) are paid a daily, tiered rate to contract with private, unlicensed AFC homes that serve one to two people in a family home setting.
    - Homes provide personal care, laundry/housekeeping and more.
- Enhanced Residential Care (ERC) Approved Licensed Level III Residential Care Homes and Assisted Living Residences provide services such as:
    - Personal Care
    - Meal preparation
    - Medication Management
    - Activities
    - 24-hour Supervision
    - Laundry/Housekeeping
- Licensed Nursing Homes provide a wide range of services including:
    - Personal Care
    - Meals/Nutritional Services
    - 24-hour Skilled Nursing
    - Rehabilitation and Therapy
    - Activities
    - 24-hour Supervision
    - Social Services
    - Laundry/Housekeeping

Target Population

- 65 years of age or older OR 18 years of age or older with a physical disability.

[6] https://asd.vermont.gov/sites/asd/files/documents/Choice_for_Care_Brochure_1.pdf

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