

A Balancing Act: State Long-Term Care Reform

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Research Report

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AARP's Public Policy Institute informs and stimulates public debate on the issues we face as we age. Through research, analysis and dialogue with the nation's leading experts, PPI promotes development of sound, creative policies to address our common need for economic security, health care, and quality of life.

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Executive Summary

This paper examines the extent to which states have balanced the delivery of Medicaid-funded long-term services and supports to people in their homes (or in more home-like settings in their communities) and in institutions. What is unique about this report is its primary focus on older people and adults with physical disabilities separate from other long-term care populations, such as people with developmental disabilities. The paper explores what states have been able to accomplish under current Medicaid law and addresses the impact that federal policies have on the states' ability to balance service delivery.

Introduction

People want choice and control over everyday decisions, such as when they get up, who helps them to bathe, what foods they eat, or with whom they converse. Yet the Medicaid program—our nation's single largest source of funding for long-term services and supports (LTSS)—does not provide the range of choices people want. Instead, it continues to allocate a disproportionate share of its resources for institutional services.

On average, Medicaid dollars can support nearly three older people and adults with physical disabilities in home and community-based services (HCBS) for every person in a nursing home. Thus, **to the extent that states provide HCBS instead of nursing home services, this shift in service delivery can be both cost-effective and responsive to the preferences of people with disabilities.**

Background

Looking at Medicaid's long-term care (LTC) spending for *all* populations in 2006, services in nursing homes or intermediate care facilities for mental retardation (ICF/MR) accounted for 63 percent. However, the proportion varied significantly by population. Seventy-five percent of Medicaid LTC spending for older people and adults with physical disabilities paid for institutional services, compared to only 39 percent for people with mental retardation/developmental disability (MR/DD). Regardless of the population, progress in shifting more LTSS to HCBS is uneven among the states.

What is “balancing”?

“Balancing,” sometimes called “rebalancing,” is a term that generally refers to:

- serving a greater number of people with LTC needs in their homes or in more home-like settings in their communities than in nursing homes; and
- shifting more resources toward HCBS to “balance” Medicaid LTSS spending between institutional services and HCBS.

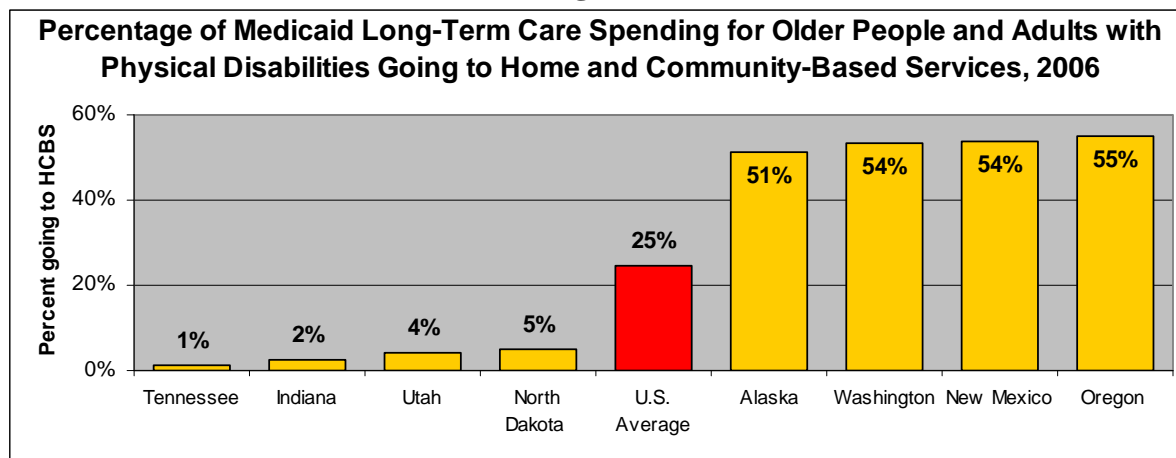
How can we measure balancing?

The most commonly used measure is *the proportion (percentage) of total Medicaid LTC spending going toward HCBS*. These data produce a quantitative measure for comparing the relative level of balance among states and vis-à-vis the national average. This proportion also can be observed over time to gauge the amount of progress made toward balance.

This report was designed to separate Medicaid participation and spending data for older people and adults with physical disabilities from participation and spending data for the population with mental retardation/developmental disability (MR/DD) and other LTC populations. Medicaid home health data are excluded from all calculations.

Finding: There is great variation among states, ranging from 5 percent or less to more than 50 percent of Medicaid LTSS funds going toward HCBS for older people and adults with disabilities (see Figure I).

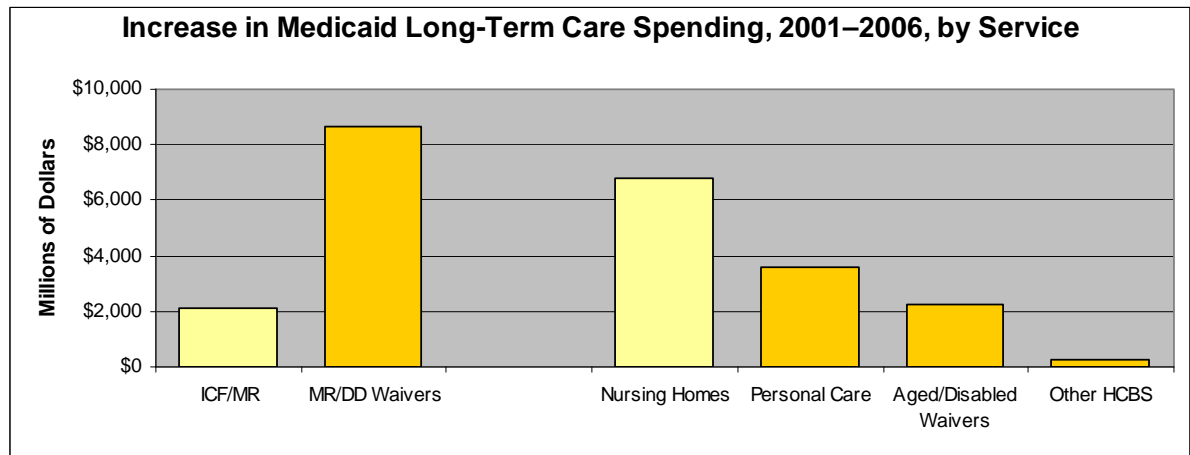
Figure I



Source: AARP Public Policy Institute calculations based on: Burwell, B., Sredl, K., and Eiken, S. (2007). *Medicaid Long-Term Care Expenditures in FY 2006*. Cambridge, MA: Thomson Reuters.

Finding: Figure II indicates that the *spending increase* for MR/DD waiver programs was four times as great as the *spending increase* for ICF/MR from 2001 to 2006. In contrast, the *spending increase* for HCBS for older people and adults with physical disabilities was roughly equivalent to the *spending increase* for nursing homes over this period.

Figure II



Source: AARP Public Policy Institute calculations based on: Burwell, B., Sredl, K., and Eiken, S. (2007). *Medicaid Long-Term Care Expenditures in FY 2006*. Cambridge, MA: Thomson Reuters.

Other balancing measures include changes in the number of Medicaid *beneficiaries* and *dollar* (as opposed to percentage) changes in *expenditure amounts*.

Finding: As illustrated in Table I, the nation made considerable progress by increasing the *number* of older people and adults with physical disabilities receiving HCBS, compared to the number served in nursing homes from 1999 to 2004.

Table I

Type of Service	Medicaid Participants			
	1999	2004	# Change	% Change
HCBS	935,160	1,337,010	+ 401,850	+ 43%
Nursing Homes	1,615,695	1,707,572	+ 91,877	+ 6%

Sources: AARP Public Policy Institute calculations based on: Kitchener, M., Ng, T., Harrington, C., and O'Malley, M. (2007). *Medicaid Home and Community-Based Service Programs: Data Update*. Kaiser Commission on Medicaid and the Uninsured; Harrington, C. and Kitchener, M. (2001). *Medicaid 1915(c) Home and Community-Based Waivers: Program Data 1992-1999*. University of California San Francisco; Center for Medicare & Medicaid Services (CMS), Medicare & Medicaid Statistical Supplement, 2001 and 2007 editions. Participant data excludes Arizona because comparable data for the state are not available.

Finding: From 1999 to 2004, the number of HCBS participants increased in 43 states and declined in seven. In 27 states, the number of nursing home participants increased over the same period, and the number declined in 23 states.

Finding: As illustrated in Table II, the nation made progress in balancing its Medicaid LTC expenditures for older people and adults with disabilities from 2001 to 2006 by increasing HCBS spending by \$6.1 billion, compared to a \$6.6 billion increase for nursing home services.

Because HCBS spending started from a much lower base, this dollar increase represents a more rapid *rate* of spending increase: 65 percent for HCBS compared to 16 percent for nursing homes. It is important to note that this rate of change is not distributed evenly among the states.

Table II

Type of Service	Medicaid Expenditures (millions)			
	2001	2006	\$ Change	% Change
HCBS	\$9,320	\$15,386	+ \$6,066	+ 65%
Nursing Homes	\$40,357	\$46,941	+ \$6,583	+ 16%

Source: AARP Public Policy Institute calculations based on: Burwell, B., Sredl, K., and Eiken, S. (2007). *Medicaid Long-Term Care Expenditures in FY 2006*. Cambridge, MA: Thomson Reuters. Expenditure data excludes Arizona and Vermont because comparable data for the state are not available.

Finding: Progress in balancing Medicaid spending varied greatly among states. In 22 states, the dollar increase in Medicaid spending on HCBS from FY 2001 to FY 2006 was greater than the dollar increase in spending on nursing home care. Another 27 states added more Medicaid funds to nursing home services than to HCBS during these five years.

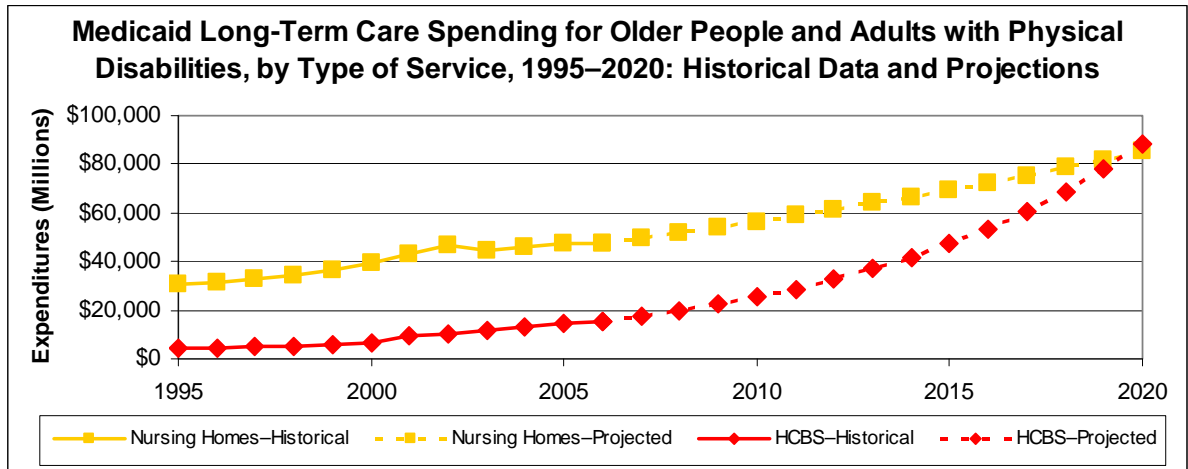
What constitutes a reasonable balance between institutional services and HCBS?

Given that only one in four Medicaid LTC dollars currently supports HCBS for older people and adults with physical disabilities, there is considerable room for improvement. Only four states spend more than 50 percent of their Medicaid LTC dollars for HCBS.

What is a reasonable pace of change?

Looking at the nation as a whole, Medicaid spending on HCBS for older people and adults with physical disabilities has increased at a faster rate than has Medicaid spending for nursing homes. As a result, the *proportion* of Medicaid LTC spending going to HCBS has gone up at a rate of about 1 percentage point per year since 1995. If recent average rates of change in HCBS and nursing home spending continue, the nation will not reach a 50/50 spending balance between HCBS and institutional services for these populations until 2020. This finding is illustrated in Figure III.

Figure III



Sources: AARP Public Policy Institute calculations based on: Burwell, B., Sredl, K., and Eiken, S. (2007). *Medicaid Long-Term Care Expenditures in FY 2006*. Cambridge, MA: Thomson Healthcare (historical); AARP Public Policy Institute (projections).

Even if the nation as a whole achieved a certain balancing benchmark, variation among states is likely to continue. While experts may disagree on what pace of change is adequate, is it unreasonable to expect at least some level of progress? These issues raise a public policy question: Should federal policy enact financial incentives to advance the pace of change? For example, should states be rewarded with a higher Federal Medical Assistance Percentage (FMAP) for achieving greater balance?

Why have some states made more progress than others?

Although there is no single predictor of a state’s success in balancing LTSS, experts have identified several success factors:

- **Philosophy**—The state’s intention to deliver services to people with disabilities in the most independent living situation and expand cost-effective HCBS options guides all other decisions.
- **Array of Services**—States that do not offer a comprehensive array of services designed to meet the particular needs of each individual may channel more people to institutions than will states that provide an array of options.
- **State Organization of Responsibilities**—Assigning responsibility for overseeing the state’s LTSS system to a single administrator has been a key decision in some of the most successful states.
- **Coordinated Funding Sources**—Coordination of multiple funding sources can maximize a state’s ability to meet the needs of people with disabilities.
- **Single Appropriation**—This concept, sometimes called “global budgeting,” allows states to transfer funds among programs and, therefore, make more rational decisions to facilitate serving people in their preferred setting.

- **Timely Eligibility**—Hospitals account for nearly half of all nursing home admissions. When decisions must be made quickly at a time of crisis, state Medicaid programs must be able to arrange for HCBS in a timely manner.
- **Standardized Assessment Tool**—Some states use a single tool to assess functional eligibility and service needs, and then develop a person-centered plan of services and supports. This standardized tool helps to minimize differences among care managers and prevent unnecessary institutionalization.
- **Single Entry Point**—A considerable body of literature points to the need for a single access point allowing people of all ages with disabilities to access a comprehensive array of LTSS.
- **Consumer Direction**—The growing movement to allow participants a greater role in determining who will provide services, as well as when and how they are delivered, responds to the desire of people with disabilities to maximize their ability to exercise choice and control over their daily lives.
- **Nursing Home Relocation**—Some states have made systematic efforts to regularly assess the possibility of transitioning people out of nursing homes and into their own homes or more home-like community alternatives.
- **Quality Improvement**—States are beginning to incorporate participant-defined measures of success in their quality improvement plans.
- **Integrating Health and LTC Services**—A few states have developed methods for ensuring that the array of health and LTC services people with disabilities need are coordinated and delivered in a cost-effective manner.

How does federal Medicaid law affect state LTSS reform?

While this report indicates that a number of states have moved forward in balancing LTSS delivery to older people and adults with disabilities through their Medicaid programs, there may be limits to what states can achieve under existing rules.

- **Institutional Bias**—One factor is that the Medicaid entitlement to nursing facility services creates an uneven playing field for the development of noninstitutional alternatives.
- **Asset Test**—To what extent does the Medicaid asset test complicate providing HCBS? In most states, Medicaid beneficiaries may retain no more than \$2,000 in assets (excluding their homes). For many homeowners, this very low level of assets could make it difficult or impossible to remain in their homes.
- **Case Management**—Transitioning people out of nursing facilities is a key element of state LTSS reform efforts and the focus of substantial federal grant activity under the “Money Follows the Person” initiative. In general, transitioning people out of nursing homes and into home and community-based alternatives will save Medicaid funds, as HCBS generally can be provided at lower cost. However, people with complex medical and/or social needs may require substantial assistance from case

Will progress in Medicaid reshape the LTSS delivery system?

While the focus of this paper has been the role Medicaid plays in delivering LTSS, there will be limits to the ability of Medicaid to reform the entire LTC system of any state or of the nation as a whole. Despite Medicaid's role as the largest source of funding for LTSS, many people will never qualify for Medicaid because their incomes or assets exceed allowable levels. Nor should all individuals expect to rely on Medicaid to pay for their future LTSS needs, as it is meant to be a program of last resort for people with few financial resources.

- A thorough review of LTC reform should include the role of the federal government in providing LTSS and the role of Medicare and its policies in meeting the needs of people with chronic conditions and postacute care needs.
- The role of individual responsibility, whether through the purchase of private LTC insurance, reverse mortgages, or other mechanisms, is another important component. More affordable financing options with good consumer protections will help to broaden the reach of private alternatives to LTC financing.
- The need to provide more support to family caregivers is also critical. The current LTSS system would be strained to the breaking point without these caregivers' contributions.
- Finally, developing broader systemic reform that establishes a universal system for helping people with disabilities pay for the services they need is a longer-range goal for our nation.

What lessons can inform policy decisions at the federal level?

Reforming a state's Medicaid LTSS system is a complex process that requires commitment from state officials and cooperation from federal authorities. Positive transformational change of Medicaid's LTSS system will not occur without a philosophy that embraces the right of people with disabilities to live in the least restrictive environment; effective leadership; a creative problem-solving attitude that can find innovative ways to work within existing laws; and innovative ways to encourage federal policy makers to waive or overturn rules that hinder states' ability to balance their service delivery in favor of HCBS.

This report is designed to stimulate LTSS reform that will improve and increase options for older adults and people with disabilities. The ability of some states to accomplish substantial reforms for older people and adults with physical disabilities—as well as successes in the MR/DD movement, which have led to increased HCBS options for many—demonstrates that obstacles to change can be overcome.

About the data

This report separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with MR/DD and other long-term care populations. The number of participants and amount of spending for HCBS include all enrollees/spending for 1915(c) waiver programs for older people and adults with physical disabilities (sometimes referred to as “aged and disabled” waivers), as well as the personal care services (PCS) option, if offered under the state’s Medicaid plan.

After consultation with a national advisory committee,¹ the authors decided to exclude participants and spending for Medicaid home health, since home health programs in many states provide mostly or entirely postacute care, not LTC; it is impossible to differentiate the spending and participants receiving postacute care from those receiving longer-term services. Postacute services provided under Medicaid home health can contribute to better chronic care management and may prevent the need for institutional services. However, on balance, the authors decided that the characterization of state balancing is better served by excluding home health participants and spending from this analysis. In particular, including home health participants would overstate the number of LTC participants in many states, and misstate the change in the number of Medicaid LTC beneficiaries from 1999 to 2004 in others. The impact of excluding home health is fairly minor in terms of spending.

Because the data used in this report exclude Medicaid home health and separate the population of older people and adults with physical disabilities from other LTC populations, they differ from those reported elsewhere.

To facilitate comparison with HCBS participant numbers, the data reported for nursing home participants are the unduplicated counts of the number of people who use nursing homes over the course of a year, *not* the average number of residents on a given day. Most nursing home stays are for less than a full year, or begin or end during the year; therefore, the number of users over the course of a year is usually substantially higher than the average number of residents on a given day. *Readers should not interpret the number of nursing home users as an indicator of the number of nursing home beds needed in each state.* The average daily census is a better indicator. Thus, Table A-4 in the *Tables* tab also includes the average daily census of Medicaid nursing home residents in 1999 and 2004.

More information about the data and their limitations is contained in the *About the Data* tab of this report.

¹ The national advisory committee comprised Lisa Alecxih, Brian Burwell, Donna Folkemer, Charlene Harrington, Robert Mollica, and Charley Reed.

Overview

This paper examines the extent to which states have balanced the delivery of Medicaid-funded long-term services and supports to people in their homes (or in more home-like settings in their communities) and in institutions. What is unique about this report is its primary focus on older people and adults with physical disabilities separate from other long-term care populations, such as people with developmental disabilities. The paper explores what states have been able to accomplish under current Medicaid law and addresses the impact that federal policies have on the states' ability to balance service delivery. An individual profile for each state and summary tables with additional data follow the overview.

Introduction

“There’s no place like home.” So said Dorothy in *The Wizard of Oz*, and most Americans agree with this sentiment. Surveys show that the overwhelming majority of people age 50 and older (84 percent) want to “age in place,”ⁱ and that those with disabilities (87 percent) prefer to live in their own homes.ⁱⁱ People want choice and control over everyday decisions, such as when they get up, who helps them to bathe, what foods they eat, or with whom they converse. Yet the Medicaid program—our nation’s single largest source of funding for long-term services and supports—does not provide the range of choices people want. Instead, it continues to allocate a disproportionate share of its resources for institutional services.

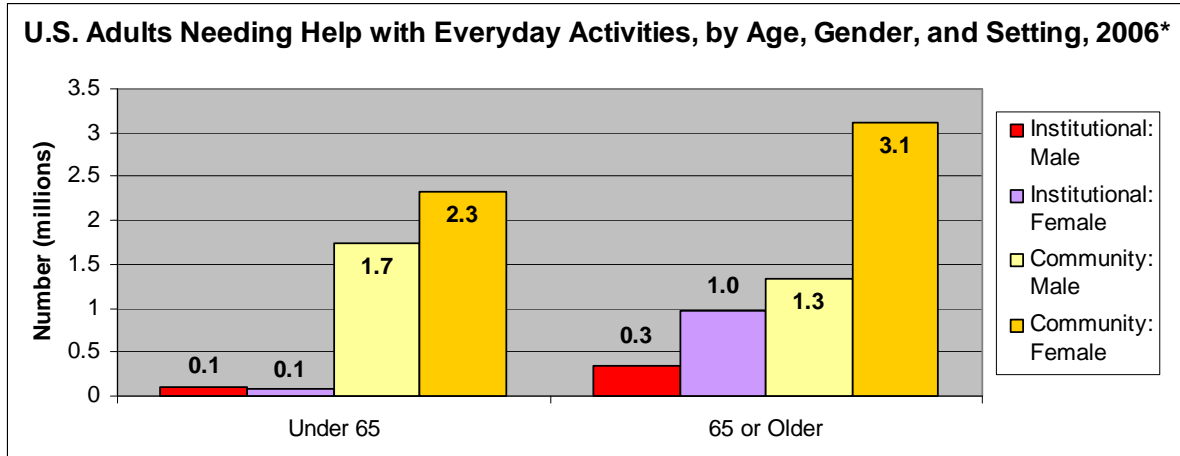
Background

Approximately 10 million U.S. adults need assistance from others to perform everyday activities, and more than 30 million have some type of activity limitation. Long-term services and supports (LTSS), also called long-term care (LTC), are used by people who need assistance to function in their daily lives.¹ For many, these services and supports help preserve the ability to live in their community or to remain employed. Of the 10 million Americans needing help with everyday activities, 58 percent are age 65 or over, and the vast majority (85 percent) lives outside of institutions (see Figure 1).

Among adults who live in the community, more than three-fourths (76 percent) receive *only* informal help from family members and other unpaid caregivers.ⁱⁱⁱ The economic value of family caregiving was estimated at about \$350 billion per year in 2006, which exceeded total spending for either Medicare or Medicaid in 2005.^{iv} When it comes to *paying* for LTC services, the Medicaid program finances nearly half (49 percent). Medicare finances smaller amounts (20 percent, mostly for postacute and rehabilitative services), out-of-pocket accounts for 18 percent, and private insurance accounts for 7 percent. The remainder is paid for by other public and private sources.^v

¹ The terms LTSS and LTC are used interchangeably in this report.

Figure 1



Source: AARP Public Policy Institute Analysis of data from 2006 National Health Interview Survey and 2004 National Nursing Home Survey. *Nursing home data are from 2004, the most recent available.

Because of its dominant role in funding services, Medicaid is the primary focus of this report. Although older people and people with disabilities comprise only one-fourth of all Medicaid enrollees, these populations account for two-thirds of all Medicaid spending, largely because of the high cost of LTC services.

- One in three Medicaid dollars pays for LTC.
- Among Medicaid beneficiaries classified as “aged,” nearly 71 percent of Medicaid expenditures are for LTC.
- Among Medicaid beneficiaries classified as “disabled,” 36 percent of Medicaid expenditures are for LTC.^{vi}

Policy makers are concerned about the high cost of Medicaid spending for LTC and have responded in a variety of ways. Approaches to reforming Medicaid LTSS spending have included measures to ensure that only those with financial need access the program, incentives to purchase private LTC insurance, and policies to develop more cost-effective ways to deliver services.

The people who receive Medicaid LTSS are eligible for services due to a wide array of conditions, including physical disability, severe cognitive impairment, chronic mental illness, HIV/AIDS, and mental retardation/developmental disability (MR/DD). In many cases, a different array of services is authorized for each population. Some services are delivered in institutional settings, such as nursing facilities and intermediate care facilities for mental retardation (ICF/MR); others are delivered in people’s homes or in more home-like community settings, such as assisted living or small group homes. The latter are referred to as home and community-based services (HCBS).

Looking at Medicaid’s LTC spending for *all* populations, in 2006, services in nursing homes or ICF/MR accounted for 63 percent. However, the proportion varied significantly by population. Seventy-five percent of Medicaid LTC spending for older people and adults with

physical disabilities paid for institutional services, compared to only 39 percent for people with MR/DD.²

Regardless of the population, progress in shifting more LTSS to HCBS is uneven among the states. Although the federal government pays for, on average, 57 percent of Medicaid expenditures, the states largely direct how Medicaid funds are spent.³ Within broad federal guidelines, the states decide who will be covered, what services they will get, and how those services will be delivered. A confluence of factors has accelerated the attempts of federal and state policy makers to deliver a greater proportion of Medicaid LTC services to people in HCBS settings. These factors include responding to consumer preferences; the high cost of LTC services, particularly in institutions; the portion of state budgets that are consumed by Medicaid spending; and legal rulings regarding the rights of people with disabilities.

What is “balancing?”

“Balancing,” sometimes called “rebalancing,” is a term that generally refers to:

- serving a greater number of people with LTC needs in their homes or in more home-like settings in their communities than in nursing homes; and
- shifting more resources toward HCBS to “balance” Medicaid LTSS spending between institutional services and HCBS.

At the inception of the Medicaid program in 1965, the only LTC services Congress mandated were nursing home and home health agency services. At that time, the demographics of the older population were very different, and nursing homes were viewed as the preferred form of care. Intermediate care facilities for mental retardation (ICF/MR) and personal care services (PCS) were added later as optional Medicaid services. In addition, some states developed their own state-funded HCBS programs.⁴

Efforts to overcome institutional bias were accelerated when Congress passed Section 1915(c) amendments to the Social Security Act in 1981 permitting the Department of Health and Human Services to “waive” federal rules, thereby allowing states to develop HCBS programs as alternatives to institutional care. Currently all 50 states and the District of Columbia offer HCBS waiver programs,⁵ and there are approximately 300 active HCBS waiver programs across the states. More recently, some states have begun using broader Section 1115 demonstration waivers to reform their LTSS delivery systems. The PCS option, available in 34 states plus the District of Columbia in FY 2006, plays a significant role in some states, including Arkansas, California, New Mexico, New York, and North Carolina.

² AARP analysis of Burwell, B., Sredl, K., and Eiken, S. (2007). *Medicaid Long-Term Care Expenditures in FY 2006*. Cambridge, MA: Thomson Reuters.

³ The Federal Medical Assistance Percentage (FMAP) ranges from 50 to 76 percent, depending on the state’s per capita income.

⁴ A forthcoming AARP Public Policy Institute report examines state-funded programs that deliver HCBS.

⁵ Arizona and Vermont offer programs under Section 1115 demonstration waiver authority.

The U.S. Supreme Court ruling in *Olmstead vs. L.C.*⁶ also prompted attempts to offer Medicaid beneficiaries more alternatives to institutional care. This ruling required states to provide services to people with disabilities in the “least restrictive setting.” The federal government responded with its New Freedom Initiative grant-making process. The *LTC Initiatives and Innovations* tab describes these grants, which include the Real Choice Systems Change grants, Nursing Facility Transition grants, Money Follows the Person initiatives, Aging and Disability Resource Centers, and other initiatives.

Experts may disagree about what constitutes a reasonable balance between institutional services and HCBS. One factor to consider is whether people with disabilities are able to receive the services they need in the setting of their choice. While the needs and preferences of people with disabilities have changed considerably over the past 40 years, allocation of Medicaid funding has not followed those preferences. A survey of people age 50 and older with disabilities found that only 1 percent preferred to receive help with daily activities in a nursing home. Even if 24-hour help was required, only 6 percent expressed a preference to receive care in a nursing home.^{vii} Given the overwhelming proportion of people who express a strong preference for HCBS, it would seem evident that a system that devotes the majority of its resources to institutional services has not achieved “balance.”

How can we measure balancing?

Researchers and policy makers use several measures of balancing LTSS. The most commonly used of these is *the proportion (percentage) of total Medicaid LTC spending going toward HCBS*. These data produce a quantitative measure for comparing the relative level of balance among states and vis-à-vis the national average. This proportion also can be observed over time to gauge the amount of progress made toward balance. Each of the state profiles that follow compares that state’s percentage of Medicaid LTC spending for nursing homes and HCBS for older people and adults with physical disabilities to the national average as one important measure of a state’s balancing progress.⁷ In addition, Table A-1 in the *Tables* tab portrays these data for all states.

The percentage of Medicaid LTSS spending going to HCBS also can be used as a benchmark to measure changes over time in the nation as a whole. Looking at Medicaid LTSS spending for all populations, the nation has made progress. In 1995, just 17 percent of Medicaid LTSS spending paid for HCBS; by 2006 that proportion had increased to 37 percent. Figure 2 illustrates the change in Medicaid funding allocated to HCBS versus institutions, by population.

This report was designed to separate Medicaid participation and spending data for older people and adults with physical disabilities from participation and spending data for the population with MR/DD and other LTC populations. Medicaid participants receiving HCBS who are classified as “older people and adults with physical disabilities” include all enrollees in 1915(c) waiver programs for older people and adults with physical

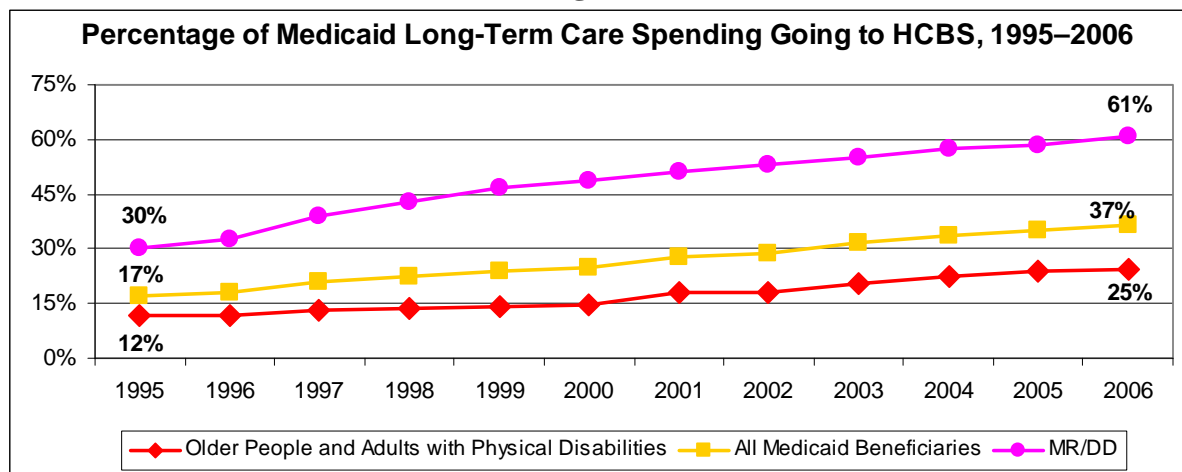
⁶ 119 S. Ct. 2176 (1999).

⁷ All national Medicaid participant findings exclude Arizona because of a lack of comparable data in relation to other states. All national Medicaid LTSS spending data exclude two states—Arizona and Vermont, because they operate large managed care programs through 1115 waivers. As a result, comparable spending data are not available for these states.

disabilities (sometimes referred to as “aged and disabled” waivers), as well as all participants in the PCS option, if the state’s Medicaid plan offers it. While it is possible to separate participants and spending for waiver services by population, adequate data were not available to do so for PCS participants or spending. However, most PCS participants are older people and adults with physical disabilities, and this population accounts for the majority of PCS spending (see the *About the Data* tab for a further discussion of PCS). All beneficiaries receiving nursing home services are included as older people and adults with physical disabilities, regardless of the type of disability or reason for admission. Residents in ICF/MR are treated separately and are compared to people enrolled in MR/DD waiver programs.

After consultation with a national advisory committee,⁸ the authors decided to exclude participants and spending for Medicaid home health, since home health programs in many states provide mostly or entirely postacute care, not long-term care. It is impossible to differentiate the spending and participants receiving postacute care from those receiving longer-term services. Postacute services provided under Medicaid home health can contribute to better chronic care management and may prevent the need for institutional services. However, on balance, the authors decided that the characterization of state balancing is better served by excluding home health participants and spending from this analysis. In particular, including home health participants would overstate the number of LTC participants in many states, and misstate the change in the number of Medicaid LTC beneficiaries from 1999 to 2004 in others. The impact of excluding home health is fairly minor in terms of spending. Because the data used in this report exclude Medicaid home health and separate the population of older people and adults with physical disabilities from other LTC populations, they differ from those reported elsewhere.

Figure 2



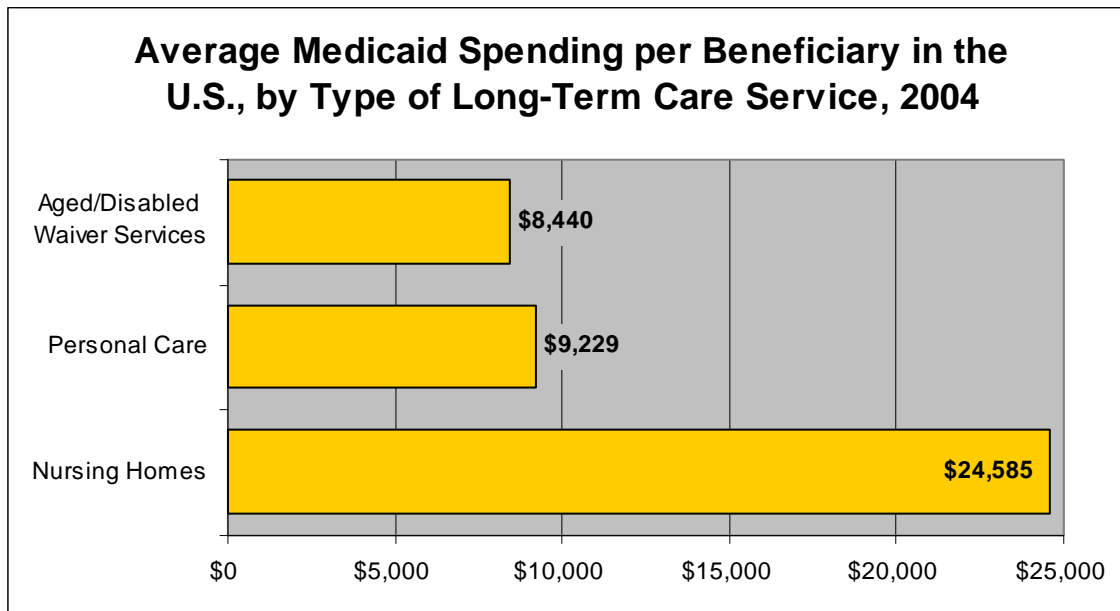
Sources: AARP Public Policy Institute calculations based on: Burwell, B., Sredl, K., and Eiken, S. (2007) *Medicaid Long-Term Care Expenditures in FY 2006*. Cambridge, MA: Thomson Reuters; Burwell, B. (2002) *Medicaid HCBS Waiver Expenditures, FY1995–2001*. Cambridge, MA: Thomson Reuters.

⁸ The national advisory committee comprised Lisa Alecxih, Brian Burwell, Donna Folkemer, Charlene Harrington, Robert Mollica, and Charley Reed.

Medicaid spending per HCBS participant was approximately \$9,000 per year in FY 2004, compared to nearly \$25,000 per person per year for nursing home services. On average, Medicaid dollars can support nearly three older people and adults with physical disabilities in HCBS (PCS or waiver services) for every person in a nursing home.⁹

Thus, **to the extent that states provide HCBS *instead* of nursing home services, this shift in service delivery can be both cost-effective and responsive to the preferences of people with disabilities.** Figure 3 illustrates average spending per beneficiary by type of service.

Figure 3



Sources: HCBS from Kitchener, M., Ng, T., Harrington, C., and O'Malley, M. (2007). *Medicaid Home and Community-Based Service Programs: Data Update*. Kaiser Commission on Medicaid and the Uninsured; Nursing Homes from Center for Medicare & Medicaid Services (CMS), Medicare & Medicaid Statistical Supplement, 2007 edition.

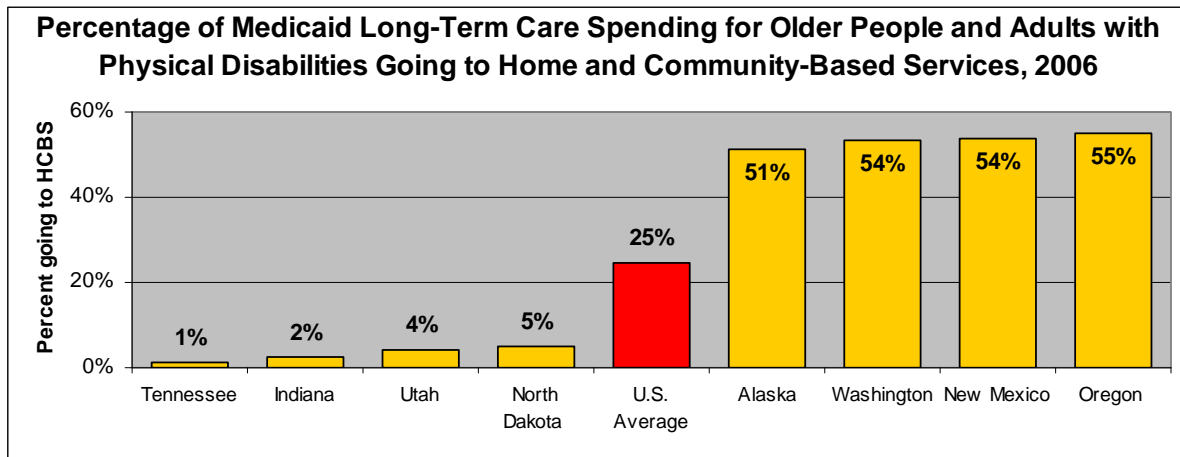
It also is important to note that, consistent with other national analyses, the data in this report do not include Medicaid spending for adult day care or case management when they are provided as part of a state's Medicaid plan. Also, because the report includes only Medicaid spending and participants, it does not include state efforts to provide HCBS to older people and adults with physical disabilities through general revenue funds. In some of the state profiles that follow, these programs are noted where they play a major role in providing HCBS. However, it was beyond the scope of this report to provide a comprehensive view of all state-funded HCBS programs.

⁹ Note that a state can hold steady or even decrease the number of nursing home residents yet still have increased expenditures. Increases may be attributable to medical care inflation, capital costs being spread over a smaller resident population, higher costs for a greater number of residents with heavy care needs, provider taxes, or other factors.

Finding: As illustrated in Figure 4, there is great variation among states, ranging from 5 percent or less to more than 50 percent of Medicaid LTSS funds going toward HCBS for older people and adults with physical disabilities.

In 2006, four states—Oregon, New Mexico, Washington, and Alaska—spent more than 50 percent of their Medicaid LTSS dollars on HCBS. On the other hand, Tennessee, Indiana, Utah, and North Dakota spent the lowest percentages on HCBS: 5 percent or less (see the *Tables* tab for information on all states). However, Indiana and North Dakota have significant state-funded HCBS programs, so an examination of Medicaid spending alone does not fully reflect these states’ LTSS delivery systems.

Figure 4

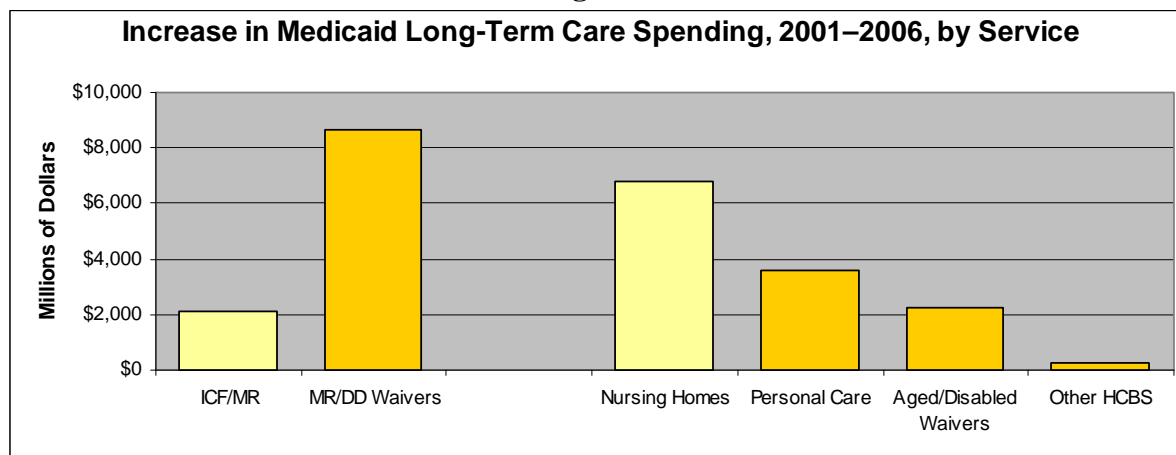


Source: AARP Public Policy Institute calculations based on: Burwell, B., Sredl, K., and Eiken, S. (2007). *Medicaid Long-Term Care Expenditures in FY 2006*. Cambridge, MA: Thomson Reuters.

Another measure of balancing is to evaluate *increases in the percentage of Medicaid expenditures on HCBS in a state*, looking at change from a point in time forward. The flaw in this measure is that *percentage change* in HCBS spending can give the appearance of progress in states with low HCBS spending. For example, because the majority of spending in most states goes to nursing home care, a state can substantially increase its *percentage of spending growth* on HCBS while still allocating little of its overall increased funding to HCBS. This would not constitute significant progress toward a balanced LTC system. One can use this measure, however, to compare the progress in the nation as a whole for various populations and types of services.

Finding: Figure 5 indicates that the *spending increase* for MR/DD waiver programs was four times as great as the *spending increase* for ICF/MR from 2001 to 2006. In contrast, the *spending increase* for HCBS for older people and adults with physical disabilities was roughly equivalent to the *spending increase* for nursing homes over this period.

Figure 5



Source: AARP Public Policy Institute calculations based on: Burwell, B., Sredl, K., and Eiken, S. (2007). *Medicaid Long-Term Care Expenditures in FY 2006*. Cambridge, MA: Thomson Reuters.

Other balancing measures include changes in the number of Medicaid *beneficiaries* and *dollar* (as opposed to percentage) changes in *expenditure amounts*. For every state, this report provides data on the changes in beneficiaries and expenditures over five years for older people and adults with physical disabilities (using, in each case, the most current data available). While no single balancing measure is perfect, we believe that presenting a series of data points can help the reader evaluate the extent of progress in each state, and for the nation as a whole.

For *beneficiaries*, the authors compare the number of Medicaid participants receiving HCBS and nursing home services from 1999 to 2004. One limitation of this measure is that some beneficiaries receive HCBS from more than one Medicaid program; for example, some participants may receive both PCS and HCBS waiver services. To facilitate comparison with HCBS participant numbers, the data reported for nursing home participants are the number of people who use nursing homes over the course of a year, *not* the average number of residents on a given day. Most nursing home stays are for less than a full year, or begin or end during the year; therefore, the number of users over the course of a year is usually substantially higher than the average number of residents on a given day. Nevertheless, in consultation with our national advisory committee, the authors deemed it important to compare the total annual number of nursing home users to the total annual number of HCBS users as one in a series of data elements.¹⁰

Readers should not interpret the inclusion of the higher number of nursing home users as an indicator of the number of nursing home beds in each state. The average daily census is a better indicator of a state's nursing home bed inventory, although most states have a substantial nursing home vacancy rate—in 2004, the national nursing home occupancy rate

¹⁰ Many short-term nursing home users receive postacute care, not LTC. Thus, the comparison to HCBS participants is not perfectly parallel, because of the exclusion of home health, much of which comprises postacute services. The effect of these data features (the possible duplication of HCBS participants, the inclusion of short-term nursing home users, and the inclusion of all PCS participants), may be to slightly overstate or understate the extent of balancing that states have achieved for older people and adults with physical disabilities.

was about 86 percent.^{viii} Table A-4 in the *Tables* tab presents the average daily census of Medicaid nursing home residents in 1999 and 2004.

These data provide a more accurate picture of recent trends in nursing home use. While there was a 6 percent increase from 1999 to 2004 in the number of Medicaid nursing home participants at any time during the year, the average daily census actually shows a 4 percent *decrease* during these years. The explanation for this difference is that fewer people are long-term nursing home residents. This finding indicates that there may be more progress in reducing the use of nursing homes for *LTC* than the total annual use figures indicate. Moreover, as states progress in balancing their LTSS systems, the number of nursing home beds needed may be expected to further decline.

Finding: As illustrated in Table 1, the nation made considerable progress by increasing the number of older people and adults with physical disabilities receiving HCBS, compared to the number served in nursing homes from 1999 to 2004.

Table 1

Type of Service	Medicaid Participants ¹¹			
	1999	2004	# Change	% Change
HCBS	935,160	1,337,010	+ 401,850	+ 43%
Nursing Home	1,615,695	1,707,572	+ 91,877	+ 6%

Finding: The number of HCBS participants increased from 1999 to 2004 in 43 states and declined in seven. In 27 states, the number of nursing home participants increased over the same period, while the number declined in 24 states. See the *State Profiles* tab and the *Tables* tab for state-specific information.

For *expenditures*, the authors examine *dollar* changes in Medicaid spending on HCBS compared to nursing home services from fiscal year 2001 to fiscal year 2006.¹² It is important to note that a dollar spent on HCBS is not equivalent to a dollar spent on nursing home services for a variety of reasons. Nursing home services are generally more costly than are HCBS. Medicaid pays for services *and* room and board costs in nursing homes. By law, however, Medicaid excludes coverage of room and board costs for HCBS beneficiaries, even if they live in assisted living facilities. Thus, each dollar spent for HCBS generally results in more people receiving services than does a dollar spent for nursing home services. More information about the data and their limitations is contained in the *About the Data* section of this report.

¹¹ Medicaid participants receiving HCBS include all enrollees in 1915(c) waivers for older people and adults with physical disabilities and the personal care services option, if the state offers one. This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD); it is possible to separate waiver services by population, but data were not available to do so for personal care. Because mostly older people and adults with physical disabilities use personal care, all beneficiaries receiving these services and their corresponding expenditures are included. All beneficiaries receiving nursing home services are included as well, regardless of type of disability or reason for admission. Residents in intermediate care facilities for mental retardation (ICF/MR) are excluded, as are individuals receiving services through managed care programs that provide LTC services.

¹² For the state balancing findings, nursing home expenditures were used from FY 2000—instead of FY 2001—for seven states because of reporting irregularities in these states in FY 2001.

Finding: As illustrated in Table 2, the nation made progress in balancing its Medicaid LTC expenditures for older people and adults with disabilities from 2001 to 2006 by increasing HCBS spending by \$6.1 billion, compared to a \$6.6 billion increase for nursing home services.

Table 2

Type of Service	Medicaid Expenditures (millions) ¹³			
	2001	2006	\$ Change	% Change
HCBS	\$9,320	\$15,386	+ \$6,066	+ 65%
Nursing Homes	\$40,357	\$46,941	+ \$6,583	+ 16%

Because HCBS spending started from a much lower base, this dollar increase represents a more rapid *rate* of spending increase: 65 percent for HCBS compared to 16 percent for nursing homes. It is important to note that this rate of change is not distributed evenly among the states.

Finding: Progress in balancing Medicaid spending varied greatly among states. In 22 states, the dollar increase in Medicaid spending on HCBS from FY 2001 to FY 2006 was greater than the dollar increase in spending on nursing home care. Another 27 states added more Medicaid funds to nursing home services than to HCBS during these five years. See the *State Profiles* tab and the *Tables* tab for state-specific information.

Other Issues Related to System Balancing

As we examine LTSS balancing, this report addresses several questions:

- What constitutes a reasonable balance between institutional services and HCBS?
- What is a reasonable pace of change?
- Why have some states made more progress than others?
- How does federal Medicaid law affect state LTSS reform?
- Will progress in Medicaid reshape the LTSS delivery system?
- What lessons can inform policy decisions at the federal level?

What constitutes a reasonable balance between institutional services and HCBS?

As Table 1 indicates, the *number* of older people and adults with physical disabilities who receive HCBS is beginning to approach the number in nursing homes. Even so, few people express a preference to live in nursing homes. Moreover, only one-fourth of Medicaid LTSS spending for older people and adults with physical disabilities goes toward HCBS.

Looking at the balance of Medicaid service delivery to people with MR/DD, nationally about \$6 of \$10 supports HCBS. It is unlikely that this constitutes the “best” that states can do to

¹³ As with participants, expenditures for HCBS include all waiver services for older people and adults with physical disabilities and all PCS expenditures. Nursing homes include all expenditures for nursing home services, regardless of type of disability or reason for admission. Excluded are expenditures for ICF/MR, HCBS waivers for other populations such as MR/DD, and individuals receiving services through managed care programs that provide LTC services.

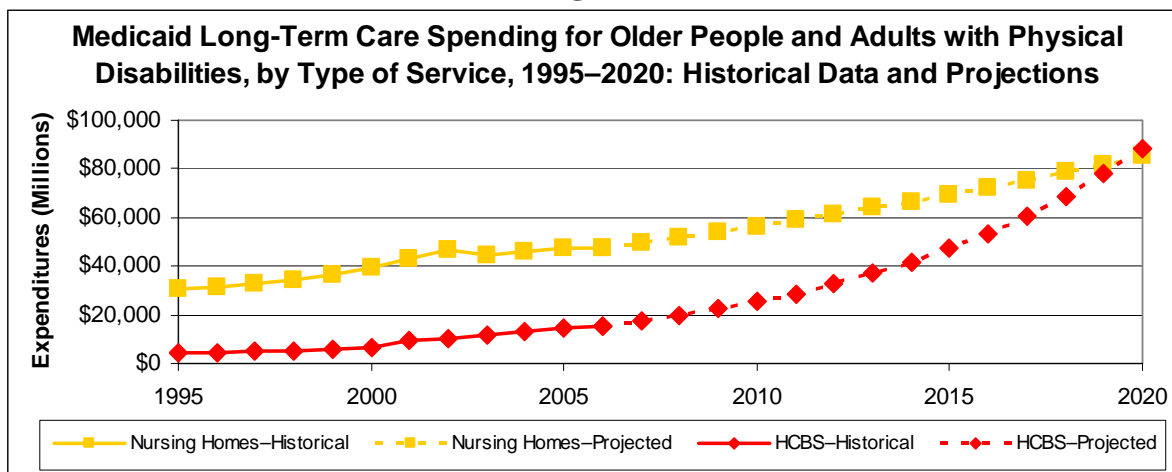
ensure access to services in the most preferred setting. For example, in 2006, four states (Alaska, Oregon, New Hampshire, and Michigan) spent 98 to 100 percent of their LTSS dollars for people with MR/DD on HCBS.

A few states are close to achieving a 60/40 benchmark for older people and adults with physical disabilities. For example, Oregon, New Mexico, Washington, and Alaska exceed 50 percent of Medicaid LTSS spending on HCBS for older people and adults with physical disabilities. Most states have further to go to emulate this success. Whether a person of any age or disability faces a few months, years or a lifetime in an institution, public policy should strive to help people live in the least restricted environment, using both private and public resources as efficiently as possible. In 2006, only seven states spent 40 percent or more of their LTSS dollars on HCBS for older people and adults with physical disabilities: the four states listed above plus California, Texas, and Minnesota. The question is, what is needed to accelerate the pace of change toward a more balanced LTC system in all states?

What is a reasonable pace of change?

The answer to this question depends in part on political will and the intensity of advocacy for older adults and other people with disabilities. Looking at the nation as a whole, Medicaid spending on HCBS for older people and adults with physical disabilities has increased at a faster rate than has Medicaid spending for nursing homes. As a result, the *proportion* of Medicaid LTC spending going to HCBS has gone up at a rate of about 1 percentage point per year since 1995. If recent average rates of change in HCBS and nursing home spending continue, the nation will not reach a 50/50 spending balance between HCBS and institutional services for these populations until 2020. This finding is illustrated in Figure 6.

Figure 6



Sources: AARP Public Policy Institute calculations based on: Burwell, B., Sredl, K., and Eiken, S. (2007). *Medicaid Long-Term Care Expenditures in FY 2006*. Cambridge, MA: Thomson Reuters (historical); AARP Public Policy Institute (projections).

Variation among states is likely to continue. While experts may disagree on what pace of change is adequate, is it unreasonable to expect at least some level of progress? These issues raise a public policy question: should federal policy enact financial incentives to advance the

pace of change? For example, should states be rewarded with a higher Federal Medical Assistance Percentage (FMAP) for achieving greater balance and/or sanctioned for failing to do so by losing a portion of their FMAP? There is some precedent for this type of incentive. For example, the Deficit Reduction Act of 2005 (DRA 05) provides a temporarily enhanced FMAP when states that enact Money Follows the Person initiatives transition individuals from nursing homes into HCBS. Another example of a successful incentive occurred with the State Children’s Health Insurance Program (SCHIP), under which states received an enhanced FMAP for establishing these services, and all states have done so.¹⁴

There currently is no clear relationship between a state’s overall FMAP and its degree of LTSS balancing. There is some concern that fiscal sanctions for failure to achieve progress would result in even poorer service delivery to people in need, but positive incentives have precedent and may accelerate the pace of change. Whether cost savings from a more balanced system would offset the federal cost of an enhanced FMAP—an important consideration—is unknown.

Why have some states made more progress than have others?

Clearly, by any of the measures used in this report, some states have achieved more balanced LTSS systems for older people and adults with physical disabilities than have others. Three of the most balanced states in terms of the percentage of Medicaid spending going toward HCBS—Oregon, Washington, and New Mexico—*continue* to balance their LTSS systems through new initiatives and thoughtful planning. In these three states, many more participants receive HCBS than reside in nursing homes. **The number of participants receiving HCBS increased significantly, while nursing home participants decreased from 1999 to 2004.** Medicaid spending on HCBS far outpaced spending on nursing home services in these states, which allocated significantly more money from 2001 to 2006 to HCBS than to nursing homes. During this time, **nursing home expenditures in Washington actually decreased.**

Policy makers and researchers have attempted to identify successful practices. A review of the literature reveals several studies that analyze and identify key determinants that contribute to more balanced LTSS systems. But there is no magic formula that will accomplish system change without strong leadership and the political will to do so. “Success” cannot be measured only by looking at the allocation of a state’s Medicaid dollars. An analysis of the hallmarks of a balanced system identified the components of an ideal LTSS system:^{ix}

Philosophy—The state’s intention to deliver services to people with disabilities in the most independent living situation and expand cost-effective HCBS options guides all other decisions. How a state views quality of life for older adults and people with disabilities, and the importance of participants having a choice in how their services are provided, may be the most important factor in having a balanced LTSS system.

¹⁴ Note, however, that the cost of providing services to children is generally low, compared to the generally high cost of providing LTC.

Array of Services—States that do not offer a comprehensive array of services designed to meet the particular needs of each individual, and to address the needs of people of all income levels, may channel more people to institutions than will states that provide an array of options. No one service is most important. Participants should have an array of services from which to choose, enabling them to select those that are most important to meet their needs and preferences.

State Organization of Responsibilities—Assigning responsibility for overseeing the state’s LTSS system to a single administrator has been a key decision in some of the most successful states.

Coordinated Funding Sources—Coordination of multiple funding sources can maximize a state’s ability to meet the needs of people with disabilities.

“Global Budgeting”

Some states are using global budgeting, also known as “pooled financing,” as a financing mechanism to allow for consolidation of LTSS funding, whether for institutional services or HCBS, in one budget. State officials then have discretion, within a spending limit, to allocate LTSS funds as appropriate.

In 2004 and 2005, gubernatorial executive orders in New Jersey helped set the stage for global budgeting. In June 2006, the New Jersey legislature enacted The Independence, Dignity and Choice in Long-Term Care Act authorizing the global budgeting process to be implemented in FY 2008. In Ohio, the FY 2007–2008 budget bill authorized development of a unified budget for long-term care. States such as Oregon, Vermont, and Washington also have global budgeting procedures.

Single Appropriation—This concept, sometimes called “global budgeting,” allows states to transfer funds among programs and, therefore, make more timely decisions to facilitate serving people in their preferred setting.

Timely Eligibility—Hospitals account for nearly half of all nursing home admissions. When decisions must be made quickly at a time of crisis, state Medicaid programs must be able to arrange for HCBS in a timely manner. Successful states have implemented procedures that either presume financial eligibility for Medicaid HCBS or “fast track” the eligibility determination process.

Standardized Assessment Tool—Some states use a single tool to assess functional eligibility and service needs, and then develop a person-centered plan of services and supports. This standardized tool helps to minimize differences among care managers and prevent unnecessary institutionalization. Such a tool also can be used to collect consistent data, leading to better system management.

Single Entry Point—A considerable body of literature points to the need for a single access point allowing people of all ages with disabilities to access a comprehensive array of LTSS. Effective systems that determine eligibility, coordinate services, and monitor quality can support people who have their own resources to pay for services, as well as those who qualify for public programs. A robust system of information and assistance is critical, as most people with disabilities and their families have a difficult time negotiating a complex system.

Consumer Direction—The growing movement to allow participants a greater role in determining who will provide services, as well as when and how they are delivered, responds to the desire of people with disabilities to maximize their ability to exercise choice and control over their daily lives.

Nursing Home Relocation—Some states have made systematic efforts to regularly assess the possibility of transitioning people out of nursing homes and into their own homes or more home-like community alternatives. Medicaid payment for transition services is a critical component of the success of these efforts. Some states assign staff to visit nursing homes regularly to identify, assess, and help people relocate from the nursing home to the community.

Quality Improvement—States are beginning to incorporate participant-defined measures of success in their quality improvement plans.

“Housing Alternatives”

While there may, indeed, be “no place like home,” there is a range of alternatives to institutions that are far more home-like in nature, including adult foster care, small-group homes, and assisted living. A number of states have used these cost-effective alternatives, but the need for housing options is critical. There are profound shortages of accessible and affordable housing that states can coordinate readily with needed services. States that develop mechanisms to provide access to both housing and services will meet the needs of a broad range of people with disabilities more effectively. State housing agencies or authorities in many states are providing tax credits or otherwise supporting the development of assisted living facilities or other residential housing for low-income people with disabilities.

For example, Illinois and Ohio are encouraging development of Medicaid-supported assisted living. Alaska is developing assisted living options in rural areas of the state.

Louisiana is using its Systems Transformation grant to undertake a 3,000-unit Permanent Supportive Housing Initiative for people with disabilities. The project is also financed with Low Income Housing Tax Credits and Community Development Block Grant funds. In addition, the federal grant was used to develop a housing locator website, www.LAHousingSearch.org, supported by a toll-free bilingual call center. In Las Vegas, Nevada, an assisted living facility opened in August 2006 that was a first of its kind in that it uses tax credit financing, donated public land, and Medicaid service reimbursement to provide affordable assisted living to low-income older people. It is a model for other such assisted living developments throughout the state.

Several states also are using part of their MFP grants to address housing; New Jersey is using its MFP grant to expand transition services to aid in finding housing; New York is using its grant to establish a housing task force to focus on housing barriers to community integration; and Pennsylvania is using its funds to hire housing coordinators to provide assistance to state and local staff to identify housing resources for people who transition into the community and to provide training and technical assistance to transition consultants.

Integrating Health and Long-Term Care Services

—A few states have developed methods for ensuring that the array of health and LTC services people with disabilities need are coordinated and delivered in a cost-effective manner. For many people, the ability of states to do so is complicated by differences in how Medicare and Medicaid programs are administered. Especially among people age 65 and older, the great majority of those receiving Medicaid are eligible for Medicare as well.

There are many ways to achieve more integrated systems. Some states have adopted the Program of All-Inclusive Care for the Elderly (PACE), which integrates Medicare and Medicaid funding and provides both health and LTC services, and a number of states have implemented managed care systems. For example, the Wisconsin Family Care program is an example of a successful managed care program.

“Participant Direction”

Another major trend in the delivery of LTSS is the growing use of self-directed services, also called consumer direction, Cash and Counseling, or participant direction. In the 1990s, the federal government and the Robert Wood Johnson Foundation funded a Cash-and-Counseling Demonstration program in Arkansas, Florida, and New Jersey under Section 1115 waivers that allow Medicaid-eligible individuals in the three states to manage their own LTSS budget and purchase services. In October 2004, 12 additional states received grant funds to replicate the Cash-and-Counseling model. Most other states allow some form of participant direction under their Medicaid programs, although the scope each program varies. The Deficit Reduction Act of 2005 expanded the opportunity for self-direction by allowing all states to offer self-directed personal assistance services without having to seek a federal waiver.

While it is beyond the scope of this project to evaluate whether each state had incorporated all of the measures identified above, the state profiles that follow highlight many initiatives that address one component or more. While there is no simple answer to why some states have made more progress than others, there are many possibilities. States that have not achieved greater balance may have failed to embrace the philosophy of independence and make it a priority because they may have lacked the initiative or ability to address administrative and/or budgetary reorganization. For a variety of political and/or economic reasons, states may not have had the budget capacity to invest in the infrastructure necessary for achieving greater balance between institutional and HCBS systems.

How does federal Medicaid law affect state LTSS reform?

While this report indicates that a number of states have moved forward in balancing LTSS delivery to older people and adults with disabilities through their Medicaid programs, there may be limits to what states can achieve under existing rules. Several states have virtually eliminated institutional services to the population with MR/DD. While few would suggest that nursing facilities can or should be eliminated for older persons, why is it so difficult for many states even to approach a 50/50 balance between nursing home and HCBS spending? Discussion of several factors follows.

Institutional Bias—One factor is that the Medicaid entitlement to nursing facility services creates an uneven playing field for the development of noninstitutional alternatives. Establishing an entitlement to HCBS under Medicaid has not occurred for a number of reasons, one of which is that mandating provision of HCBS under Medicaid could result in a “woodwork effect.”

The woodwork effect means that people who currently receive only informal services from family and friends would demand HCBS if they were available at little or no cost. Such individuals do not seek nursing home services most likely because they are less desirable than home care. A woodwork effect could result in more and difficult-to-control spending. States like Oregon and Washington have demonstrated that they can serve more people at a lower cost per case by using noninstitutional settings whenever preferable and feasible. These states do serve more people with “unmet needs,” absorbing them in the savings achieved through lower nursing home utilization and overcoming the fear of uncontrollable spending demands. Other states are just learning these lessons, which may become more evident through the Money Follows the Person demonstration.

Some advocates have recommended leveling the playing field by eliminating the Medicaid entitlement to nursing facility services, which would engender some political concerns. First, there would be resistance from nursing facility services providers. Moreover, nursing facility residents and their families could be left with no viable means of paying for services. Would states continue to pay for nursing facility services through their Medicaid programs, and, if not, how would people pay for these services, given their high cost?

There are ways to address these concerns. For example, Vermont has instituted an innovative program to put access to nursing homes and HCBS on an equal footing. To do so, the state developed a Section 1115 waiver proposal. Although the approval process was lengthy, this fundamental system change demonstrates that a state, working with the Centers for Medicare & Medicaid Services (CMS), can restructure its Medicaid LTSS payment and delivery system. The Vermont system is described in more detail in its state profile.

State Plan Option—Section 6086 of the DRA 05, which authorized a new option for states to provide HCBS under their Medicaid state plans without having to seek a federal waiver, requires states to establish functional eligibility criteria for HCBS that are less stringent than those used for nursing homes. This provision addresses concerns that states find it difficult to *prevent* the need for institutional services because HCBS waiver programs require participants to meet the same functional eligibility criteria as those used for nursing home admission. To date, only one state (Iowa) has adopted this provision. Major concerns about this option include a limitation on the services that can be provided and a restriction on income eligibility (150 percent of the federal poverty guideline, or \$15,600, per year in 2008) that is more stringent than what states may use for waiver programs (300 percent of the federal Supplemental Security Income [SSI] level, or \$22,932, in 2008).

Asset Test—To what extent does the Medicaid asset test complicate providing HCBS? In most states, Medicaid beneficiaries may retain no more than \$2,000 in assets (excluding their homes). For many homeowners, this very low level of assets could make it difficult or impossible to remain in their homes. For example, the cost of a new furnace or roof would

likely exceed \$2,000. Further research on the impact of the Medicaid asset test on the ability of older people to receive services in their own homes would be useful. Section 1902(r)(2) of the Social Security Act allows states to expand eligibility by using more generous resource methodologies, and a few states have taken advantage of this option. For example, Pennsylvania has raised the allowable asset level to \$8,000.

Spousal Protection—Another factor that affects access to HCBS is the Medicaid provision requiring states to allow spouses of nursing home residents to protect additional income and assets to prevent their impoverishment. In 2008, a community spouse may retain half the couple’s assets, up to a maximum of \$104,400, and between \$1,711 and \$2,610 per month in the spouse’s income, if his or her own income is less than this amount. (The lower amount is a federally mandated minimum, but states have the flexibility to allow amounts up to the maximum.) While states may extend these protections to HCBS waiver couples, they are not required to do so. Moreover, CMS has interpreted its rules on spousal impoverishment to allow states to extend these protections to HCBS waiver spouses only if they qualify under the “300 percent” rule. Spousal impoverishment protection is not allowed if individuals qualify for services because their health and LTC costs allow them to “spend down” to eligibility.^x Denying a state the ability to prevent impoverishment of spouses of waiver beneficiaries may reinforce a bias toward delivery of services in institutions.

Case Management—Transitioning people out of nursing facilities is a key element of state LTSS reform efforts and the focus of substantial federal grant activity under the Money Follows the Person initiative. In general, transitioning people out of nursing homes and into home and community-based alternatives will save Medicaid funds, as HCBS generally can be provided at lower cost. However, people with complex medical and/or social needs may require substantial assistance from case managers to ensure a smooth and sustainable transition.

In 2000, on the heels of the *Olmstead* decision, a CMS State Medicaid Director’s letter authorized and effectively encouraged states to use up to 180 days of targeted case management to help transition Medicaid beneficiaries from nursing homes to HCBS. This policy directive sought to help states address the complex service needs of people with disabilities. However, in November 2007, CMS issued an interim final rule (CMS-2237-IFC) that may undermine states’ ability to achieve these important transition activities. As of this writing, case management is limited to 60 days of transitional assistance or less, depending on how long the individual had lived in the institution. Reimbursement is prohibited if the individual ultimately fails to achieve a transition out of the institution. Additionally, reimbursement is limited to a single case manager, regardless of the complexity of the individual’s condition.^{xi}

Threats to Medicaid Funding—Of the Medicaid LTSS spending for older people, some 84 percent is considered “optional,” because either the participants are eligible as a result of optional eligibility criteria or the services they receive are optional (i.e., not mandatory).^{xii} For example, all states allow nursing homes residents to qualify for services on the basis of either “medically needy spend down,” or the so-called 300 percent rule, which allows participants to have incomes of up to 300 percent of the federal SSI benefit level. Were it not for these more expansive income eligibility criteria, only older people with incomes at or

below the SSI benefit level (\$637 per month in 2008) would qualify for Medicaid. In addition, only nursing home and home health services are mandatory; all personal care and “waiver” services are optional.

When states face economic challenges and have to balance their budgets, the Medicaid program may be a target for cutbacks. Optional services are the easiest to cut, so they are at high risk for elimination or reduction. A state survey in 2006 revealed that all states reported using cost controls in their HCBS waiver programs. These controls included restrictive financial and functional eligibility criteria, enrollment limits, and waiting lists. The researchers found that 280,176 individuals were on waiting lists for HCBS waiver services: 147,610 for MR/DD waivers and 117,556 for aged or aged/disabled waivers. The average waiting time for aged waivers was 42 months.^{xiii} These long waiting lists may be an indication that the current allocation of resources is not adequate to meet existing needs for HCBS. However, waiting lists may not always be accurate reflections of need, as some states do not maintain them at all and other states may not update them regularly. Also, people on waiting lists may not meet the state’s financial or functional eligibility criteria and, ultimately, may not qualify for Medicaid.

Expectations—The Medicaid program allows states considerable flexibility within the framework of federal law, although they must provide a number of services and include certain categories of participants. Beyond these requirements, there are limits to federal oversight and few, if any, incentives for states to provide a rich array of services or transform their programs to address the needs and preferences of people with disabilities. For example, the federal government does not expect states to provide a certain percentage of their LTC services in home and community-based settings. Perhaps a CMS benchmark for states, and a set of expectations regarding the pace at which they are expected to achieve standards, would result in greater state balancing. Of course, states are starting in very different places, but a specific set of expectations might provide the necessary incentive for states that are behind national norms to improve their programs. Policy makers might consider whether fiscal incentives and/or sanctions for meeting, exceeding, or failing to meet benchmarks would be a useful tool, if states fail to meet established benchmarks voluntarily.

Will progress in Medicaid reshape the LTSS delivery system?

While the focus of this paper has been the role Medicaid plays in delivering LTSS, there necessarily will be limits to the ability of Medicaid to reform the entire LTC system of any state or of the nation as a whole. Despite Medicaid’s role as the largest source of funding for LTSS, many people will never qualify for Medicaid because their incomes or assets exceed allowable levels. Nor should all individuals expect to rely on Medicaid to pay for their future LTSS needs, as it is meant to be a program of last resort for people with few financial resources.

A thorough review of LTC reform should include the role of the federal government in providing LTSS and the role of Medicare and its policies in meeting the needs of people with chronic conditions and postacute care needs. The role of individual responsibility, whether through the purchase of private LTC insurance, reverse mortgages, or other mechanisms, is another important component. More affordable financing options with good consumer

protections will help to broaden the reach of private alternatives to LTC financing. The need to provide more support to family caregivers is also critical. The current LTSS system would be strained to the breaking point without family caregivers' contributions. Finally, developing broader systemic reform that establishes a universal system for helping people with disabilities pay for the services they need is a longer-range goal for our nation.

Although Medicaid reforms will never transform the LTSS system for *all* Americans, they will affect the lives of hundreds of thousands of people with disabilities who need services and have nowhere else to turn. Therefore, it would be nearly impossible to achieve meaningful LTC reform, at least in the near term, without making meaningful changes in Medicaid. Moreover, as the largest source of payment for LTSS, the Medicaid program influences the larger market for LTC and has played a major role in developing the service delivery infrastructure that assists people of all incomes. For example, the Medicaid system influences the administration of universal pre-admission assessments for nursing facilities, and it has been a major force in the development of single entry points of access to LTSS, including the Aging and Disability Resource Centers (ADRC) that serve people of all income levels in most states. State Medicaid programs also are leading the way in the development of more broadly applicable quality improvement systems.

What lessons can inform policy decisions at the federal level?

Reforming a state's Medicaid LTSS system is a complex process that requires commitment from state officials and cooperation from federal authorities. Positive transformational change of Medicaid's LTSS system will not occur without a philosophy that embraces the right of people with disabilities to live in the least restrictive environment; effective leadership; a creative problem-solving attitude that can find innovative ways to work within existing laws; and inventive ways to encourage federal policy makers to waive or overturn rules that hinder states' ability to balance their service delivery in favor of HCBS.

Federal grants have made substantial investments in state LTSS balancing. Some states have used these funds in a variety of innovative and effective ways and have made significant changes to the allocation of funds, thereby expanding the delivery of HCBS. Others have failed to make substantial progress in reallocating LTSS spending. Some of the federal grants have provided temporary financial incentives to help states transition people with disabilities out of institutions and into their homes or more home-like community settings. Once the financial incentives expire, will states be willing and/or able to sustain people in HCBS settings? Even if people who have been transitioned are sustained in the community, will states continue their efforts to transition more people out of institutions, or divert them from entering in the first place, without enhanced financial incentives?

Moreover, the federal policy-making environment can reverse progress that has been made. For example, the previously mentioned federal policy change with regard to payment for case management services is likely to hinder states' ability to move people successfully from institutions into HCBS settings.

The challenge for states is to reform their Medicaid LTSS systems in sustainable, cost-effective ways that meet the needs and preferences of people with disabilities. We are

encouraged by the findings that some states have made substantial progress in balancing. But it is discouraging to see that many states still devote 90 percent or more of their Medicaid LTSS funding to institutional services. Failure to balance inhibits the ability of people with disabilities to exercise the choices and preferences that constitute some of their fundamental human rights.

The state profiles that follow share promising practices and new, innovative developments as well as budgetary numbers for each state (see the *State Profiles* tab). These state profiles are not intended to be a comprehensive catalogue of all LTC balancing initiatives, nor do they include the same information for each state. The landscape of each state is unique and changes rapidly. The selection of initiatives included was somewhat subjective, and, in some cases, may be out of date by publication. Most of the data on state initiatives were collected during the latter half of 2007, and all state profiles were reviewed and updated in May 2008.

The summary tables that follow the state profiles provide a more consistent set of data for all states, allowing readers to evaluate how states compare on a number of LTSS balancing measures as well as several other LTC reform initiatives. This report is designed to stimulate LTSS reform that will improve and increase options for older adults and people with disabilities. The ability of some states to accomplish substantial reforms for older people and adults with physical disabilities—as well as successes in the MR/DD movement, which have led to increased HCBS options for many—demonstrate that obstacles to change can be overcome.

ⁱ AARP *Beyond 50.05 Survey*, April 2005, available at http://www.aarp.org/research/housing-mobility/indliving/beyond_50_communities.html

ⁱⁱ Gibson, Mary Jo, et al. (2003, April). *Beyond 50.03: A Report to the Nation on Independent Living and Disability*. Washington, DC: AARP.

ⁱⁱⁱ Feder, Judith, Komisar, Harriet L., and Friedland, Robert B. (2007, June). *Long-Term Care Financing: Policy Options for the Future*. Washington, DC: Georgetown University.

^{iv} Gibson, Mary Jo, and Houser, Ari N. (2007, June). *Valuing the Invaluable: A New Look at the Economic Value of Family Caregiving*. Washington, DC: AARP.

^v Feder et al.

^{vi} Congressional Budget Office. (2007, November). *The Long-Term Outlook for Health Spending*, available at <http://www.cbo.gov/ftpdocs/87xx/doc8758/AppendixA.4.1.shtml#1069607>

^{vii} Gibson, et al.

^{viii} National Center for Health Statistics. (2006, December). *National Nursing Home Survey 2004 Facility Tables*, Table 1, available at <http://www.cdc.gov/nchs/about/major/nnhsd/Facilitytables.htm>

^{ix} Mollica, Robert L., and Reinhard, Susan C. (2005). *Rebalancing State Long-Term Care Systems*. *Ethics, Law, and Aging Review*, 11.

^x Arden, Gale P., Director, CMS Center for Medicaid and State Operations, Disabled and Elderly Health Programs Group (DEHPG). (2006, November 9). Letter to Bruce Darling.

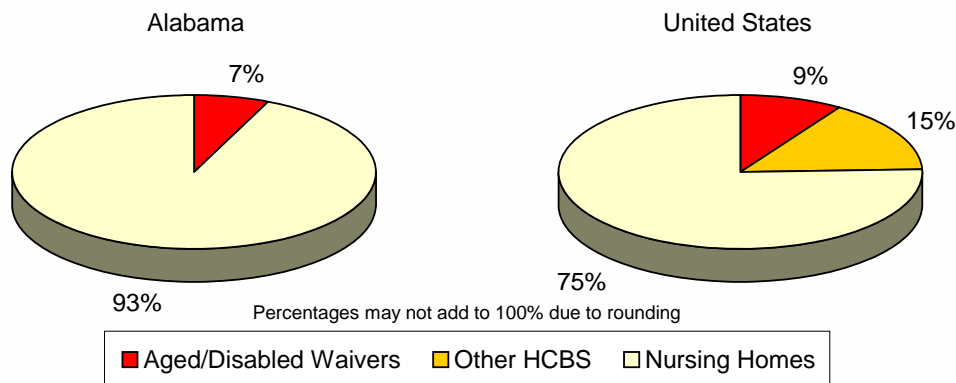
^{xi} Kaiser Commission on Medicaid and the Uninsured. (2008, January) *Medicaid: Overview and Impact of New Regulations*. Washington, DC.

^{xii} Kaiser Commission on Medicaid and the Uninsured. (2005, June). *Medicaid: An Overview of Spending on “Mandatory” vs. “Optional” Populations and Services*. Washington, DC.

^{xiii} Kitchener, Martin, et al. (2007, December). *Medicaid Home and Community-Based Service Programs: Data Update*. Washington, DC. Kaiser Commission on Medicaid and the Uninsured.

ALABAMA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Alabama and the U.S., 2006



Compared to the U.S. average, Alabama allocates a greater percentage (93 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Alabama spent 7 percent on waiver services.

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	6,161	8,215	+2,054	\$48	\$60*	+\$12
Nursing Homes	24,576	26,723	+2,147	\$674	\$839	+\$165

Recent Medicaid trends indicate that Alabama still has an unbalanced LTC system for older people and adults with physical disabilities. Many more Medicaid participants receive nursing home services than receive home and community-based services (HCBS). However, the number of participants receiving HCBS and nursing home care both increased about the same amount from 1999 to 2004. From FY 2001 to FY 2006, the increase in Medicaid spending on nursing homes was more than 13 times as great as the increase in spending on HCBS.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

* The state reported a significant portion of 2006 waiver expenditures under 1115 waivers, reports for which do not include target population information; therefore, the HCBS numbers may be underreported.

The Elderly and Disabled Medicaid waiver program has been in existence since 1982 and had 8,600 participants in FY 2006. State officials estimate that the waiver program has saved Alabama about \$22,000 per participant compared to the cost if each waiver participant had instead received institutional care.

Major Initiative

In May 2007, Alabama became the first state to take advantage of a provision in the federal Deficit Reduction Act of 2005 (DRA) that allows states to make consumer-directed care for Medicaid HCBS a part of their Medicaid State Plan. Before the enactment of the DRA, states had to request periodic approval from the federal Centers for Medicare & Medicaid Services for amendments to Medicaid HCBS waiver programs to add consumer direction.

Alabama received federal approval in October 2004 to implement “Personal Choices,” a three-year Cash and Counseling Demonstration project funded by the Robert Wood Johnson Foundation and the U.S. Department of Health and Human Services. Under this program,

“Personal Choices”

Alabama became the first state to make consumer-directed care for Medicaid HCBS a part of its Medicaid State Plan.

individuals receive a monthly allowance to spend on the services they need. They may hire someone to help with their care or use the money for equipment purchases. Financial counselors from Area Agencies on Aging are available to assist participants in developing a budget and managing their funds. Waiver participants must choose personal caregivers from a list of approved providers.

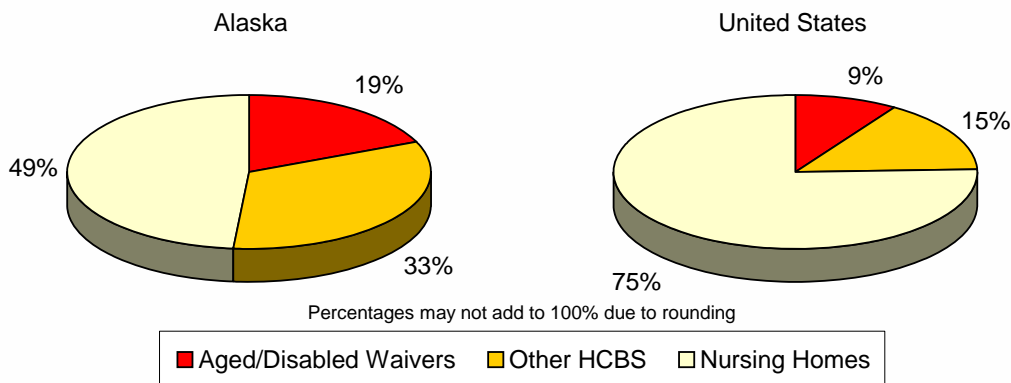
The new program is voluntary and open to participants in the Elderly and Disabled waiver program and the State of Alabama Independent Living (SAIL) waiver program. (Administered by the state Department of Rehabilitation Services, SAIL provides services to adults age 18 and older with disabilities who have specific medical diagnoses and who otherwise would qualify for care in a nursing facility.) The program became effective in August 2007 on a pilot basis for 700 older adults and persons with disabilities in seven west Alabama counties. The first participants were enrolled in September 2007.

Other Developments

Task Force. The Alabama Medicaid Agency created a Long Term Care Choices work group in April 2006 to explore opportunities offered by federal initiatives (such as the Systems Change grants) to support community options for elderly and disabled Medicaid recipients.

ALASKA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Alaska and the U.S., 2006



Compared to the U.S. average, Alaska allocates a greater percentage (52 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to home and community-based services (HCBS). In FY 2006, Alaska spent 19 percent on waiver services and 33 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	2,299	4,838	+2,539	\$33	\$131	+\$98
Nursing Homes	929	967	+38	\$72	\$123	+\$52

Alaska has one of the most balanced LTC systems for older people and adults with physical disabilities in the nation, and recent trends indicate that the state is continuing to make even more progress toward balancing. The vast majority of Medicaid participants with LTC needs receive HCBS rather than nursing home services. From FY 2001 to FY 2006, Medicaid spending on HCBS increased significantly and far outpaced the growth of spending for nursing home services, which also increased during this time. Alaska is one of the few states that spends more on HCBS than it does on nursing homes.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Yet, LTC experts called in by the state to review its LTC system noted that the spending totals for HCBS mask several problems. As one study noted, Alaska’s system “remains fragmented and without an over-arching infrastructure.” The state “suffers from parallel systems of care, ineffective rates, and a continuum of LTC that does not provide complete and consistent delivery of services.”²

Major Initiative

In the last several years, the Medicaid Personal Care Assistant (PCA) program has expanded significantly, providing home care services to individuals with disabilities of all ages. The program cost \$7.6 million and served 1,300 consumers in 2000. By 2005, PCA served 3,800 consumers, and the cost of the program had increased to \$79 million.

“Personal Care Assistant Program”

The state implemented reforms to control the costs of the personal care assistant program.

As a result of these dramatic increases, the Alaska legislature directed the Department of Health and Social Services (DHSS) in 2005 to develop regulations to better manage the PCA program. DHSS issued revised regulations in 2006 that established training, education, and Medicaid certification requirements for PCA providers; mandated certification from a physician regarding the medical condition of the client to authorize PCA services; and required that PCA plans be coordinated with Home and Community-Based Waiver Service plans. A participant now must require substantial assistance with at least two activities of daily living (ADLs) to qualify for services. The regulations also require that either the Division of Senior and Disabilities Services or an independent contractor conduct client assessments to reduce the potential for conflict of interest for PCA providers.

Other Developments

Personal Care. The PCA regulations described above have slowed the growth of PCA services. State officials estimate that PCA services grew 4.8 percent between FY 2005 and FY 2006, compared to a 23 percent growth between FY 2004 and FY 2005.

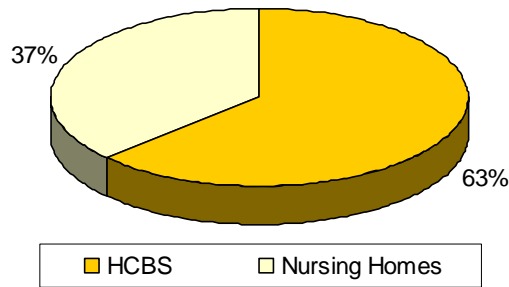
Rural Long-Term Care. To address the scarcity of services in Alaska’s rural areas, the state has created the Rural Long-Term Care Development program, funded by a grant from the Alaska Mental Health Trust Authority. The program assists older adults with services such as care coordination, chore and respite services, Personal Care Assistant Program, and adult day service centers.

Assisted Living. With the financial assistance of the Robert Wood Johnson Foundation Coming Home grant, the state also created the Assisted Living Development program to develop assisted living facilities in the rural areas of the state. As of April 2006, five affordable assisted-living facilities have been completed in the rural areas of Alaska. According to the grant program, affordable assisted living typically refers to licensed residential projects that provide apartment-style housing, together with supportive services to older residents, at least 25 percent of whom are financially eligible for Medicaid.

² Public Consulting Group. (2006, February). *Alaska Long Term Care and Cost Study: Final Report*. Anchorage, AK.

ARIZONA

Older People and Adults with Physical Disabilities, Arizona Long-Term Care System, by Type of Service, 2005



Arizona was the first state to undertake a major demonstration of capitated managed long-term care when it added the Arizona Long Term Care System (ALTCS) in 1988 to the Arizona Health Care Cost Containment System (AHCCCS).

Type of Service	Participants		Enrollment & Services, 2005	
	2001	2007	Older People and Adults with PD as a % of Enrollees	Older People and Adults with PD Receiving HCBS
Arizona Long Term Care System	32,710	43,145	39%	63%

ALTCS combines Medicaid acute and long-term care (LTC) services. Medicare reimburses the provider on a fee-for-service basis for any Medicare services provided to an ALTCS member. Services include a complete array of acute medical services, institutional care, home and community based services (HCBS), and case management. All covered services are integrated into a single delivery package, coordinated and managed by program contractors. Once enrolled, a member has a choice of available primary care providers who coordinate care and act as gatekeepers.

Although part of AHCCCS, LTC is administered as a distinct program from the acute care program. The program is still considered a demonstration project, with federal approval of a five-year extension in 2006. When the program began, there was a cap on the percentage of members that could receive HCBS. However, the percentage cap increased over time and was removed entirely in 2000. The program has been growing steadily since. Between October 1, 2000, and September 30, 2001, enrollment totaled 32,710. As of June 2007, enrollment had reached 43,145. Older people comprised about 39 percent of the enrollment in 2005, and about 63 percent of older people and persons with disabilities received services in their homes or in community residential settings.

Major Initiative

In 2000, a class action lawsuit (*Ball v. Biedess*) alleged that the AHCCCS failed to provide Medicaid beneficiaries with the attendant and personal care services authorized in their care plans, in part because of low payment rates for direct-care workers, which led to the unavailability of such workers. In 2004, a District Court judge ruled that the state must fill any gaps in services. The state appealed the decision, but the 9th Circuit Court of Appeals affirmed it in July 2007.

AHCCCS

Arizona has achieved major system balancing through a unique managed care model, called the Arizona Health Care Cost Containment System (AHCCCS), that operates under special demonstration authority from the U.S. Centers for Medicare & Medicaid Services (CMS). Because of a court decision, Arizona has implemented several reforms to AHCCCS, including revising pay rates for direct-care workers.

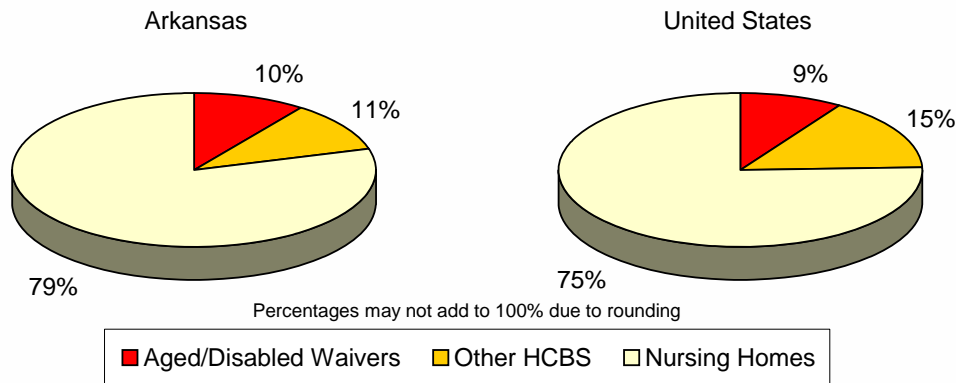
As a result, AHCCCS adjusted Medicaid payment rates for direct-care workers and established a revised rate determination process for Medicaid HCBS. The revised rate incorporates employee-related expenses, hourly and annual wages, administrative mileage, administrative overhead, and an adjustment factor for non-direct-care service hours, such as time to complete notes or records.

Other Developments

Aging and Disability Resource Center. The state received a \$750,000 grant in 2005 to implement the Arizona Aging and Disability Resource Center (AzADRC). With these funds, state officials are creating a Uniform Assessment Instrument (UAI), a Web-based tool to determine eligibility for all target populations across all agencies. Funds will also be used to create community sites where consumers can receive information and assistance regarding LTC options, counseling services, and other assistance. State officials also plan to allocate funds toward more education and outreach.

ARKANSAS

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Arkansas and the U.S., 2006



Compared to the U.S. average, Arkansas allocates a greater percentage (79 percent) of its Medicaid long-term care (LTC) spending to nursing homes for older people and adults with physical disabilities, even though most people with disabilities prefer to remain in their own homes and communities. In FY 2006, Arkansas spent 10 percent on waiver services and 11 percent on other home and community-based services (HCBS), including personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	26,814	24,207	-2,607	\$111	\$136	+\$24
Nursing Homes	20,699	28,854	+8,155	\$370	\$522	+\$152

Recent Medicaid trends indicate that Arkansas still has an unbalanced LTC system for older people and adults with physical disabilities. The number of Medicaid participants receiving nursing home services increased from 1999 to 2004, while participants receiving HCBS actually declined (specifically, the number of personal care beneficiaries declined from 1999 to 2004). From FY 2001 to FY 2006, the increase in Medicaid spending on nursing homes was more than six times as great as the increase in spending on HCBS.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Major Initiative

Arkansas has pioneered several HCBS initiatives for older persons, including incorporating self-direction of services into its programs and developing affordable housing alternatives. Arkansas has been “branding” its HCBS programs for persons with LTC needs under the heading, “Choices.”

Arkansas was one of the first three states to implement a Cash and Counseling demonstration program of self-directed home care services, which the state has called “IndependentChoices.” The Medicaid HCBS waiver program for older persons, implemented in 1991, is called “ElderChoices,” and had about 6,400 participants in 2006.

The most recent HCBS programs include an assisted living model, called “Living Choices,” which features apartment-style housing with 24-hour supervision, support services, and personal health care; and “Next Choice,” which provides cash allowances for community services for persons leaving nursing homes. The state also planned to combine three waivers into one—ElderChoices, Alternatives for Adults with Physical Disabilities, and Living Choices/Assisted Living.

“Choices”

Arkansas brands its home and community-based programs “Choices,” which includes one of the first three Cash and Counseling demonstration programs (IndependentChoices); an HCBS waiver program for older persons (ElderChoices); an assisted living program (Living Choices); and a nursing home transition program (Next Choice).

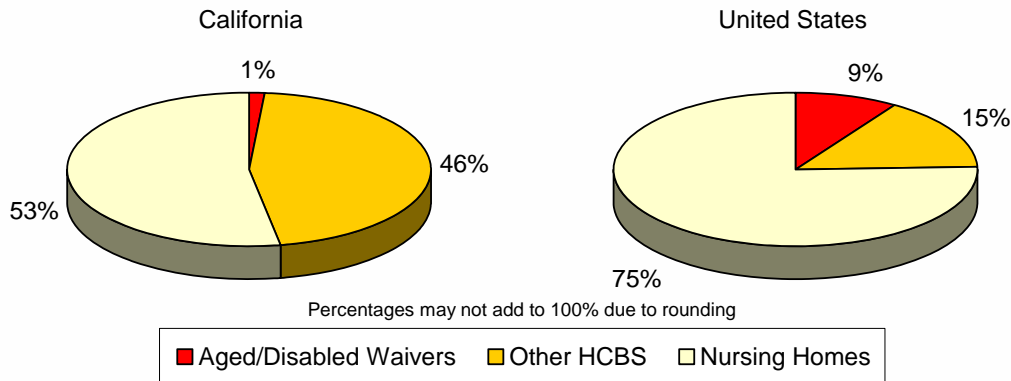
Other Developments

Adult Foster Care. State officials, with assistance from a state-appointed working group, are in the early stages of changing the Elder Choices Program 1915(c) waiver program to incorporate Adult Foster Homes as an option. In addition, the Division of Aging and Adult Services has partnered with NCB Capital Impact to create a Web-based training curriculum program for providers. Based on certification requirements, providers who meet an aggregate score of 75 or higher will be considered certified.

Single Point of Entry. The state received a \$2.9 million federal Systems Transformation grant in October 2005 to develop a statewide, single-entry-point system for LTC services. The one-stop system will include Web-based records for application, a screening assessment tool, a financial tool to predict eligibility, a process for service authorization, links to community entities that serve individuals at risk for nursing home admission, and a triage strategy for persons referred to the center. One key objective of the system is to streamline the application process for home and community waiver services so that the time it takes to determine a person’s eligibility is shortened from the current 45 days or more to less than five days.

CALIFORNIA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in California and the U.S., 2006



Compared to the U.S. average, California allocates a greater percentage (47 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to home and community-based services (HCBS). In FY 2006, California spent 1 percent on waiver services and 46 percent on the In-Home Supportive Services (IHSS) personal care services program (described on the next page).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS*	185,493	327,160	+141,667	\$1,923	\$3,348	+\$1,425
Nursing Homes	117,843	119,252	+1,409	\$2,598	\$3,761	+\$1,163

California has one of the most balanced LTC systems for older people and adults with physical disabilities in the nation, and the state is continuing to make even more progress toward balancing. Many more Medicaid participants receive HCBS than receive nursing home services. In addition, the number of participants receiving HCBS increased by almost 50 percent, while the number of participants in nursing homes remained relatively constant from 1999 to 2004. From FY 2001 to FY 2006, the increase in Medicaid spending on HCBS was slightly more than the increase in spending on nursing homes. The effect of these trends

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

* Adult day health is a Medicaid state plan service and is not included in HCBS expenditures.

shows that the state was able to serve many more additional people in their homes and communities than in nursing homes. Expenditure increases were fairly comparable because a dollar spent on HCBS can serve more people than a dollar spent on nursing homes. Although California appears to have a strong HCBS system because of the IHSS program and other smaller community LTC services, consumer advocates and policy makers contend that a Californian in need of LTC still faces a “bewildering maze of policies, bureaucracies, and programs...”² Another report noted that the state’s administration of LTC programs “reflect[s] a piecemeal approach in program development and funding.” Thirty-eight programs are housed in five different departments.³

“In-Home Supportive Services”
California has the largest personal care program in the country, called the In-Home Supportive Services program.

Major Initiative

In-Home Supportive Services (IHSS). The largest publicly funded HCBS program in the state is the IHSS program, which provided personal care services to about 375,000 individuals in 2006. About 40 percent of the IHSS caseload consists of individuals age 65 or older. Counties administer the IHSS program under the direction of the California Department of Social Services. Funding, which comes from Medicaid, state funds, and a county match, totaled about \$3.2 billion in FY 2006, up from \$1.8 billion in 2001. A key program feature is the self-direction component: participants may select an agency to provide their worker, or they can hire an independent provider, which is the choice of the majority of the participants.

Other Developments

System Transformation. The state received a \$3 million, five-year federal Systems Transformation grant in fall 2006 for “California Community Choices.” The project’s 18-member Community Choices Advisory Commission—composed of advocates, consumers, and providers—held its first meeting in January 2007. A draft strategic plan was submitted to the federal Centers for Medicare & Medicaid Services in June 2007. The project’s goals include:

- establishing one-stop information and resource centers in two counties/regions to provide a coordinated system of information and access for older persons and persons with disabilities seeking LTC services and supports;
- developing a website to provide up-to-date information on HCBS; and
- completing a study to improve the state’s understanding of financial and structural barriers to increasing access to HCBS.

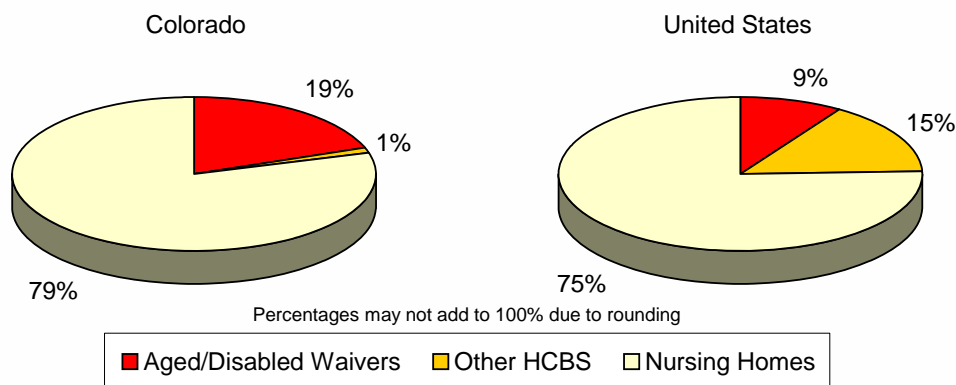
Single Point of Entry. Two new one-stop LTC centers (to be called CommunityLink Resource Centers) and two existing Aging and Disability Resource Centers will pilot and field-test California’s aging and LTC Web portal CalCareNet by establishing community connections and collaboration through community kiosks and outreach and training for local health and service providers. The centers will also focus on increasing public awareness of one-stop services and available HCBS and will encourage consumer referral to these centers.

² California HealthCare Foundation. (2006, December). *Long-Term Care Reform: Ten Years after Little Hoover*. Oakland, CA.

³ California Assembly Committee on Aging and Long-Term Care. (2006, September). *Building an Aging Agenda for the 21st Century*. Sacramento, CA.

COLORADO

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Colorado and the U.S., 2006



Compared to the U.S. average, Colorado allocates a greater percentage (79 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Colorado spent 19 percent on waiver services and 1 percent on other home and community-based services (HCBS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	11,481	15,425	+3,944	\$75	\$119	+\$44
Nursing Homes	18,918	16,474	-2,444	\$360	\$462	+\$102

Although Colorado has yet to achieve an overall balanced LTC system for older people and adults with physical disabilities, an increase in Medicaid HCBS participants and a decrease in nursing home participants indicate that progress has occurred in recent years. From FY 2001 to FY 2006, however, the increase in Medicaid spending on nursing homes was more than double the increase in spending on HCBS.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Major Initiative

Colorado was one of the first states to receive federal approval for a Medicaid HCBS waiver program in the mid-1980s. Another early innovation was the establishment of a single-entry-point (SEP) system, phased in throughout the state from 1993 to 1995. Most recently, Colorado has introduced consumer direction to its HCBS programs.

Consumer Direction. In May 2002, the Colorado legislature created a consumer-directed care pilot program for older people, called Consumer Directed Care for the Elderly (CDCE). That same year, the state received a federal \$725,000 Community Personal Assistance Services and Supports (C-PASS) Systems Change grant to design and implement consumer-directed services, and to develop materials and training for the option. Since then, Colorado has steadily increased the number of HCBS waiver participants to whom the state offers a self-direction option.

Single-Entry-Point (SEP). In 2005, Colorado received an \$800,000 federal grant to further strengthen its SEP system, which covers client assessment, care planning, service arrangement, and client monitoring. The Department of Human Services and the Colorado Department of Health Care Policy and Financing (CHCPF) are working jointly to fund Aging and Disability Resource Centers in three areas, building on the work of the existing SEP system and Area Agencies on Aging.

“Consumer Direction and Single-Entry-Point”

Colorado is implementing initiatives to offer self-directed care options to its HCBS waiver participants and to enhance its Single-Entry-Point.

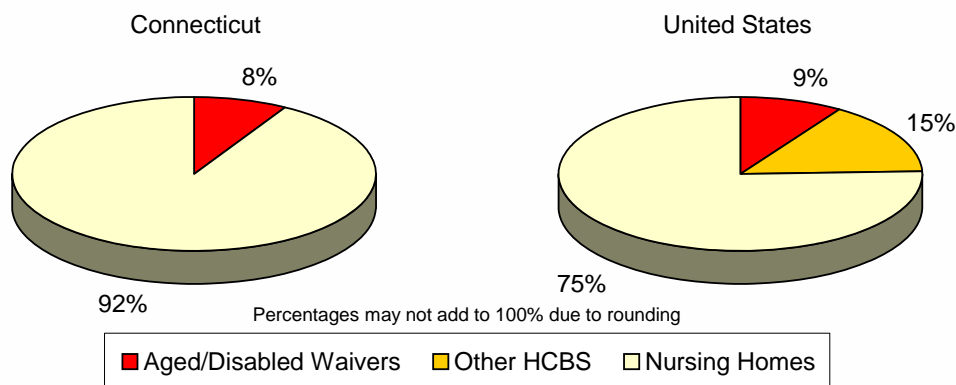
Other Developments

Planning. In 2005, the legislature enacted SB 05-173 creating a 22-member Long-Term Care Advisory Committee to make recommendations to CHCPF to balance the state’s LTC system by increasing emphasis on home-based and assisted living care. In its final July 2006 report, the committee made 18 recommendations, which included: 1) expand alternative housing options such as assisted living, adult foster care, and other residential care settings; 2) provide financial incentives to nursing homes to develop alternative uses of beds to achieve a more home-like environment; 3) add a personal care option to the Medicaid State Plan; 4) reduce care manager caseloads from a statewide average of 80 persons to no more than 50 persons per manager; 5) speed up the financial eligibility process so that LTC consumers have quicker access to services; and 6) increase consumer awareness and use of services, such as home modifications and equipment, that will help consumers to make the transition from hospital to home.

CHCPF reported to the legislature in late 2006 that the state had added transition services to the HCBS waiver for older people and adults with disabilities who are moving from nursing homes to the community. CHCPF also noted that case management agencies had begun the transition to an automated system to manage client information for the HCBS waiver programs.

CONNECTICUT

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Connecticut and the U.S., 2006



Compared to the U.S. average, Connecticut allocates a greater percentage (92 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Connecticut spent 8 percent on waiver services.

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	9,176	11,335	+2,159	\$68	\$112	+\$43
Nursing Homes	38,862	36,868	-1,994	\$1,024	\$1,226	+\$201

Although Connecticut has yet to achieve an overall balanced LTC system for older people and adults with physical disabilities, an increase in Medicaid home and community-based services (HCBS) participants and a decrease in nursing home participants indicate that some progress has occurred in recent years. However, more Medicaid participants receive nursing home services than receive HCBS. From FY 2001 to FY 2006, the increase in Medicaid spending on nursing homes was more than 4.5 times the increase in spending on HCBS.

The state operates the Connecticut Home Care Program for Elders (CHCP), which is both Medicaid- and state-funded. CHCP has a three-tier structure through which individuals can

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receive home care services in amounts corresponding to their financial eligibility and functional status. Two categories are funded with state dollars, and the third, under a Medicaid waiver. The total number of participants in FY 2006 was 16,646, with total expenditures of almost \$200 million (about \$29 million in state general revenue). To continue the program, including maintaining a no-waiting-list policy and a new Personal Care Assistance (PCA) pilot initiative begun in 2005, the legislature increased funding by \$2.1 million in SFY 2005, \$4.6 million in 2006, and \$9.7 million in 2007. The PCA pilot, which started with 100 slots, was expanded to 150 slots for 2006 and to 250 slots in 2007.

Major Initiative

Long-Term Care Vision and Benchmark. In 2005, the Connecticut legislature codified in law a broad philosophical statement requiring the state to “provide...individuals with long-term care needs...the option to choose and receive long-term care and support in the least restrictive, appropriate setting.” The 2004 report of the Connecticut Long-Term Care Planning Committee² had proposed that 75 percent of Medicaid LTC clients be receiving HCBS by 2025 and recommended a 1 percent annual increase. In January 2007, the committee reported that, for the first time, more individuals were receiving Medicaid LTC services in the community than were receiving institutional care. (This total includes all LTC populations, not just older people and adults with physical disabilities.)

“Connecticut Benchmark”

Connecticut set the benchmark that 75 percent of Medicaid LTC clients should receive HCBS, with the remaining 25 percent in institutional care by 2025. For the first time, more Medicaid participants were receiving LTC in the community in 2007.

Developing Assisted Living. Since 2000, the Connecticut Office of Policy and Management has coordinated a multi-agency, multiyear effort to develop affordable assisted living (AL) options for low-income persons as an alternative to nursing homes. This effort has included adding AL services in state-funded congregate housing, federally funded U.S. Department of Housing and Urban Development housing facilities, new subsidized AL communities in four towns, and a 75-slot pilot in private-pay AL facilities. By January 2008, a total of 524 persons had been enrolled. In addition, in 2007, new legislation has increased AL oversight.

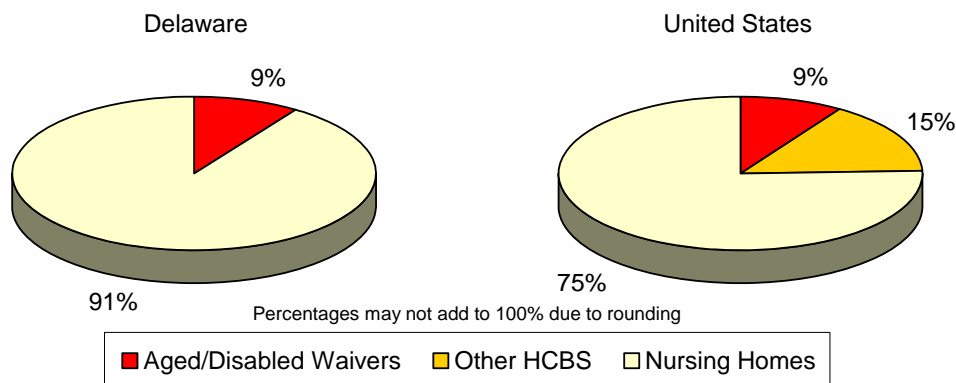
Other Developments

Long-Term Care Recommendations. In 2006, the Connecticut General Assembly authorized and funded a comprehensive statewide Long-Term Care Needs Assessment by the University of Connecticut Health Center’s Center on Aging. The researchers reported in June 2007 that efforts to balance the state’s LTC system were “progressing, though more slowly than in some leading states.” Report recommendations included: 1) create a statewide single-point-of-entry system; 2) provide a broader range of community-based LTC choices, including expanding the number of people served in pilot programs for AL and other supportive residential housing; 3) offer consumer choice and self-direction to all LTC users; 4) increase accessible and affordable transportation options; and 5) address LTC education and information needs of the public and workforce shortage issues.

² The committee is charged with developing an LTC plan every three years for the Connecticut General Assembly.

DELAWARE

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Delaware and the U.S., 2006



Compared to the U.S. average, Delaware allocates a greater percentage (91 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Delaware spent 9 percent on waiver services.

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	734	1,304	+570	\$10	\$17	+\$7
Nursing Homes	3,109	3,736	+627	\$111	\$160	+\$49

Recent Medicaid trends indicate that Delaware still has an unbalanced LTC system for older people and adults with physical disabilities. More Medicaid participants received nursing home services than received home and community-based services (HCBS). The number of participants receiving HCBS and nursing home services both increased from 1999 to 2004. Also, from FY 2001 to FY 2006, the increase in Medicaid spending on nursing homes was seven times as great as the increase in spending on HCBS.

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Major Initiative

Created by House Resolution 90 in 2002, the Governor's Commission on Community-Based Alternatives for Individuals with Disabilities has organized work groups on a number of LTC issues over the years, such as housing, transportation, direct support workforce development, and community alternatives to institutionalization.

Delaware Senate Resolution 26, enacted in June 2006, established a commission subcommittee "to facilitate and complete a study of the feasibility of implementing a Money Follows the Person initiative." Commission members helped to secure state funding for that initiative, increase state funding to eliminate waiting lists for Personal Attendant Services, and plan two conferences for direct support professionals.

"Governor's Commission"

Among its accomplishments, the Governor's Commission has secured funding for Money Follows the Person and for helping to eliminate the state's waiting lists.

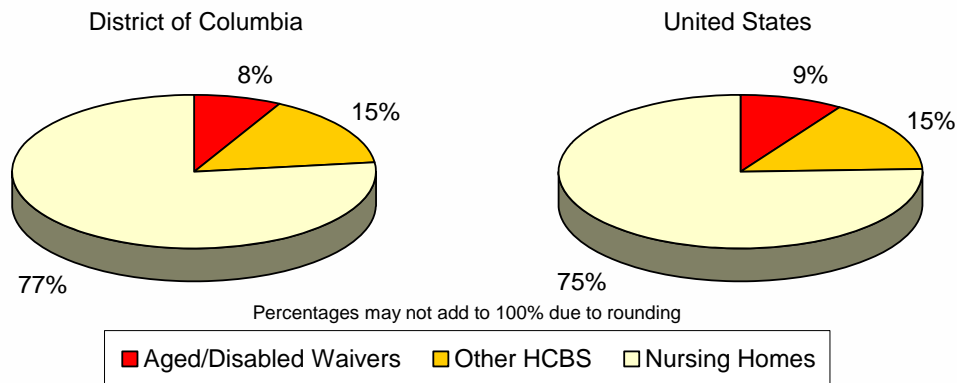
In July 2007, the Governor's Commission released a five-year strategic plan, called "A Path Forward: Building a Community-Based Plan for Delaware," whose goals include shifting the amount of Medicaid funding for LTC services weighted toward institutional care to a greater proportion for community services; expanding consumer choice and self-directed services; transitioning at least 100 persons from nursing homes to the community; developing common assessment tools (cross-disability and cross-agency) for eligibility and care planning; and monitoring progress by establishing benchmarks. The commission plans to accomplish its goals "in increments" and plans to continue to meet to review and set priorities.

Other Developments

Money Follows the Person. The state was awarded a \$5.4 million Money Follows the Person Demonstration grant in June 2007 to facilitate the transition of 100 persons from nursing homes to the community. Delaware proposed also using the funds to coordinate existing transition efforts, expand consumer direction in its HCBS programs, and implement a series of budgetary and financing strategies to allow LTC funds to move among agencies.

DISTRICT OF COLUMBIA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in the District of Columbia and the U.S., 2006



Similar to the U.S. average, the District allocates a greater percentage (77 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, the District spent 8 percent on waiver services and 15 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	1,624	2,701	+1,077	\$2	\$52	+\$50
Nursing Homes	4,359	6,089*	+1,730	\$159	\$173	+\$15

More Medicaid participants received nursing home services than received home and community-based services (HCBS) in 2004. The number of participants receiving nursing home services increased more than the number of participants receiving HCBS from 1999 to 2004. From FY 2001 to FY 2006, the increase in Medicaid spending on HCBS, however, was more than three times as much as the increase in spending on nursing homes.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if offered. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

* Due to reporting abnormalities, the number of nursing home participants reported in 2003 and 2004 was usually high. From 1999 to 2002, the number of participants was approximately 4,300 per year.

Major Initiative

The D.C. Council's Committee on Health convened a Long-Term Care Task Force in June 2005 "to examine the factors that contribute to the over-reliance on institutional care in the District and to identify measures that will produce wider accessibility to home and community-based services."

In a December 2005 report, the task force said that major barriers District residents faced in trying to access LTC services included: 1) lack of an effective single point of entry to services; 2) lack of a program and agency to assist nursing home residents to move to the community; and 3) lack of uniformity in the level-of-care determination process.

"Resource Center for Aging and Persons with Disabilities"

With a federal grant, the District is expanding its Resource Center to become the primary pathway into the Medicaid LTC system for older persons and adults with disabilities.

To move forward on the Task Force recommendation about improving access to LTC services, the District planned to use a 2005 federal grant of \$629,507 to expand its current Resource Center for Aging and Persons with Disabilities, and to increase public awareness of the Center. City officials said the Center would become "the primary pathway" into the District's Medicaid LTC system for adults with disabilities and older persons by conducting medical and social assessments, screening for Medicaid eligibility, offering LTC options counseling, and providing the linkage to care for persons who were eligible for Medicaid services.

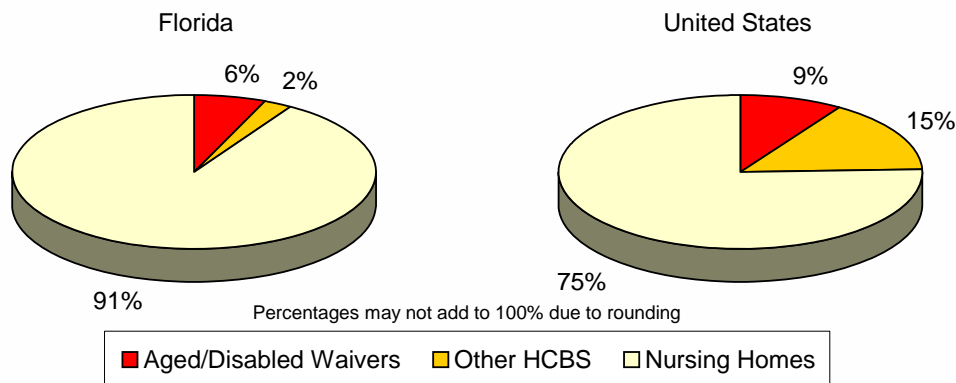
Other Developments

Assisted Living. The D.C. Council enacted the Assisted Living Residence Regulatory Act in 2000, requiring the Department of Health (DOH) to develop licensure requirements for assisted living facilities in the city. However, when the DOH had not issued any regulations after six years, the D.C. Long-Term Care Ombudsman took legal action in October 2006, filing a case with the D.C. Superior Court to force the city to create and implement a licensure system. The Ombudsman won the legal action in September 2007. As a result, the DOH had to ensure the courts that all 11 assisted living facilities were licensed; a survey team was developed and in place; and application protocols, policies, and procedures were created and implemented by April 1, 2008. As of May 2008, seven assisted living facilities have received licenses, and the remaining four are going through the licensing application. A survey team is monitoring all the facilities.

Money Follows the Person. The District was awarded a \$26.4 million Money Follows the Person Demonstration grant in 2007, which the city said it would use, among other things, to relocate 1,100 persons from nursing homes to community settings.

FLORIDA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Florida and the U.S., 2006



Compared to the U.S. average, Florida allocates a greater percentage (91 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Florida spent 6 percent on waiver services and 2 percent on other home and community-based services (HCBS), including personal care.

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	40,115	55,680	+15,565	\$210	\$384	+\$174
Nursing Homes	91,985	114,134	+22,149	\$1,703	\$2,396	+\$693

Florida still has an unbalanced Medicaid LTC system for older people and adults with physical disabilities, but it has a state-funded HCBS program for low-income, older adults. The number of Medicaid participants who received nursing home services greatly outnumbered those who received HCBS. From FY 2001 to FY 2006, the increase in Medicaid spending on nursing homes was nearly four times the increase in spending on HCBS (participants and expenditures are underreported because they do not include the Florida Frail Elder Option or the Diversion programs, Medicaid-managed care programs for people who are nursing home eligible).

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Medicaid is not the only source of funding for LTC in Florida. Community Care for the Elderly (CCE), a state-funded program for persons age 60 and older, served approximately 33,000 people in FY 2007 with expenditures of about \$44 million. This program diverts frail elders from nursing home and hospital care by providing adult day services, adult day health, case management, chore, companionship, home-delivered meals, home health aide, homemaker, information and referral, personal care, and respite care. The state's area agencies on aging subcontract with about 58 agencies to provide services, and clients are assessed a co-payment based on a sliding income scale. CCE saves Florida nearly \$500 million annually in nursing home costs and currently has more than 17,000 individuals on its waitlist.

Major Initiative

The 2004 Florida legislature created a statewide Aging Resource Center initiative to reduce fragmentation in the elder services delivery system by having the state's 11 Area Agencies on Aging (AAAs) transition to Aging Resource Centers (ARCs). This involves taking on additional responsibilities, including screening older persons for services and streamlining eligibility determinations. The Department of Elder Affairs selected three AAAs as pilot sites to receive start-up and implementation funding. For FY 2006–07, the legislature appropriated \$3.3 million for statewide implementation. As of 2008, all AAAs successfully transitioned to ARCs. Based on a March 2008 report by the Florida Office of Program Policy Analysis & Government Accountability (OPPAGA), the agencies reported positive results since becoming ARCs, including “wider recognition as seniors’ gateway to services, more control over access to services...and more statewide uniformity in the information collected about information and referral services.” To share information on a range of new community programs and services, each ARC has a Local Coalition Workgroup composed of representatives of agencies and organizations serving elders, stakeholders, consumers, housing authorities, local government, and selected community-based organizations. The members also contribute their individual professional expertise to train ARC staff and stakeholders.

“Aging Resources Centers”

The 2004 Florida legislature created a statewide Aging Resource Center initiative to reduce fragmentation in the elder services delivery system by having the state's 11 Area Agencies on Aging transition to Aging Resource Centers.

Other Developments

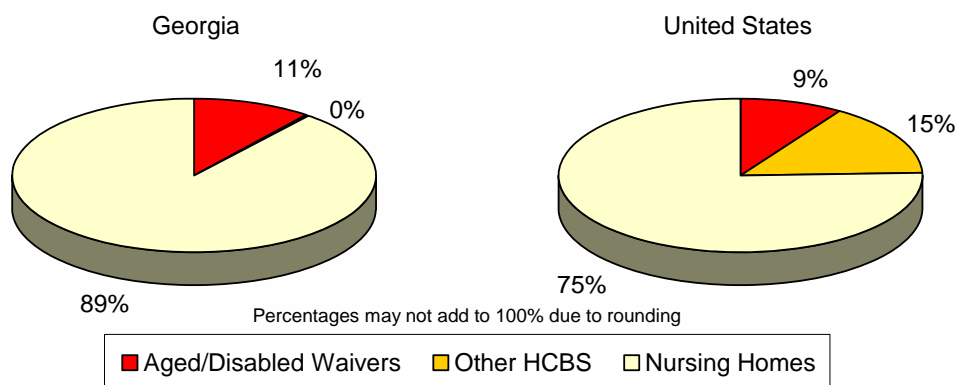
Consumer Direction. The state received federal approval to expand its Consumer-Directed Care Plus program to 1,168 persons, up from the 125 enrolled in the program in early 2007. Enrollment began March 1, 2007, with services effective July 1, 2007. Effective March 2008, Consumer Direction became a 1915(j) state plan amendment, making consumer-directed services available to anyone on the Aged and Disabled Adult Waiver as well as those on the Traumatic Brain Injury/Spinal Cord Injury Waiver.

Nursing Home Diversion. This Medicaid-funded, voluntary managed care program seeks to provide LTC in the least restrictive setting. During the 2008 legislative session, Florida expanded the program by 4,000 slots, on top of the current cap of 10,000, to help address some of the 4,716 individuals on the waitlist.

Managed LTC. Florida is implementing an integrated capitated demonstration project for Medicaid beneficiaries and those age 60 and older in two areas of the state. Participation in the program (“Senior Care”) will be voluntary and open to any willing provider. The federal Centers for Medicare & Medicaid Services approved the waiver application in September 2006, and the state expects to enroll participants in November 2008.

GEORGIA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Georgia and the U.S., 2006



Compared to the U.S. average, Georgia allocates a greater percentage (89 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Georgia spent 11 percent on waiver services and less than 0.5 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	14,018	15,418	+1,400	\$90	\$157	+\$67
Nursing Homes	39,720	43,349	+3,629	\$760	\$1,287	+\$526

Despite recent efforts, Georgia still has an unbalanced LTC system for older people and adults with physical disabilities. Many more Medicaid participants received nursing home services than received home and community-based services (HCBS), and the number of participants in nursing homes increased more than the number of participants receiving HCBS from 1999 to 2004. From FY 2001 to FY 2006, the increase in Medicaid spending on nursing homes was nearly eight times as great as the increase in spending on HCBS. In fact, the increase in nursing home spending (\$526 million) was more than three times the total

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HCBS spending for older people and adults with physical disabilities (\$157 million) in FY 2006.

The Medicaid waiver program, called Community Care Services Program (CCSP), served 14,534 people in FY 2006, a 15 percent increase over 10 years. The state estimates that each consumer in CCSP saves the state \$11,534 a year compared to the cost of nursing home care for that individual.

Major Initiative

In 2006, Georgia put its service coordination demonstration project, called Service Options Using Resources in a Community Environment (SOURCE), under its Medicaid State Plan. The program had been a demonstration project to provide enhanced primary care case management for frail older adults and persons with disabilities. One of the major differences between the CCSP and the SOURCE programs is that the CCSP program is open to those with higher incomes.

The goal of SOURCE is to improve health outcomes and reduce hospitalizations and emergency room visits for persons with chronic health conditions by linking primary medical care with HCBS. A case manager conducts an assessment during a home visit before the appointment with the disciplinary team. Case managers contact participants at least once a month and make home visits at least four times a year, and care path protocols are followed at each quarterly home visit. Based on functional ability (*not* on diagnosis), care paths include keeping medical appointments, service provider performance, skin care, medication compliance, and key clinical indicators.

SOURCE contractors receive a flat per member/per month case management fee. State officials estimated that there are over 6,900 elderly and disabled beneficiaries statewide.

“SOURCE”

Georgia’s Service Options Using Resources in a Community Environment (SOURCE) program seeks to improve health outcomes and reduce hospitalizations for people with chronic conditions by providing enhanced primary care case management for frail elders and people with disabilities.

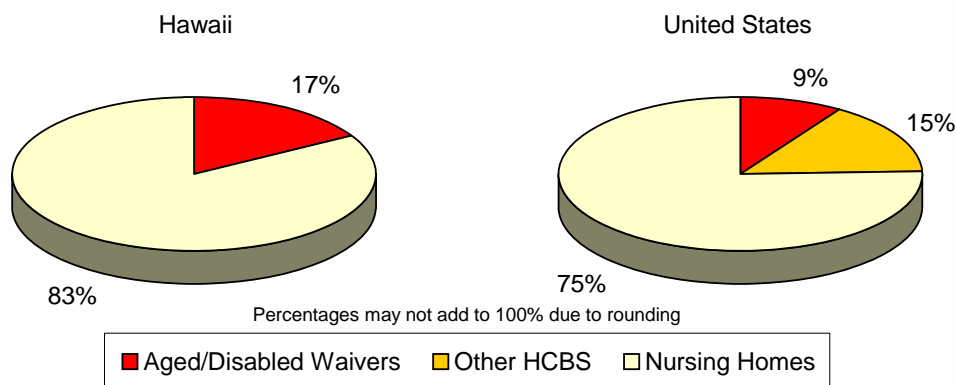
Other Developments

Gateway. A statewide Aging and Disability Information Management System network, “Gateway,” provides a single point of consumer access to information, referral, and assessment for Medicaid and non-Medicaid community services and resources. Each of the state’s 12 Area Agencies on Aging uses Gateway.

Money Follows the Person. In 2007, the state was awarded a \$34.1 million, five-year federal Money Follows the Person grant to relocate 1,347 persons from institutional care to community settings. In the grant narrative, Georgia officials noted that the funding allows the state “to take rebalancing to the next level.”

HAWAII

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Hawaii and the U.S., 2006



Compared to the U.S. average, Hawaii allocates a greater percentage (83 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Hawaii spent 17 percent on waiver services.

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	923	2,043	+1,120	\$22	\$39	+\$17
Nursing Homes	4,274	5,425	+1,151	\$148	\$195	+\$47

Hawaii has an unbalanced Medicaid LTC system for older people and adults with physical disabilities, but the state serves a large number of people through a state-funded program and is expanding its Medicaid managed care program. Many more Medicaid participants receive nursing home services than receive home and community-based services (HCBS). From FY 2001 to FY 2006, the increase in spending on nursing homes was about three times as much as the increase in spending on HCBS.

Low-income, non-Medicaid-eligible consumers can apply for “Kupuna Care,” which provided adult day services, assisted transportation, attendant care, home-delivered meals,

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case management, chores, and personal care for 7,217 Hawaii residents in FY 2006, with state funding totaling about \$5.8 million. In May 2007, the legislature approved approximately an additional \$500,000 for each of the next two years to expand in-home and access services under the program.

Major Initiative

Hawaii is planning to integrate its Medicaid aged, blind, and disabled populations into its managed care health plan, QUEST. The new plan, QUEST Expanded Access program, will enable Medicaid beneficiaries age 65 and older, persons who are blind, and persons with disabilities to access primary, acute,

behavioral health, and LTC services under a capitated payment. QUEST will also expand services to cover institutional care and home and community-based waiver services.

“QUEST Expanded Access”

Hawaii is moving to a managed care program, called QUEST Expanded Access, for Medicaid aged, blind, and disabled populations to better integrate primary, acute, behavioral health, and LTC services under a capitated payment.

Enrollment counselors will help these Medicaid participants switch from a fee-for-service to a managed care plan. Those who do not choose a plan will be auto-enrolled. The Department of Human Services expects the managed care plans that participate in QUEST Expanded Access to increase HCBS use by a minimum of 5 percent each year. Beneficiaries will have the option of directing their own personal care, respite, and attendant care services. In addition, they will be able to pay family and friends as caregivers.

The Request for Proposals for managed care plans to participate was released in October 2007, and contracts were awarded to two health plans in February 2008.

Other Developments

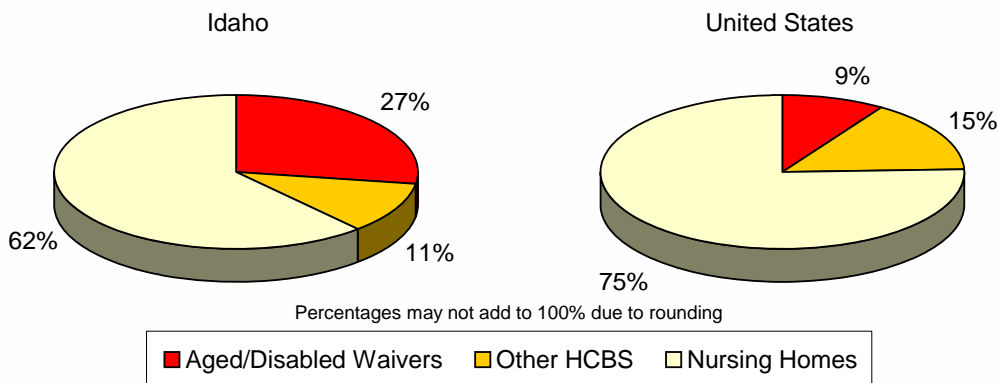
Residential Care. Hawaii has several categories of residential alternatives for persons who cannot remain in their own homes but want a residential alternative to a nursing home, such as Adult Residential Care Homes, Assisted Living Facilities, and Residential Alternative Community Care facilities. However, state officials say that both the physical infrastructure of these facilities and staff resources are inadequate to meet the needs of an aging population.

The 2006 legislature enacted Senate Concurrent Resolution 144 S.D.1, urging the development of an LTC infrastructure plan for Hawaii “to ensure public safety while supporting aging in place.” A task force of local and state government officials and representatives of the provider industry convened to examine Hawaii’s regulations affecting residential care for older persons and issued a report in December 2007. The State Building Code Council is in the process of adopting recommendations for all new assisted living facilities to support aging-in-place, as requested by the Department of Human Services.

Aging and Disability Resource Centers. Two sites are being developed in two counties: a virtual site in Honolulu (Honolulu County) and a physical site in Hilo (Hawaii County). At the Hilo site, service providers from the aging and disability communities, including the Department of Human Services, co-locate with the Hawaii County Office of Aging.

IDAHO

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Idaho and the U.S., 2006



Compared to the U.S. average, Idaho allocates a greater percentage (38 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to home and community-based services (HCBS). In FY 2006, Idaho spent 27 percent on waiver services and 11 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	3,196	10,838	+7,642	\$42	\$85	+\$43
Nursing Homes	5,014	5,075	+61	\$119	\$137	+\$18

Idaho has made significant progress toward balance in recent years, with large increases in both Medicaid HCBS participants and expenditures. The number of Medicaid participants receiving HCBS tripled from 1999 to 2004, while the number of participants in nursing homes remained almost flat. In 1999, the numbers of participants in nursing homes outnumbered those receiving HCBS, but by 2004, the number receiving HCBS far outnumbered those in nursing homes (specifically, the people receiving waiver services increased dramatically). From FY 2001 to FY 2006, the increase in Medicaid spending on HCBS was more than double the increase in spending on nursing homes.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Major Initiative

Idaho was one of the first states to use provisions of the Deficit Reduction Act of 2005 to implement a Medicaid health plan that targets a specific package of benefits to three different categories of enrollees, one of which includes an integrated benefit plan for persons eligible for both Medicare and Medicaid coverage (dual-eligibles).

The plan for people with dual coverage, called the “Medicare-Medicaid Coordinated Plan,” gives persons the option of enrolling in an integrated benefits plan offered by participating Medicare Advantage Plans (private managed care plans). Participants in the coordinated plan use the same provider network to access both Medicare and Medicaid benefits. The plan, which is voluntary, began operating in April 2007 in areas of the state where Medicare Advantage plans were available, and was expected to expand throughout the state over time. If individuals choose not to join the coordinated plan, they are enrolled in the Enhanced Plan.² As of April 2007, 13,416 people were participating in the Coordinated Plan, with 873 of the total selecting a Medicare Advantage Plan as their primary payer.

“Medicare-Medicaid Coordinated Plan”

Dual-eligibles can enroll voluntarily in coordinated plans and receive additional benefits such as preventive and nutrition services.

The Coordinated Plan includes additional benefits to encourage enrollees to adopt healthy lifestyles, such as preventive and nutrition services. Electronic health records also will be incorporated into LTC assessments to create an integrated health information system.

Other Developments

Aging Resource Centers. Another feature of Idaho’s Medicaid reform plan is the Long-Term Care Options Counseling Program to promote non-publicly financed LTC arrangements, such as reverse mortgages and private LTC insurance. The Idaho Department of Health and Welfare is operating a pilot program of Aging Resource Centers in three Idaho communities to be central sources of LTC information for older persons.

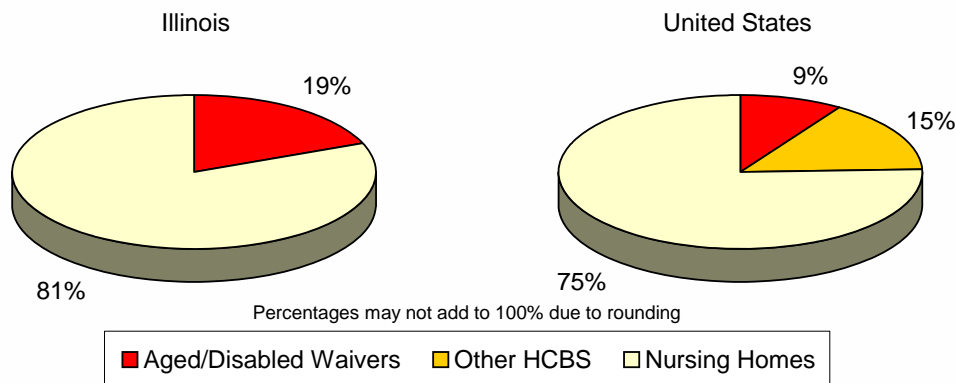
The state also received a federal grant in 2005 to develop a program, called “Aging Connections,” to make it easier for residents in the five northernmost counties of the state to access LTC information and resources. The program opened September 2006 at the Aging and Adult Services location in Coeur d’Alene. With the grant expiring in 2008, the state has provided funding to make the positions permanent and will expand the program statewide.

LTC Public Outreach. AARP, the state Department of Insurance, and the University of Idaho published a single comprehensive guide in 2007, called *Idahoans Guide to Long-term Care Insurance and Services Prices*, that makes the prices of local assisted living facilities, nursing homes, and LTC insurance policy prices transparent to the public for the first time.

² The heart of the new reform is a Medicaid Basic Plan for low-income children and working-age adults. An Enhanced Plan provides all the benefits of the Basic Plan plus additional benefits for persons with disabilities or other special health needs.

ILLINOIS

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Illinois and the U.S., 2006



Compared to the U.S. average, Illinois allocates a greater percentage (81 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Illinois spent 19 percent on waiver services.

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	29,783	50,279	+20,496	\$170	\$350	+\$180
Nursing Homes	81,791	77,370	-4,421	\$1,500	\$1,502	+\$3

Although Illinois has yet to achieve an overall balance between HCBS and nursing home spending, recent Medicaid trends indicate that significant progress has occurred in recent years. Many more Medicaid participants received home and community-based services (HCBS) than those who received nursing home services. The number of participants receiving HCBS increased significantly from 1999 to 2004, while the number in nursing homes decreased. From FY 2001 to FY 2006, Medicaid spending on HCBS doubled, while spending on nursing homes stayed constant.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Medicaid is not the only source of LTC funding in Illinois. The Community Care Program (CCP) is projected to provide average monthly services to approximately 46,200 persons age 60 and older in FY 2008. Total funding for the program in FY 2008 is \$374.1 million, about half of which is state general revenue. Homemaker services are the core component of the program. In FY 2007, the Department on Aging added emergency home response services to homemaker services and implemented a flexible services demonstration project. In November 2007, the department began enrolling CCP clients in a Cash and Counseling demonstration program that gives participants substantial control over their care plans.

Major Initiative

The Illinois Older Adult Services Act (P.A. 093-1031 / SB 2880) was enacted in 2004, calling for a “transformation of [the state’s] comprehensive system of older adult services from funding a primarily facility-based service delivery system to primarily a home-based and community-based system.” The restructuring, the legislation added, should encompass housing, health, financial, and supportive older adult services. The bill also created a 32-member advisory committee to guide the restructuring process.

“Older Adult Services Act”

State legislation enabled Illinois to restructure its case management system by requiring the use of a single comprehensive assessment tool as one of its reforms.

To make eligibility determinations and care planning more coherent and coordinated, the Older Adult Services Act called for comprehensive care coordination. In 2006, the Illinois Department on Aging began restructuring the existing case management system by requiring the use of a single comprehensive care assessment tool. The system was to be implemented statewide in three phases, with the first Care Coordination Units (CCUs) in 2006 and the remaining ones in 2007. The new system permits customized care plans, client follow-up, flexible services such as respite and assistive technologies, and enhanced training for case managers.

The legislature provided an additional \$1.5 million in 2006 for the CCP to raise the asset limits from \$12,500 to \$17,500, which the state estimated would allow an additional 400 people to be eligible for services.

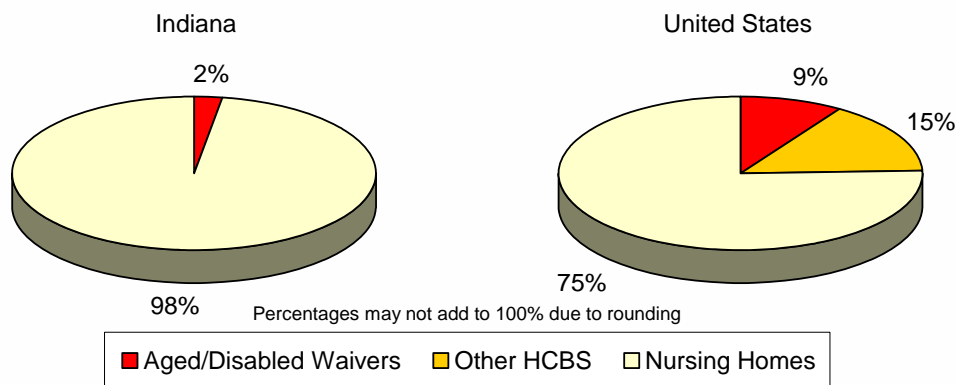
Other Developments

Assisted Living. The state has been encouraging the development of Supportive Living Facilities (SLFs), a Medicaid-model of assisted living. The concept is affordable apartment-like housing with personal care and health-related services. In 2007, 70 SLFs containing more than 5,500 apartments were in operation. The service rates paid by the department are based on 60 percent of the amount that would be spent on nursing facility care in the same geographic area. (CCP participants are not eligible to participate in the SLP program.)

Money Follows the Person. Illinois was awarded a \$55.7 million, five-year federal Money Follows the Person Demonstration grant in 2007 to transition 3,357 persons from nursing homes to community settings. In their grant proposal, state officials said that Illinois would increase the percentage of spending on community services each year of the project.

INDIANA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Indiana and the U.S., 2006



Compared to the U.S. average, Indiana allocates a greater percentage (98 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Indiana spent 2 percent on waiver services.

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	2,338	3,979	+1,641	\$18	\$32	+\$14
Nursing Homes	47,988	42,952	-5,036	\$818	\$1,289	+\$472

Although Indiana has yet to achieve an overall balance between home and community-based services (HCBS) and nursing home spending, some progress in the Medicaid program has occurred in recent years, and the state has a large state-funded HCBS program. Many more Medicaid participants received nursing home services than received HCBS. However, from 1999 to 2004, the number of participants receiving HCBS increased, while the number of participants in nursing homes decreased. From FY 2001 to FY 2006, the increase in Medicaid spending on nursing homes was more than 33 times the increase in spending on HCBS (most of the increase in nursing home spending occurred between 2004 and 2005). Medicaid, however, is not the only source of funding for LTC services. The state-funded

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

CHOICE program increased enrollment from 10,275 in 2005 to 15,100 by 2007.² The waiting list for CHOICE services was still high—about 5,800 people in May 2007—but the state decreased the number on the waiting list by several thousand from 2006 to 2007.

Major Initiative

In July 2005, the Indiana Family and Social Services Administration (FSSA) announced a new strategic direction for LTC. FSSA proposed to improve access to an array of LTC services, expand the capacity of HCBS, close nursing facility beds, promote consumer choice of LTC options, and balance public funding for LTC.

“The Aging Reform Initiative”

Indiana reforms call for increasing the number of people served in the waiver, integrating LTC services, and expanding financial eligibility criteria for community-based services.

The Indiana plan for reforming its LTC system, called “The Aging Reform Initiative,” includes integration of all HCBS, nursing facility care, and hospice service into a single, integrated LTC program, called Indiana Options for Long Term Care (OPTIONS). With a phase-in schedule over several years (beginning with Phase I in July 2006), the state plans to increase capacity and access to existing LTC services and add or expand services.

Another step was to increase to 3,500 the number of slots for the AD Medicaid Waiver program as of September 2006, with 1,000 slots targeted to people on the program’s waiting list. Phase II of the plan, beginning July 2007, calls for increasing transportation and housing options for older persons and people with disabilities.

Senate Enrolled Act 493 (enacted in 2003) played a key role in driving the state’s actions. SEA 493 required the state to take a number of steps to balance Indiana’s LTC system, including implementing the 300 percent of Supplemental Security Income (SSI) financial eligibility standard.

Other Developments

Administration. On April 25, 2006, Governor Mitch Daniels signed Senate Bill 41, creating the Division of Aging as a separate division in FSSA. Complete budgetary responsibility for nursing facilities and nursing facility level-of-care HCBS waivers was transferred from the Office of Medicaid Policy and Planning to the Division of Aging.

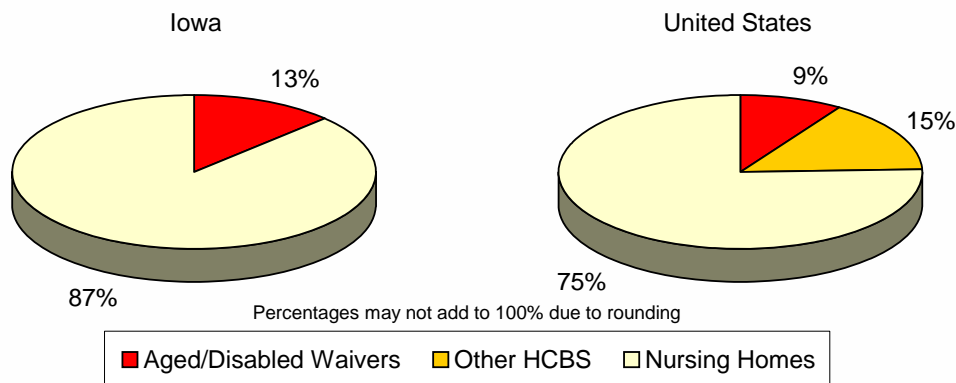
Aging and Disability Resource Centers (ADRCs). The state expected to develop and open ADRCs statewide by 2007. With assistance from a \$778,000 grant in 2004, the state created six ADRCs to coordinate information and determine eligibility for services. Funds from the ADRC grant were used to integrate the current management information systems between the aging and disabilities network and to develop an information marketing strategy.

Money Follows the Person (MFP). Indiana was awarded a \$21 million MFP grant in 2007 to transition 1,039 persons from institutional care to community settings. The state also hopes to strengthen integration and coordination of the services of all HCBS programs by using grant funds to improve information technology system integration.

² Community and Home Options to Institutionalized Care for the Elderly and Disabled.

IOWA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Iowa and the U.S., 2006



Compared to the U.S. average, Iowa allocates a greater percentage (87 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Iowa spent 13 percent on waiver services.

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	3,994	8,501	+4,507	\$24	\$64	+\$40
Nursing Homes	21,882	20,155	-1,727	\$505*	\$441	-\$65

Although Iowa has yet to achieve an overall balance between home and community-based services (HCBS) and nursing home spending, recent Medicaid trends for both participants and expenditures indicate that significant progress has occurred in recent years. Many more Medicaid participants received nursing home services than received HCBS in 2004. However, the number of participants in nursing homes decreased, while the participants receiving HCBS increased significantly from 1999 to 2004 (specifically, the number of people served in the waivers doubled). From FY 2001 to FY 2006, Medicaid spending on HCBS increased by \$40 million, while spending on nursing homes decreased by \$65 million.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

* Expenditures for nursing homes were used from FY 2000—instead of FY 2001—because of state reporting irregularities.

Major Initiative

Enacted in 2005, House File 841, the IowaCare Medicaid Reform Act calls in part for balancing the state's Medicaid LTC system by improving consumer access to HCBS. This goal calls for faster eligibility determinations, so consumers have speedier access to Medicaid HCBS waiver services, and expanding choices of where and how consumers access services.

"IowaCare"

IowaCare seeks to reform Medicaid in the state. Important LTC features include higher level-of-care eligibility standards for nursing home care, case management for individuals at risk of nursing home care, and consumer direction with credit unions providing financial services.

A central component of the original legislation called for higher level-of-care standards for entry into nursing homes while maintaining the current level-of-care standard for HCBS, thus encouraging expansion of HCBS. The state had not been able to implement this provision, however, as of spring 2008, although officials were still reviewing strategies to achieve that result. The legislation also requires the state to target individuals at imminent risk for institutionalization, which includes case management services for potential HCBS clients. The Iowa Department of Elder Affairs implemented case management as a service under the Elderly Waiver program in October 2006.

Another feature of the legislation promotes consumer choice by allowing waiver participants to choose whether they wish to self-direct their services. The Consumer Choice option became available in December 2006, initially to Elderly Waiver participants in a 12-county north central area of the state, with statewide coverage in 2007. An innovative feature of the option is the use of credit unions to provide financial services; specifically, the credit unions pay for goods and services on behalf of the participants.

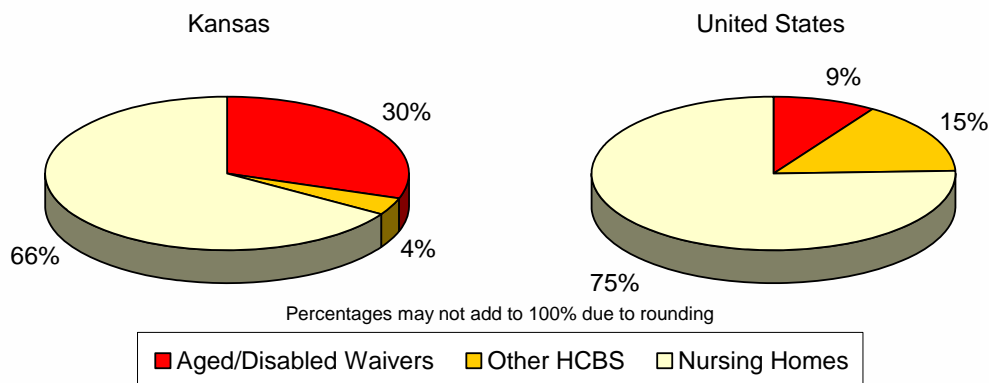
Other Developments

Systems Transformation Grant. Iowa received a \$2.3 million federal Real Choice Systems Transformation grant in 2005, which the state proposed using to provide financial and technical support for implementation of the balancing provisions of the IowaCare Act. The grant, which provides funding for planning, analysis, and policy and program development, is also assisting in the development of a statewide database of accessible housing.

Single Point of Entry. The Iowa Department of Elder Affairs, with funding from a federal Aging and Disability Resource Center grant, is leading a multi-agency collaborative to create a "Single Point of Entry to Long Term Care" Web-based information and referral system for Iowans seeking LTC assistance. The collaborative is linking several existing information and referral networks, expanding databases, and ensuring regular updating. "Eligibility calculator" software was being developed to help consumers and professionals determine potential eligibility for a wide range of services.

KANSAS

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Kansas and the U.S., 2006



Compared to the U.S. average, Kansas allocates a greater percentage (34 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to home and community-based services (HCBS). In FY 2006, Kansas spent 30 percent on waiver services and 4 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	10,523	12,105	+1,582	\$121	\$164	+\$43
Nursing Homes	17,644	17,804	+160	\$349*	\$321	-\$27

Recent Medicaid trends to increase HCBS participants and expenditures while holding nursing home participants and expenditures fairly constant indicate that Kansas has made significant progress toward balancing. From 1999 to 2004, the number of participants receiving HCBS increased significantly, while the number of participants in nursing homes remained relatively constant. From FY 2001 to FY 2006, Medicaid spending on nursing homes decreased by \$27 million, while spending on HCBS increased by \$43 million.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

* Expenditures for nursing homes were used from FY 2000—instead of FY 2001—because of state reporting irregularities.

About 5,800 older persons participated in the Medicaid Frail and Elderly HCBS waiver program in 2007, a 21 percent increase in enrollment over the 2000 total. About 6,100 older Kansans not eligible for Medicaid-funded services received one or more home care services through the state-funded Senior Care program in 2007, with state general revenue contributing \$6.8 million. With local match and participant fees, the total funding reached about \$8 million in 2007.

Major Initiative

The state has received several federal grants in recent years, which it has used to reform the financing and delivery of LTC services.

Self-Direction. The state received a \$2.2 million federal Systems Transformation grant in 2006 to increase consumer choice and control over HCBS. Kansas has made self-direction of services a major focus of its state LTC system since enacting a law in 1989 that stipulates that all persons age 16 and older who receive PCS have the right to choose to direct those services themselves if they wish. The Medicaid Frail Elders waiver and other waiver programs offer consumer-directed attendant options.

Self-Direction

It is state law that all people age 16 and older who receive personal care services in Kansas have the option to direct the services themselves.

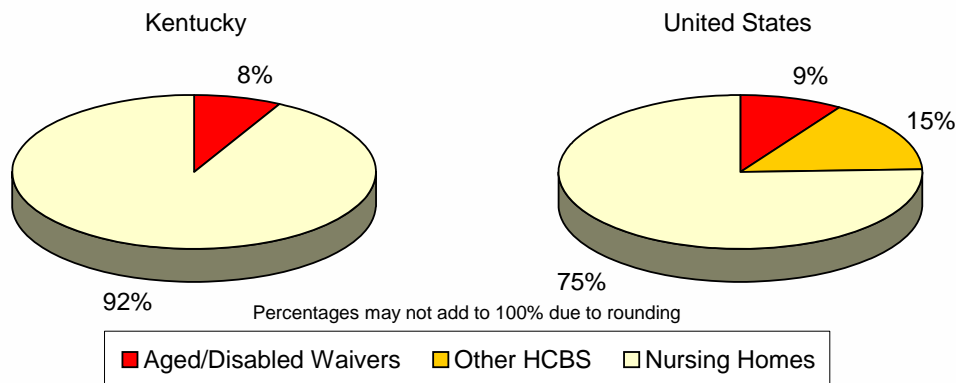
Aging and Disability Resource Centers. The state received \$800,000 in 2005 to implement an Aging and Disability Resource Center. The funds were to be used to create two pilot centers in the state's urban and rural areas. In addition, the state was to use these funds to streamline long-term care supports as well as improve access to Medicaid by creating a Web-based tool to expedite the financial eligibility determination process.

Other Developments

Money Follows the Person. Kansas also was awarded a \$36.8 million Money Follows the Person grant in 2007 to support efforts to move more than 900 persons out of nursing homes into community settings over the grant's five-year period.

KENTUCKY

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Kentucky and the U.S., 2006



Compared to the U.S. average, Kentucky allocates a greater percentage (92 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Kentucky spent 8 percent on waiver services.

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	13,391	12,744	-647	\$77	\$62	-\$15
Nursing Homes	27,739	26,736	-1,003	\$565	\$734	+\$169

Recent Medicaid trends in spending on home and community-based services (HCBS) and nursing homes indicate that Kentucky still has an unbalanced LTC system for older people and adults with physical disabilities. The numbers of Medicaid participants receiving nursing home services and HCBS both decreased from 1999 to 2004. From FY 2001 to FY 2006, Medicaid spending on nursing home services increased by \$169 million, while spending on HCBS decreased by \$15 million (specifically, most of the increase in nursing home expenditures occurred from FY 2004 to FY 2006).

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Major Initiative

Under the provisions of the Deficit Reduction Act of 2005 allowing states to vary the benefits packages they offer to some groups of Medicaid beneficiaries, Kentucky obtained a state plan amendment on May 3, 2006, for its new Medicaid program, KyHealth Choices. The program provides tailored benefits packages for four categories of beneficiaries. The standard benefits package is “Global Choices,” which provides basic medical care for adults, foster children, and older people not eligible for nursing facility level of care.

“Comprehensive Choices” is the benefit package for those older people who meet nursing facility level of care, need LTC services, are at risk of being institutionalized, and/or are covered under a Medicaid waiver program. Comprehensive Choices is expected to cover 27,000 people who are eligible for all Global Choices benefits and other benefits, depending on the level of care they need. An individual’s care plan will identify whether the person fits into a basic or high-intensity level; the latter level receives nursing facility services. The program has service limits and co-payments.

In October 2006, the state implemented a “Consumer-Directed Option” for 14,000 KyHealth Choices members who were receiving services under the Medicaid Home and Community-Based waiver program. Consumers choosing self-direction are assigned to a support broker who provides case management and assists with care planning.

“KyHealth Choices”

Under Kentucky’s new Medicaid program, KyHealth Choices, a benefits package includes consumer-direction options for older people who need LTC.

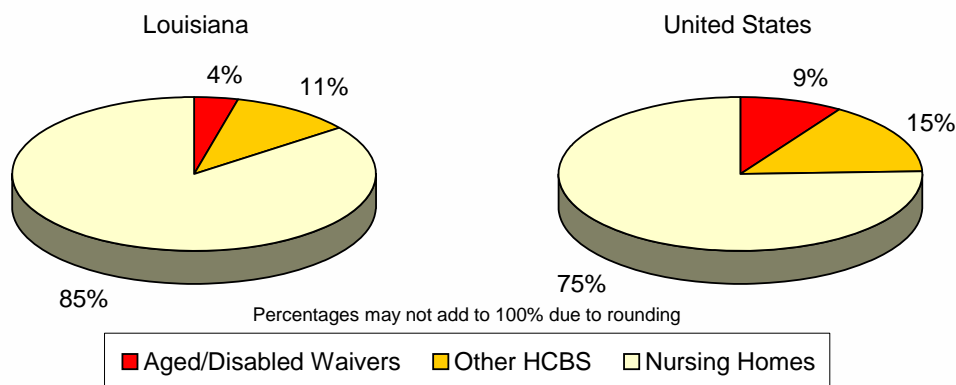
Other Developments

Administration. In December 2006, Governor Ernie Fletcher signed an executive order creating the Department for Aging and Independent Living to centralize policy coordination, services, and leadership on aging issues. In partnership with the state’s 15 Area Agencies on Aging, the department administers LTC programs and services and certifies assisted living facilities.

Money Follows the Person. In 2007, the state was awarded approximately \$50 million for a five-year Money Follows the Person Demonstration. The state plans to use the funds to expand home and community-based options and transition 431 people into the community. Resources will also go toward collaborating with stakeholders in the public, private, and nonprofit sectors to design a comprehensive transition process that reduces the burden for consumers while giving them more home and community-based options.

LOUISIANA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Louisiana and the U.S., 2006



Compared to the U.S. average, Louisiana allocates a greater percentage (85 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Louisiana spent 4 percent on waiver services and 11 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	872	3,210	+2,338	\$10	\$109*	+\$100
Nursing Homes	35,508	32,306	-3,202	\$515**	\$637	+\$122

Although Louisiana has not achieved an overall balanced LTC system for older people and adults with disabilities, the state has made progress in recent years. Medicaid participants in nursing homes far outnumber those who received home and community-based services (HCBS) in 2004. However, the number of participants receiving HCBS increased from 1999 to 2004, while the number in nursing homes decreased. From FY 2001 to FY 2006, both Medicaid spending on nursing homes and on HCBS increased, but the *increase* in spending

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* The state reported a significant portion of 2006 waiver expenditures under 1115 waivers, whose reports do not include target population information; therefore, the HCBS numbers may be underreported.

** Expenditures for nursing homes were used from FY 2000—instead of FY 2001—because of state reporting irregularities.

on nursing homes was larger than the *total* HCBS spending for older people and adults with disabilities.

The state's Medicaid Elderly and Disabled Adults waiver program served about 2,750 persons in 2007, but the program also had a waiting list of approximately 7,500 people. The Louisiana legislature provided additional funding in 2007 to increase the number of people served by 1,500.

“Executive Order for Choice in Long-Term Care”

The governor issued an executive order, which, along with several federal grants, has promoted affordable and accessible housing for people with disabilities.

Major Initiative

The governor issued Executive Order 43, “Louisiana’s Plan for Choice in Long-Term Care,” in October 2004. In the first phase, an interagency team developed a Plan for Immediate Action, which was approved by the governor in March 2005. The Department of Health and Hospitals issued a report on October 1, 2007, that included work plans for accessible transportation, affordable and accessible housing, information technology, and aging and adult services. Under the last category, for example, the Office of Aging and Adult Services proposed focusing its review on assisted living, self-directed service options, a single point of entry for aging services, and chronic disease management, in addition to proposing recommendations by July 2008. The state received a \$3.2 million Real Choice Systems Transformation grant in 2005, which state officials said would help support “the larger long-term care reform plan called for in the Governor’s Executive Order.” In their grant proposal, state officials said the focus was on three areas: long-term supports coordinated with affordable and accessible housing; a comprehensive quality management system; and transformation of information technology to support systems change. One of the housing strategies undertaken with the Systems Transformation grant is a 3,000-unit Permanent Supportive Housing Initiative for people with various disabilities, including older persons. Low Income Housing Tax Credits and Community Development Block Grant funds also finance this project, in which many public agencies are involved. The federal grant has also supported development of a housing resource website, www.LAHousingSearch.org.

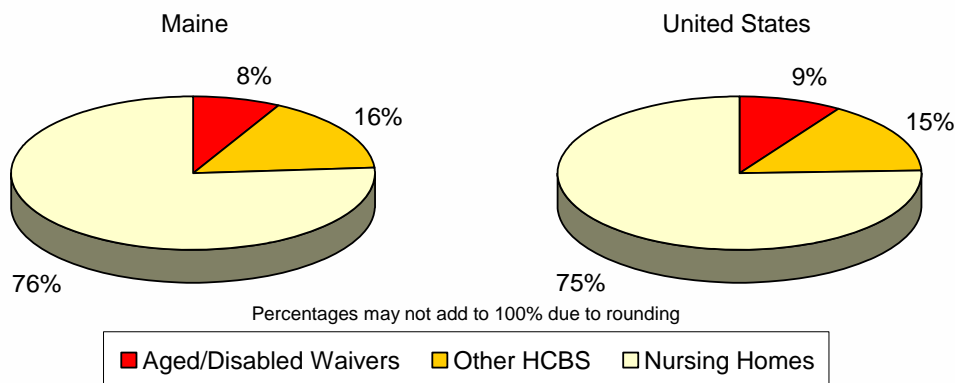
Other Developments

Money Follows the Person. Louisiana was awarded a five-year, \$31 million dollar grant in 2007 to relocate about 760 people from nursing homes to the community and to continue to build on the projects underway from previous federal Systems Change grants.

Lawsuit. In April 2000, *Barthelemy v. Louisiana Department of Health and Hospitals* alleged that the Louisiana Department of Health and Hospitals (DHH) failed to provide significant home care options for the state’s older persons and persons with disabilities, and that the state was not providing sufficient funding for community-based care. The state settled the lawsuit in 2001 and again in 2002 through an agreement to develop an additional 1,500 waiver program slots and \$118 million in additional funds. DHH then submitted an amendment to the Medicaid State Plan to add personal care, which the federal government approved in 2004. State officials expect to provide PCS to about 2,300 people.

MAINE

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Maine and the U.S., 2006



Similar to the U.S. average, Maine allocates a greater percentage (76 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Maine spent 8 percent on waiver services and 16 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	3,184	9,557	+6,373	\$29	\$78	+\$48
Nursing Homes	9,236	9,116	-120	\$201	\$247	+\$46

Although Maine has not achieved a balanced Medicaid LTC system for older people and adults with disabilities, the state has made progress in recent years and has a sizeable state-funded program that is not included in the above data. The number of participants receiving home and community-based services (HCBS) tripled from 1999 to 2004, while the number of participants in nursing homes remained relatively constant (however, there was a significant decrease in the number of nursing home participants between 1995 and 1999).²

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

² Fralich, J., et al. (2007). *Assessment of Maine's Long-term Care Needs Baseline Report: Demographics and Use of Long Term Care Services in Maine*. Portland, ME: University of Southern Maine.

In addition, the state-funded Home and Community-Based Care program serves more than 4,100 older adults and people with disabilities. Services offered include adult day care, home-based care, congregate housing services, Alzheimer's respite, homemaker services, and pre-admission assessments of nursing home applicants.

Major Initiative

In 2000, the state created a cross-disability advisory task force, called the Work Group for Community-Based Living, to develop a "single coherent vision across departments for achieving community integration." The advisory group issued a report, "Roadmap for Change," in October 2003. Increasing housing options, improving quality care measurement, and developing practices to encourage recruitment and retention of direct-care workers are among the advisory group's priorities.

"Roadmap for Change"

Maine's Roadmap for Change, along with several federal grants, has resulted in Aging and Disability Resource Centers, quality measures for community-based services, and consumer-directed care.

Maine received several grants under the federal Systems Change grant program in 2001 and 2003 that have assisted the state in moving forward on the "Roadmap for Change" recommendations. To improve access to information about LTC eligibility and services, for example, the state used grant funds to help establish three Aging and Disability Resource Centers around the state, and to develop a website (www.AccessMaine.org) with the help of people with disabilities.

Another project that has evolved from this planning process is a Personal Assistance Services Policy Review to maximize consumer choice and control across state agencies and programs. To improve quality measurement, the state developed a set of core quality indicators for HCBS across program areas. State officials said the indicators provided a way for consumers and policy makers to systematically assess the overall performance of the HCBS system, and determine the outcomes and satisfaction of people served by the HCBS waiver programs.

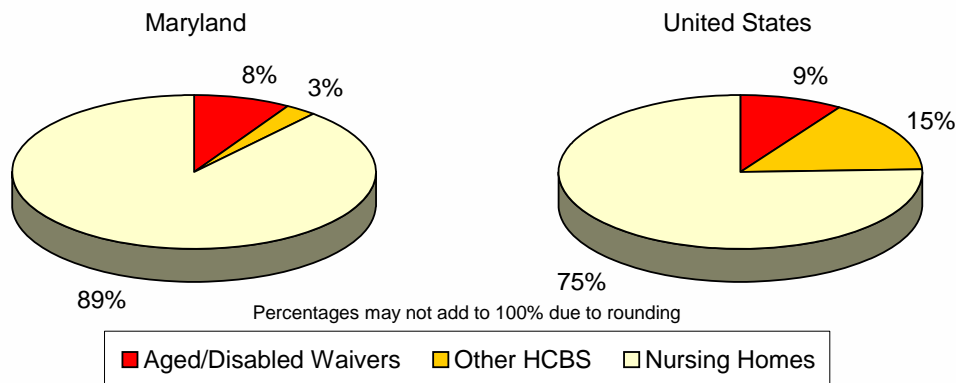
Other Developments

Workforce. Two state resolves (Chapters 194 and 199) and an appropriations provision (Chapter 519EEEE) in 2006 provided the basis for a study by the Maine Department of Health and Human Services (DHHS) of the state's direct care workforce. Issued in March 2007, the report, "Study of Maine's Direct Care Workforce: Wages, Health Coverage, and a Worker Registry," concluded that the state lagged behind all other New England states in median wages for direct-care staff. In fact, median wages for these workers in Maine were just over the federal poverty level. The department estimated that it would cost \$3 million in state dollars to raise the median wage to \$8.50 an hour for all direct-care workers in MaineCare (the state's Medicaid program) and state-funded LTC programs, and \$6 million to raise those wages to \$10 an hour. The 2007 legislature enacted legislation to increase reimbursement rates with wage adjustments for the Homemaker Program.

Consumer Direction. One of the bills that provided for the direct worker study (Chapter 199) also specified a number of steps to expand availability of consumer-directed alternatives. The legislation directed DHHS to establish a new state plan program for personal assistance services for persons with physical disabilities, using the self-directed program model authorized in the Deficit Reduction Act of 2005. Chapter 199 requires the state to provide the legislature with a plan and a timetable for the expansion of consumer direction options in all LTC programs.

MARYLAND

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Maryland and the U.S., 2006



Compared to the U.S. average, Maryland allocates a greater percentage (89 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Maryland spent 8 percent on waiver services and 3 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	4,759	8,464	+3,705	\$36	\$121	+\$85
Nursing Homes	27,920	27,109	-811	\$697	\$939	+\$243

Although Maryland still has an unbalanced LTC system for older people and adults with physical disabilities, recent Medicaid trends indicate progress has occurred. Many more Medicaid participants receive nursing home services than receive home and community-based services (HCBS). However, the number of participants in nursing homes decreased slightly from 1999 to 2004, while the number of participants receiving HCBS increased significantly. From FY 2001 to FY 2006, the increase in spending on nursing homes was nearly three times the increase in spending on HCBS.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

In FY 2007, 24,531 persons lived in Maryland nursing homes, and the Older Adults home and community-based waiver program had about 3,500 participants. The program also had a waiting list of 8,500 persons. A state-funded program, Senior Care, had more than 3,800 participants in FY 2007, with a waiting list of 2,259 people. However, the legislature had appropriated an additional \$750,000 in FY 2007 to reduce the waiting list.

Major Initiative

Maryland has put significant effort into informing nursing home residents of their options for living in the community, and providing assistance to those residents who wish to make that transition. In 2001, Maryland was one of 14 states to receive a Nursing Facility Transition grant under the new federal Systems Change grant program. Implementation of that grant led to the transition of 193 residents from nursing homes to community settings.

“Money Follows the Individual”

Maryland enacted legislation requiring its department of health to identify nursing home residents wishing to move to the community and to provide them with information and assistance.

To ensure that nursing home residents learned of their options and were able to seek assistance to return to the community if they wished, the Maryland legislature passed two laws. In 2003, legislators enacted the Money Follows the Individual Act (House Bill 478), which guarantees nursing home residents an opportunity to transition to community-based waivers, regardless of any budgetary caps on waiver enrollments. In 2004, legislators enacted the Money Follows the Individual Accountability Act (Senate Bill 620), which requires the Department of Health and Mental Hygiene (DHMH) to identify residents wishing to move to the community and provide them with information and assistance.

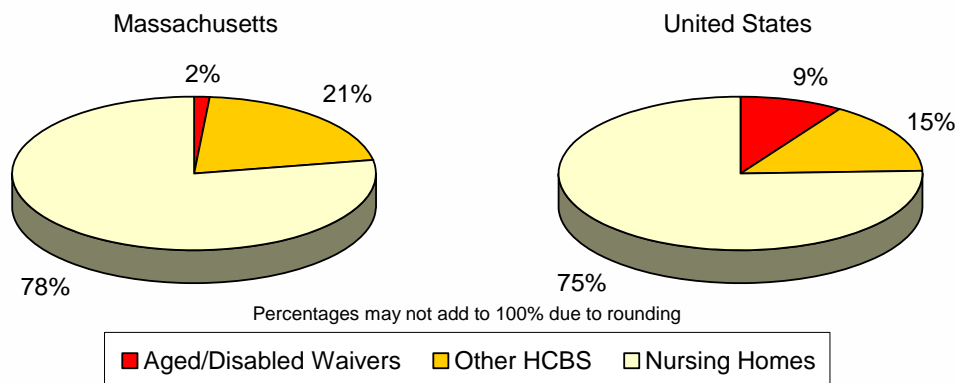
In 2007, Maryland was awarded a \$67.2 million federal grant under the Money Follows the Person demonstration program to move approximately 2,000 persons (including 1,360 older adults) out of nursing homes into community settings over five years. Under the program, the state will provide “peer mentors” to support institutional residents who want to move out, and plans to create a Statewide Transition Center to help persons with education, the application process, and housing and other transition services.

Other Developments

Managed Long-Term Care. Maryland had been developing a Medicaid capitated managed LTC program (CommunityChoice Managed Long-Term Care) since 2005, to be piloted in two regions of the state. However, a new governor and administration in 2007 decided not to pursue federal approval for a waiver for the project, which had elicited criticism from various advocacy and provider groups. Objections included concern about the size of the pilot regions and the mandatory rather than voluntary nature of the plan. Providers had also sought greater protections against potential financial losses. State officials said they wanted to reevaluate LTC reform efforts.

MASSACHUSETTS

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Massachusetts and the U.S., 2006



Similar to the U.S. average, Massachusetts allocates a greater percentage (78 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Massachusetts spent 2 percent on waiver services and 21 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	8,850	17,715	+8,865	\$249	\$475	+\$226
Nursing Homes	60,044	60,273	+229	\$1,423	\$1,673	+\$249

Although Massachusetts has yet to achieve an overall balanced LTC system for older people and adults with physical disabilities, there has been some progress in recent years. Although many more Medicaid participants receive nursing home services than receive home and community-based services (HCBS), the number of participants receiving HCBS doubled from 1999 to 2004, while the number in nursing homes remained relatively constant (specifically, there was a substantial increase in personal care beneficiaries and a small increase in waiver beneficiaries). From FY 2001 to FY 2006, Medicaid spending on both

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Note: Adult Foster Care and Group Adult Foster Care (assisted living) are services in the state Medicaid plan and are not included in the HCBS expenditures.

HCBS and nursing homes increased. The state also provides home care services to more than 33,000 persons age 60 and older through the state-funded Elder Home Care Program. The state allocated \$252 million dollars in 2008 to support this program.

Major Initiative

In 2003, Massachusetts established a “Community First” policy that emphasizes community-based supports and services to enable eligible older persons and adults with disabilities to remain in community settings. Massachusetts submitted its “Community First” demonstration proposal (“strategic plan”) to the Center for Medicare &

Medicaid Services (CMS) in December 2006 to prevent or delay admission to nursing homes or to enable certain nursing home residents to return to the community. Under the demonstration, the state proposes an array of supports to help consumers stay in the community as long as possible and divert or delay Medicaid-covered nursing facility stays. Another major feature of the demonstration raises income limits for Medicaid eligibility for specific individuals at risk of institutionalization to 300 percent of Supplemental Security Income (from \$816 a month to \$1,715) and asset limits from \$2,000 to \$10,000.

“Community First”

Community First allows individuals to remain in their communities to receive LTC services and support. This demonstration project will also allow individuals to direct their own care and transition nursing home residents back into the community.

Another goal of the demonstration is to facilitate the growth of a more flexible community-based supports delivery system by allowing participants to direct their own benefits. Also, some nursing home residents would have the opportunity to return to the community using transition funds.

The plan covers three categories of potential participants: the Imminent Risk group (persons who need nursing home level of care); the Prevention group (whose clinical and functional profile puts them on a trajectory for nursing home care within 9 to 12 months); and the Transition group, people who wish to leave a nursing home but need assistance to return to the community. The state proposed caps on the enrollment of each group, with the largest number (10,600) for the Imminent Risk category; 4,000 for the Prevention group, and 1,000 for transitioning persons (500 for persons age 65+ and 500 for the under-65 age group).

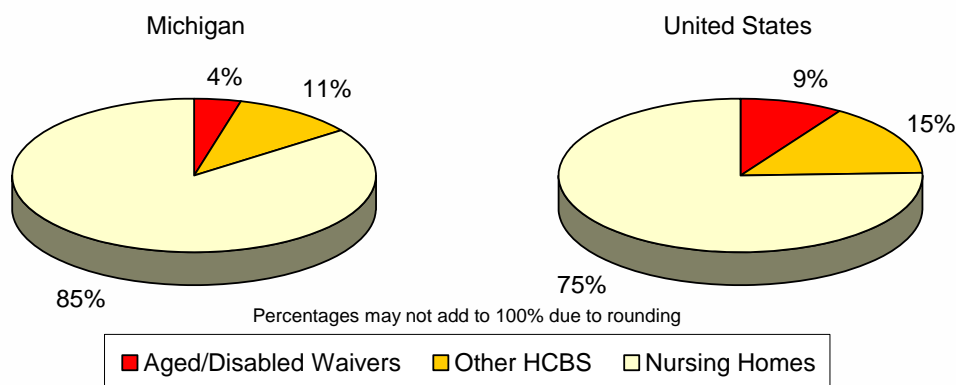
Other Developments

Equal Choices. Legislation enacted in 2006, “Equal Choices,” stipulates that persons eligible for publicly funded LTC services should be given “the choice of care setting that is the least restrictive and most appropriate” for their needs. The aim of the legislation is broader access to publicly funded community-based supports for low-income older persons and people with disabilities, particularly through broader income and asset financial eligibility standards.

The legislation directed MassHealth (the state’s Medicaid program) to submit an 1115 research and demonstration waiver to CMS to expand MassHealth income and asset financial eligibility rules to enable low-income people at risk of nursing home care to choose community supports instead.

MICHIGAN

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Michigan and the U.S., 2006



Compared to the U.S. average, Michigan allocates a greater percentage (85 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Michigan spent 4 percent on waiver services and 11 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	49,722	64,130	+14,408	\$234*	\$253	+\$20
Nursing Homes	44,180	50,431	+6,251	\$1,744	\$1,448	-\$296

Although Michigan still has an unbalanced LTC system for older people and adults with physical disabilities, an increase in Medicaid home and community-based services (HCBS) participants and a decrease in Medicaid nursing home expenditures indicate that the state has been making progress in recent years. More Medicaid participants received HCBS than received nursing home services in 2004. Although the number of participants receiving HCBS and nursing home services both increased from 1999 to 2004, the increase in the number receiving HCBS was much greater. From FY 2001 to FY 2006, spending on HCBS

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

* Reported expenditures for HCBS in FY 2001 include HCBS waiver spending for FY 2002 instead of FY 2001 because of data availability.

increased, while spending for nursing homes decreased dramatically (the majority of the decline was from 2004 to 2006).

Major Initiative

In 2004, by Executive Order, Michigan Governor Jennifer Granholm created a Long-Term Care Task Force (2004-1) whose 2005 recommendations have been the basis for continuing initiatives in Michigan to expand access to LTC services in the community and to develop person-centered services.

“Single Point of Entry”

Michigan selected four sites to serve as single-point-of-entry demonstration pilots. A total of \$35 million was allocated to the four sites to run the pilot for 27 months.

Gov. Granholm issued another Executive Order in 2005 (2005-14) creating the Office of Long-Term Care Supports and Services in the Michigan Department of Community Health and a Long-Term Care Supports and Services Advisory Commission. The new office advocated in 2007 for improved funding of LTC in state appropriations and guardianship reform, and established six work groups to continue developing Task Force recommendations. The Executive Order also included initiation of a request-for-proposals process to establish single-point-of-entry (SPE) demonstrations that would enable consumers to obtain information about LTC services and support at a single location. In June 2006, Gov. Granholm announced the selection of four sites throughout the state to serve as the SPE demonstrations.

The Michigan legislature also passed legislation in December 2006 (Public Act 634) authorizing the SPEs, but that legislation included a sunset provision prohibiting continuation or expansion of SPEs without legislative approval and funding. The legislature also acted in 2006 on a task force recommendation to establish LTC insurance partnerships, but implementation has been delayed as Michigan develops estate recovery legislation acceptable to the federal government.

The state also approved a budget measure in 2006 that increased the wages of 42,000 home care workers in the Home Help program from \$6.07 to \$7.00 an hour.

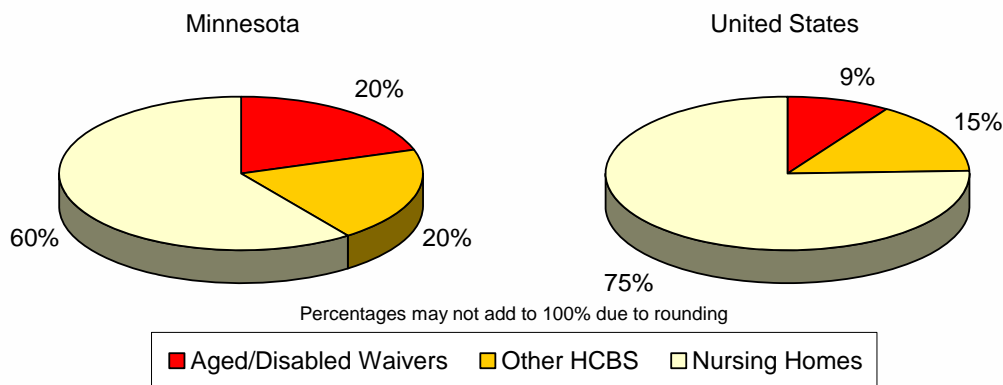
Other Developments

Systems Transformation Grant. In 2006, the state received a \$2.4 million Systems Transformation grant that state officials said would contribute to building “an integrated and highly responsive long-term care system, characterized by easy access, consumer choice and control, high quality services and outcomes, and flexible funding.”

Money Follows the Person. In 2007, Michigan was awarded a \$67.8 million Money Follows the Person Demonstration grant to move 2,500 people from nursing homes to the community over five years. The state also planned to use the funds to help develop housing coordination services for the people making the transition and to develop, with the MI Choice waiver, the option of receiving services in licensed residential housing.

MINNESOTA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Minnesota and the U.S., 2006



Compared to the U.S. average, Minnesota allocates a greater percentage (40%) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to home and community-based services (HCBS). In FY 2006, Minnesota spent 20 percent on waiver services and 20 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	18,574	34,385	+15,811	\$209	\$566	+\$358
Nursing Homes	38,925	39,016	+91	\$901	\$853	-\$48

Minnesota has made significant progress toward achieving a balanced LTC system for older people and adults with physical disabilities, and recent Medicaid trends indicate a large increase in HCBS participants and expenditures and a decrease in nursing home expenditures. While the number of participants receiving HCBS increased significantly from 1999 to 2004, the number of participants receiving nursing home care remained relatively constant. Spending on HCBS more than doubled between FY 2001 and FY 2006, while spending on nursing homes decreased. Participant and expenditure data are underreported here because they do not include Medicaid managed care programs.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Medicaid is not the only source of funding for LTC. The Alternative Care Program is a state-funded, cost-sharing program that supports certain home and community services for Minnesotans age 65 and older. In FY 2007, the program served 5,158 people, with total expenditures of \$25.7 million. Services include adult day, case management, chore, companion, home-delivered meals, homemaker, personal care, respite, and support for family caregivers.

Major Initiative

Minnesota expanded coverage in recent years for its managed care programs, which include LTC services for older persons. Medicaid beneficiaries age 65 and older are required to enroll in Medicaid managed care. Managed care plans in all counties (four additional counties were to be added in March 2008) provide additional services, such as transportation, interpreter services, and case management beyond what is typically included in fee-for-service.

“Minnesota Managed Long-Term Care”

Minnesota expanded its managed care programs through the Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+).

Launched in 1997, Minnesota Senior Health Options (MSHO) provides services to people age 65 and older who are dually eligible for Medicare and Medicaid or who have Medicaid only. MSHO plans provide Medicare services such as Part D drugs as well as health care and LTC services. Enrollment is voluntary.

Minnesota Senior Care (MSC) and Minnesota Senior Care Plus (MSC+), launched in June 2005, also provide health care and LTC services, but enrollment is mandatory. MSC+ is similar to MSHO, but it does not cover Medicare services or Medicare Part D drugs. (Beneficiaries must sign up with a separate Medicare prescription drug plan to receive Part D drugs.) The state is phasing out MSC in favor of MSC+.

Other Developments

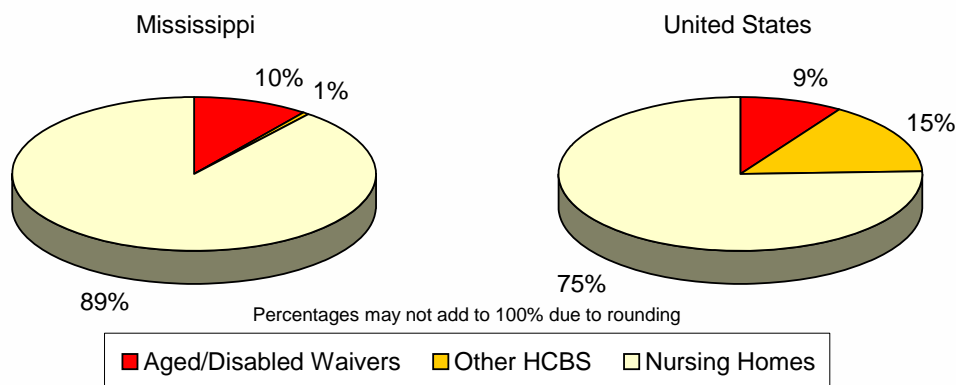
Nursing Home Bed Reduction. In a two-year period ending in 2005, nursing facility bed supply had declined by 2,348 beds or 6 percent. Several policies contributed to this outcome: 1) a Voluntary Planned Closure Program that provides an adjusted rate increase to nursing facilities that voluntarily close beds; 2) a Bed Layaway Program under which nursing facilities temporarily close beds on a voluntary basis in return for an adjusted reimbursement; and 3) a Single Bed Incentive enacted by the legislature in 2005 to encourage creation of single-bed rooms in combination with bed closures.

If those trends continued, state officials predicted in 2006 that the state would take 14,000 additional beds offline in the next 15 years, resulting in fewer than half the beds the state had at its peak in 1987—48,307 beds.

Long-Term Care Planning. In 2006, Minnesota adopted a “Transform 2010” project to identify the impact of the wave of baby boomers turning 65 in 2010, and to reexamine the state’s health and LTC systems for their ability to serve this population.

MISSISSIPPI

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Mississippi and the U.S., 2006



Compared to the U.S. average, Mississippi allocates a greater percentage (89 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2005, Mississippi spent 10 percent on waiver services and 1 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	2,667	11,747	+9,080	\$35	\$79*	+\$54
Nursing Homes	23,909	22,678	-1,231	\$416	\$648	+\$232

Although Mississippi still has an unbalanced LTC system for older people and adults with physical disabilities, the state has made progress in increasing access to home and community-based services (HCBS) for Medicaid participants in recent years. The number of participants receiving HCBS more than quadrupled from 1999 to 2004, while the number of participants in nursing homes decreased. From FY 2001 to FY 2006, however, the increase in Medicaid spending on nursing homes was more than four times the increase in spending on

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

* Mississippi reported total waiver spending for 2006, but not spending for each individual waiver. Consistent with the proportion in earlier years, we estimate that 70 percent of total waiver spending went toward waivers for older people and adults with physical disabilities.

HCBS. In fact, Medicaid spending on nursing homes increased by \$232 million, an amount larger than the total HCBS spending for older people and adults with disabilities (\$79 million) in FY 2006.

In 1999, the Medicaid Elderly/Disabled waiver had an enrollment of 2,540 persons. By 2006, the caseload had increased to 10,732 persons, and the program still had a waiting list of between 6,500 and 7,000 persons in 2007.

Major Initiative

Mississippi is focusing specific LTC reform efforts on improving coordination between the LTC and housing sectors. Using federal grant money, the state developed a statewide Action Plan with recommendations for interagency coordination of policies, resources, and services to meet the needs of persons with disabilities.

Mississippi's "Project BRIDGE" is intended to enhance collaboration between housing and long-term support services. The grant staff established a statewide BRIDGE action council composed of housing and long-term support providers, state agency staff members, individuals with disabilities, and families whose purpose is to guide an agenda for systems change.

"Project BRIDGE"

Projected Bridge brings various stakeholders together to serve as a council and guide the state through the system change process. The project has selected two regional sites in which to test an action plan.

The project plans to select two model communities to test an action plan being developed by the University of Southern Mississippi Institute for Disability Studies under the state's direction.

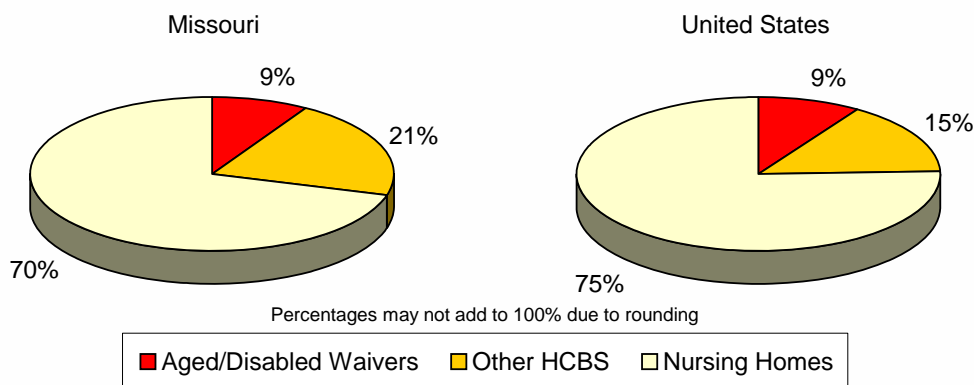
Other Developments

Pre-Admission Screening. The Division of Medicaid developed a comprehensive pre-admission screening process in 2007 that established comparable eligibility criteria for nursing facility services and Medicaid HCBS waivers. All persons seeking LTC service will be assessed by a common instrument and screening criteria. The new process was scheduled for implementation in October 2007.

Aging and Disability Resource Center (ADRC). In September 2005, Mississippi received \$750,000 from the Administration on Aging to create an Aging and Disability Resource Center. Goals for the project include creating a single point of entry to enable consumers to obtain information regarding LTC resources, streamlining and coordinating LTC services, and increasing the number of people using the single-point-of-entry system.

MISSOURI

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Missouri and the U.S., 2006



Compared to the U.S. average, Missouri allocates a greater percentage (70 percent) of its Medicaid long-term care (LTC) spending to home and community-based services (HCBS) for older people and adults with physical disabilities. In FY 2006, Missouri spent 9 percent on waiver services and 21 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	57,407	73,160	+15,753	\$228	\$320	+\$92
Nursing Homes	39,762	39,606	-156	\$726*	\$763	+\$37

Recent Medicaid trends indicate that significant progress has occurred in recent years. Many more Medicaid participants received HCBS than did nursing home services in 2004. In fact, while the number of participants receiving HCBS increased from 1999 to 2004, the number of participants in nursing homes remained relatively constant. From FY 2001 to FY 2006, the increase in Medicaid spending on HCBS was two and a half times as much as the increase in spending on nursing homes.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

* Expenditures for nursing homes were used from FY 2000—instead of FY 2001—because of state reporting irregularities.

Major Initiative

In 2005, the Missouri legislature passed a bill (Senate Bill 539) creating a Medicaid Reform Commission to consider how to restructure the state's Medicaid program. The commission issued a report in December 2005 that led to the creation of the MO HealthNet program, which focuses on health, wellness, and prevention for Missouri individuals eligible for Medicaid-funded health care. (MO HealthNet took effect in August 2007.)

Although the new Medicaid health care package does not contain LTC provisions, the commission addressed three major components of Medicaid reform that affect LTC: eligibility, availability, and delivery of services. For example, the commission recommended that the state develop a single-point-of-entry system to provide information, assistance, and access to LTC services. The commission also recommended that state officials encourage state residents to make better-informed health decisions about the cost associated with needing LTC through the use of a Long-Term Care Partnership Program that links purchase of LTC insurance with eligibility for Medicaid coverage of LTC services.

Missouri state agencies are attempting to build on the recommendations in the Commission report with the help of federal grants. Missouri was awarded a \$17.7 million, five-year federal Money Follows the Person grant in 2007 to transition 250 nursing home residents to community settings, and to remove barriers that may prevent nursing home residents from receiving services in a home and community-based setting.

“Money Follows the Person”

Missouri was awarded nearly \$18 million through the Money Follows the Person Demonstration grant to transition 250 nursing home residents back into the community and to develop strategies that will continue to support transition efforts.

Other Developments

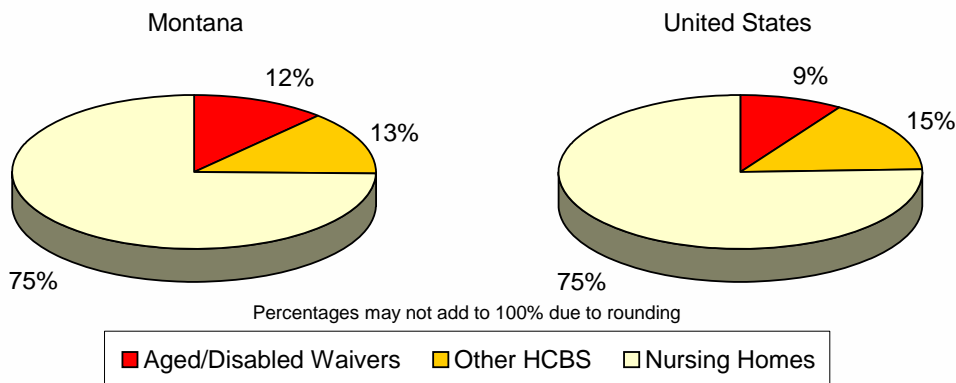
Quality Assurance and Quality Improvement Project. Missouri is using funds from the federal Real Choice Systems Change grant program to develop a consistent method of gathering quality assurance data for all of the state's HCBS waiver programs. The “Quality Assurance and Quality Improvement Project” uses grant funds to support interagency collaboration to develop a comprehensive statewide system for tracking and collecting quality assurance data.

Using the Participant Experience Survey developed by the federal government, state officials are assessing the needs and concerns of older persons and people with disabilities who use in-home services. The state conducted surveys in 2006 and 2007 and posted the results on the Department of Health and Senior Services' website.

Own Your Future. The “Own Your Future” campaign to raise awareness among consumers about planning for LTC needs kicked off on August 14, 2007, with a press conference by Governor Matt Blunt. The state also ran public service announcements, sponsored town hall meetings, and distributed education materials to the general public on a variety of available resources.

MONTANA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Montana and the U.S., 2006



Similar to the U.S. average, Montana allocates a greater percentage (75 percent) of its Medicaid long-term care (LTC) spending for older people and adults with disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Montana spent 12 percent on waiver services and 13 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	4,279	4,805	+526	\$44	\$49	+\$5
Nursing Homes	5,549	5,204	-345	\$111	\$147	+\$36

Although Montana still has an unbalanced LTC system for older people and adults with physical disabilities, Medicaid trends indicate that slight progress has occurred in recent years. The number of Medicaid participants receiving home and community-based services (HCBS) increased slightly, while the number of participants in nursing homes declined slightly from 1999 to 2004. From FY 2001 to FY 2006, the increase in Medicaid spending on nursing homes was more than seven times as much as the increase in spending on HCBS.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Major Initiative

Montana is aging at a faster rate than most other states, according to the State Plan on Aging. “Providing long-term care choices for Montana’s high-risk individuals in rural/frontier communities is going to be a challenge in the future as the population ages,” says the 2008–2011 State Plan on Aging. Consumers in these areas are “faced with the dilemma of finding any available services in their area.”

To address these issues, the State Plan on Aging recommended an increase in the number of people served by the Medicaid Home and Community-Based Waiver program by at least 100 slots over the biennium. The Montana legislature followed through on this recommendation by providing additional funding for another 102 slots for the program.

The legislature also created an Older Montanans Trust Fund (Senate Bill 155) in 2007 that will expand HCBS and develop new and innovative approaches to home-based services for persons age 60 and older. The program will be implemented using \$5 million of unspent Big Sky RX, a prescription drug program for Medicare beneficiaries.

Another bill passed in 2007 (Senate Bill 206) authorizes the Department of Public Health and Human Services to study the feasibility of increasing Medicaid payments to employers of personal care attendants and other direct-care employees so those employers can provide health insurance for their workers. SB 206 also authorizes the department to create a pilot program to test the effects of the plan. The legislature also provided a \$1.00 an hour increase for direct-care workers in state-funded LTC programs, bringing the minimum wage for these workers to \$8.50 an hour.

“Older Montanans Trust Fund”

The Older Montanans Trust Fund encourages innovations in home and community-based services for persons age 60 and older.

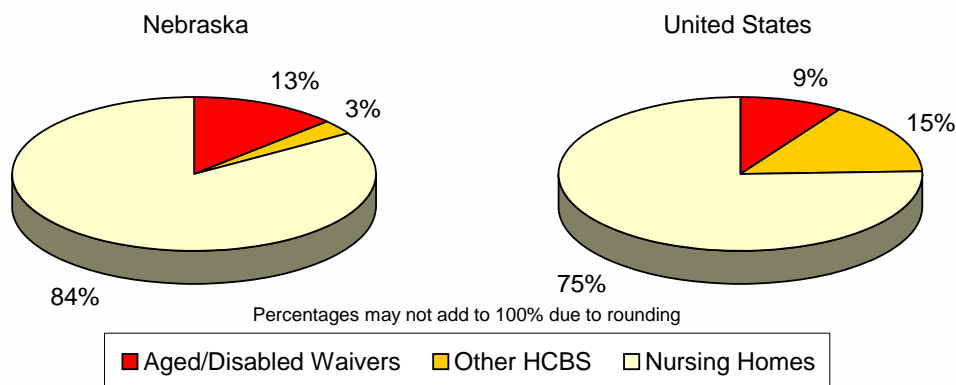
Other Developments

Self-Direction. In January 2006, the federal government approved a 1915(c) Independence Plus (IP) waiver for older persons and adults with disabilities in Montana, and provided a grant of almost a half-million dollars. The new HCBS-IP program, called Big Sky Bonanza, allows participants to purchase personal assistant services and other supplies and services using an individual-budget approach. This option is offered to persons receiving personal assistance services under Medicaid and to persons in the existing Elderly and Physically Disabled waiver program, which has had a more limited self-direction option.

Before receiving the IP grant, the state had offered self-directed personal care services that allowed participants to hire and dismiss workers but not to control an individual budget. The state applied for the IP grant to expand consumer-directed services and to increase consumer control. Participants can now be responsible, if they choose, for hiring, managing, and dismissing workers, setting payment rates (within certain limits), and scheduling services. A number of community agencies act as support brokers to provide assistance and support to participants.

NEBRASKA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Nebraska and the U.S., 2006



Compared to the U.S. average, Nebraska allocates a greater percentage (84 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Nebraska spent 13 percent on waiver services and 3 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	3,219	6,265	+3,046	\$37	\$67	+\$29
Nursing Homes	16,487	11,109	-5,378	\$370	\$347	-\$23

Although Nebraska has yet to achieve a balanced LTC system for older people and adults with physical disabilities, recent Medicaid trends indicate that the state has made significant progress. The number of participants receiving home and community-based services (HCBS) nearly doubled from 1999 to 2004, while the number of participants in nursing homes decreased by one-third. From FY 2001 to FY 2006, Medicaid spending on HCBS increased by \$29 million, while spending on nursing homes decreased by \$23 million.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Major Initiative

In the late 1990s, the Nebraska Health and Human Services System developed a Long-Term Care Plan to shift LTC from an institutional bias to expansion of home and community care. One significant initiative under that plan has been to convert nursing home beds to assisted living (AL) facility beds. The state has used tobacco settlement and intragovernmental transfer funds to create a trust fund to finance the conversion of nursing homes to AL facilities in rural areas that have had excessive nursing home capacity. Coverage for assisted living services was added to the Medicaid Aged and Disabled (AD) waiver program.

Nebraska also began to revamp its Medicaid program in 2005. The Medicaid reform plan recommends changes to be implemented over several years, including proposals to contain LTC institutional growth while expanding HCBS. “A comprehensive restructuring of the LTC system is essential,” the report said, “if the Medicaid program is to be fiscally sustainable in the future. The inherent bias in favor of institutionalization...needs to be replaced with a continuum of care that allows...persons with disabilities to receive safe and appropriate services in the least restrictive and most cost-effective environment.” (In 2006, Nebraska was authorized to increase the number of people the AD waiver served from 5,533 in FY 2007 to 8,248 by FY 2011.)

Nebraska LTC Initiatives

Nebraska has been converting nursing home beds to assisted living beds and has established a Long-Term Care Partnership Program.

Another recommendation encourages Nebraskans to make “appropriate health decisions” and contribute to the cost of their health and LTC needs, which has led to the development of a Long-Term Care Partnership Program linking purchase of LTC insurance with eligibility for Medicaid coverage of LTC services. The legislature authorized the Partnership program (LB 965) in 2006, and the state began to certify Partnership policies in September 2007.

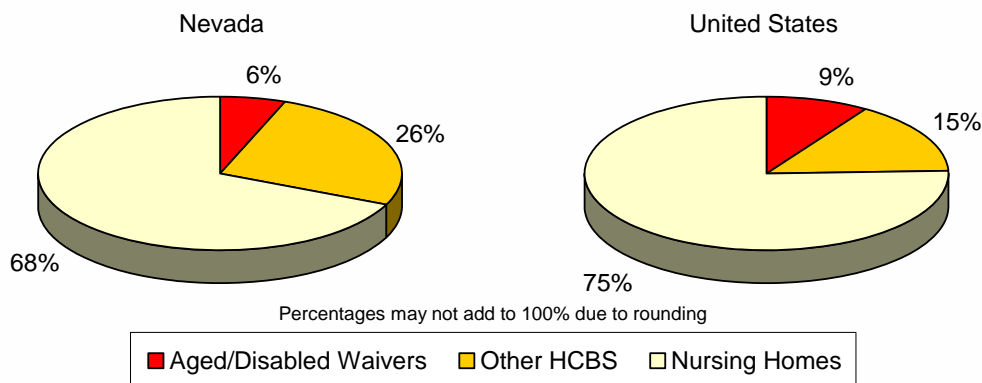
Other Developments

Long-Term Care Savings Plans. In 2006, Nebraska became the first state to create Long-Term Care Savings Plans when the legislature passed LB 965 authorizing such plans. Individuals can deduct up to \$1,000 per person per year from taxable income in calculating state income tax liability. Interest earned on such an account is not taxable. The money can be used to pay for the LTC needs of the account holder or spouses in an institution or at home. After age 50, the monies can be withdrawn tax free to pay for LTC insurance.

Own Your Future. Nebraska was one of the first states to sign on to the U.S. Administration on Aging “Own Your Future” campaign to stimulate consumer planning for future LTC needs. The campaign encourages Americans to assume greater personal responsibility for financing their own care. In each participating state, a letter from the governor has gone out to households with members between the ages of 45 and 70, explaining the campaign and encouraging consumers to request a Long-Term Care Planning Kit.

NEVADA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Nevada and the U.S., 2006



Compared to the U.S. average, Nevada allocates a greater percentage (32 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to home and community-based services (HCBS). In FY 2006, Nevada spent 6 percent on waiver services and 26 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	1,857	4,416	+2,559	\$15	\$69	+\$54
Nursing Homes	3,821	4,504	+683	\$92	\$150	+\$58

Recent Medicaid trends indicate that Nevada has made significant progress in increasing access to HCBS for Medicaid participants. In 1999, more participants received nursing home services than received HCBS, but by 2004, participants receiving HCBS nearly equaled participants in nursing homes. In fact, between 1999 and 2004, the number of participants receiving HCBS more than doubled. From FY 2001 to FY 2006, the increase in Medicaid spending on nursing homes was slightly greater than the increase in spending for HCBS. However, in general, a state can serve more people per dollar spent on HCBS than it can per dollar spent on nursing homes.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

The state also operates the Community Home-Based Initiatives Program (CHIP), which is funded by both Medicaid and state funds. In 2007, the number of Medicaid-funded participants totaled 1,251, and another 170 persons were supported through state general revenues.

Major Initiative

Since July 2003, Nevada's Department of Health and Human Services has been leading a 10-year planning process to develop a "Strategic Plan for Seniors." A Senior Services Strategic Plan Accountability Committee releases annual summaries of achievements and recommendations.

"Community Home-Based Initiatives" (CHIP)

The Community Home-Based Initiatives Medicaid waiver was expanded recently to eliminate 333 people who were on a waiting list for services.

Another effort underway since 2005 is an Inter-Agency Senior Issues Task Force in which 30 state agencies participate. At a "Senior Solutions" Policymakers Summit in June 2006, which 140 community leaders and government policy makers attended, the task force reported on a number of recommendations, including expanding the CHIP waiver program to eliminate waiting lists, providing family and volunteer caregivers with stipends for providing personal care services, and expanding respite and support groups. Funds appropriated in the state budget enacted in 2007 will increase caseloads for the CHIP program.

Other Developments

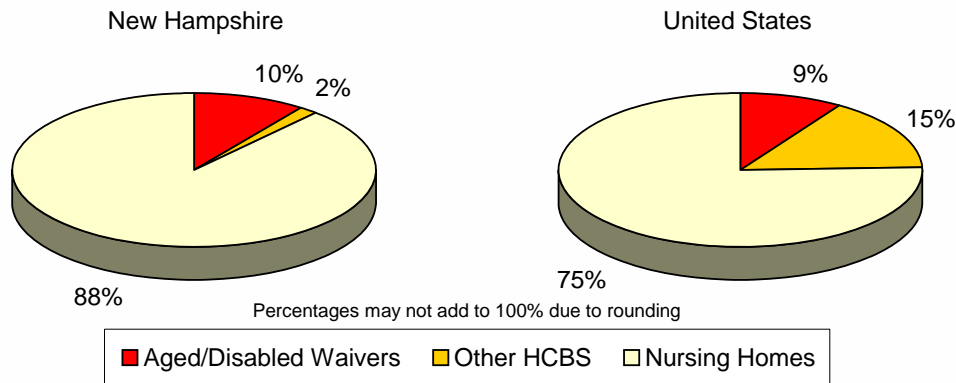
Money Follows the Person (MFP). Nevada was awarded a \$750,000 MFP federal grant in 2003, which it has used to help transition 160 persons from nursing homes to community settings. State officials also have used the MFP grant to create a global budget to ensure that programs, policies, and the financing structure for LTC do not hinder the transition efforts for individuals who desire to live in the community.

Aging and Disability Resource Center (ADRC). The state also received a \$250,000 ADRC grant in 2005. ADRCs provide citizen-centered, "one-stop" entry points into the LTC system for older people and individuals with disabilities. These centers provide information, referrals, and counseling on LTC services as well as eligibility screening.

Affordable Assisted Living. The Silver Sky Assisted Living facility opened in Las Vegas in August 2006. The facility is the first of its kind in the United States in that it uses tax credit financing, donated public land, and Medicaid service reimbursement to provide affordable assisted living to older persons with low incomes. The rent payments in 2008 range between \$359 and \$718 a month for one person and \$431 and \$862 for two persons. The monthly rent is based on income eligibility provisions that change annually. In 2008, the maximum income was \$26,820 for one person and \$30,660 for two persons. Residents are charged separately for rent and services they receive at the facility. Medicaid covers personal care services. State officials said Silver Sky would serve as a model for other such assisted living developments throughout the state.

NEW HAMPSHIRE

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in New Hampshire and the U.S., 2006



Compared to the U.S. average, New Hampshire allocates a much greater percentage (88 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, New Hampshire spent 10 percent on waiver services and 2 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	1,489	2,510	+1,021	\$21	\$38	+\$17
Nursing Homes	7,147	7,290	+143	\$210	\$291	+\$82

Although New Hampshire spent 88 percent of its Medicaid LTC dollars on home and community-based services (HCBS) for people with developmental disabilities in 2006, the state has an unbalanced LTC system for older people and adults with physical disabilities. Many more Medicaid participants received nursing home services in 2004 than received HCBS. While the number of participants in nursing homes remained relatively constant from 1999 to 2004, the number of participants receiving HCBS increased significantly because of a doubling of the number of aged/disabled waiver beneficiaries. From FY 2001 to FY 2006,

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

the increase in Medicaid spending on nursing homes was nearly five times the increase in spending on HCBS.

Major Initiative

New Hampshire is one of the first states in the nation to develop a statewide Aging and Disability Resource Center (ADRC), called a Service Link Resource Center (SLRC). With a federal ADRC grant, the state created the SLRC as the single point of entry for LTC services for older people and adults with chronic conditions or disabilities. SLRC teams—which are located in local offices

throughout the state—provide information, referrals, assessment, and eligibility counseling for HCBS and nursing home admissions. State-contracted nurses who perform clinical assessments and counseling and financial eligibility staff are located within the local offices to conduct face-to-face functional and financial assessments for nursing home services and HCBS.

“Service Link Resource Center”

New Hampshire is one of the first states in the nation to develop a statewide Aging and Disability Resource Center. The Service Link Resource Center is a single point of entry for LTC services for older people and adults with chronic conditions or disabilities.

SLRCs have reduced the amount of time between an individual’s application and the beginning of services. Also, consumers now have one place to contact for information and LTC services. A consumer satisfaction survey indicated that more than 90 percent of consumers said they would use SLRC again, and more than 94 percent said SLRC helped them make more informed decisions about their LTC needs.

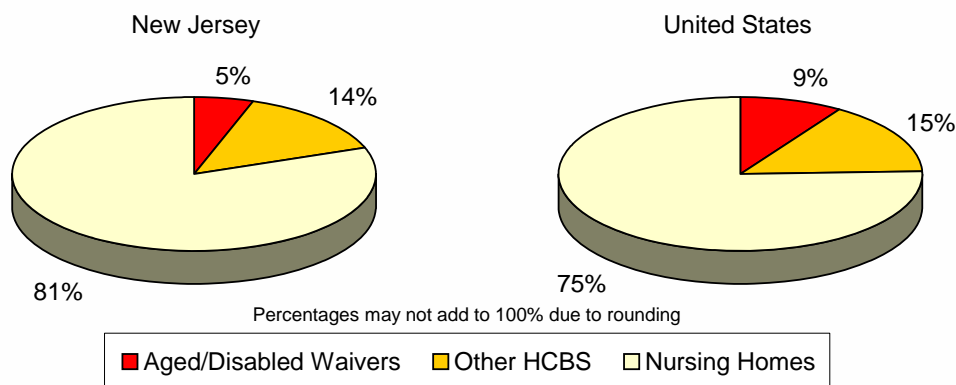
Other Developments

Systems Transformation. New Hampshire received \$2.1 million through a federal Systems Transformation grant in 2005, which was used to develop and pilot a Rapid Response Team, increase awareness of its SLRC single-point-of-entry system, and create new community-service models, such as adult family care, to increase the availability of flexible supports and services.

Money Follows the Person. The state also was awarded an \$11.4 million Money Follows the Person Demonstration grant in 2007 to transition 370 people from nursing homes to community settings. In their grant abstract, state officials said the initiative would take “lessons learned” from the state’s previous nursing facility transition grants and expand the model statewide.

NEW JERSEY

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in New Jersey and the U.S., 2006



Compared to the U.S. average, New Jersey allocates a greater percentage (81 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, New Jersey spent 5 percent on waiver services and 14 percent on other home and community-based services (HCBS) including personal care.

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS*	24,581	25,639	+1,058	\$269	\$428	+\$160
Nursing Homes	51,747	48,404	-3,343	\$1,646**	\$1,777	+\$131

Although New Jersey has yet to achieve an overall balanced LTC system for older people and adults with physical disabilities, recent Medicaid trends indicate that progress has occurred. Many more Medicaid participants received nursing home services than received HCBS in 2004. However, the number of people in nursing homes declined from 1999 to 2004, while the number of people receiving HCBS increased. From FY 2001 to FY 2006, Medicaid spending increased for both nursing homes and HCBS.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

* Adult day health is a Medicaid state plan service and is not included in HCBS expenditures.

** Expenditures for nursing homes were used from FY 2000—instead of FY 2001—because of state reporting irregularities.

Major Initiative

The impetus for LTC reform in New Jersey began with a single-point-of-entry system initiated in 1995, Easy Access Single Entry or NJEASE. In 1998, New Jersey became one of the first states with a permanent, statewide nursing facility transition program when it launched the Community Choice Initiative, which moved almost 5,000 persons from nursing homes to community settings from 1998 to 2004. In 2004 and 2005, gubernatorial executive orders helped move the state toward a global budgeting process, a financing mechanism that allows a state to consolidate LTC funding, whether for nursing homes or HCBS, in one budget. Within a set spending limit, state officials can allocate LTC funds to the most appropriate services to meet demand.

In June 2006, the New Jersey legislature enacted The Independence, Dignity and Choice in Long-Term Care Act (Assembly Bill 2823), authorizing the global budgeting process. The FY 2006 budget allocated \$30 million for this purpose. Since that time, the state budget has included a line item dedicated to global budgeting. The legislation also directed the Department of Health and Senior Services to begin pilot projects in two counties that would include a “fast-track” eligibility determination by which a person deemed eligible for Medicaid-funded services receives services for up to 90 days while the formal paperwork is completed.² As a result of this process, consumers in the pilot counties now are clinically assessed, financially screened, and approved within five to seven days. The pilot projects are also testing a revised clinical assessment instrument and a computerized tracking system for Medicaid LTC expenditures. The latter is being piloted in seven counties in 2007.

Assembly Bill 2823 mandated statewide expansion by March 2008 of the reforms, if the pilots are determined to be cost effective. The state was also planning to redesign and expand its Aging and Disability Resource Connection initiative with a \$400,000 grant in November 2006, which would build on a 2003 grant to launch the initiative.

“Independence, Dignity and Choice in Long-Term Care Act”

This act created a global budgeting process—a financing mechanism that consolidates nursing home and HCBS funding into one budget line item—and authorized two pilot programs to expedite Medicaid eligibility determination.

Other Developments

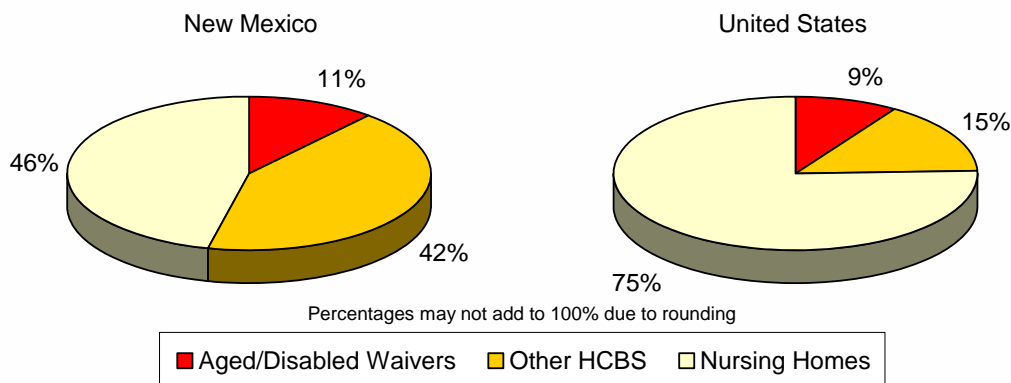
Systems Transformation. The Department of Health and Senior Services received a \$2.3 million federal Systems Transformation grant in 2006 to develop a “consumer-driven human services delivery system with a ‘no wrong door’ pathway to services, a Money Follows the Person funding structure,” and an information technology infrastructure.

Money Follow for Person. In 2007, the state was awarded a five-year, \$30.3 million Money Follows the Person Demonstration grant. Goals of the grant include piloting a support coordination model for consumer direction, expanding transition services to aid in finding housing and services, and improving access to services for individuals from all cultural and disability groups.

² This “presumptive eligibility” helps prevent a person from being forced to enter a nursing home because the usual process may take months during which home care agencies cannot assume the financial risk that many nursing homes can accept.

NEW MEXICO

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in New Mexico and the U.S., 2006



New Mexico is one of the few states that allocates the majority (53 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to home and community-based services (HCBS). In FY 2006, New Mexico spent 11 percent on waiver services and 42 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	1,404	12,118	+10,714	\$87	\$227	+\$140
Nursing Homes	7,074	6,895	-179	\$166	\$196	+\$30

New Mexico has one of the most balanced LTC systems for older people and adults with physical disabilities in the nation, and recent Medicaid trends indicate that the state is continuing to make even more progress toward balancing. Many more Medicaid participants received HCBS than received nursing home services. In fact, the number of participants receiving HCBS increased significantly from 1999 to 2004, while the number of participants in nursing homes declined slightly. From FY 2001 to FY 2006, the increase in Medicaid spending on HCBS was nearly five times the increase in spending on nursing homes.

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A major factor in the state's progress toward balancing its LTC system is the Medicaid State Plan Personal Care Option, which targets consumers at risk of nursing home care. Implemented in 1999, this program provided PCS to more than 10,400 people in 2006.

Major Initiative

Mia Via, a new waiver program offering self-directed services, began in November 2006 with a Cash and Counseling planning and development grant from the Robert Wood Johnson Foundation. The program allows participants to choose the services they need, hire their own workers, and decide where and how to spend their Mia Via budget. A consultant is available to provide assistance if needed.

Mia Via

Mia Via is a Cash and Counseling program to empower older adults and people with disabilities to direct their own care. Mia Via will provide services to 400 participants.

By February 2008, the program had received applications from 283 persons age 65 and older; 95 of them had completed the process and were receiving self-directed services.

Other Developments

Managed Long-Term Care. New Mexico has proposed creating a new capitated managed LTC program, called "Coordinated Long-Term Services" (CLTS), that will provide primary, acute, and LTC services to consumers in one coordinated and integrated program. An estimated 38,000 people will be enrolled in CLTS. The program will be phased in by geographic region starting in July 2008, beginning with Bernalillo County, the state's most populous county. Eligible populations include:

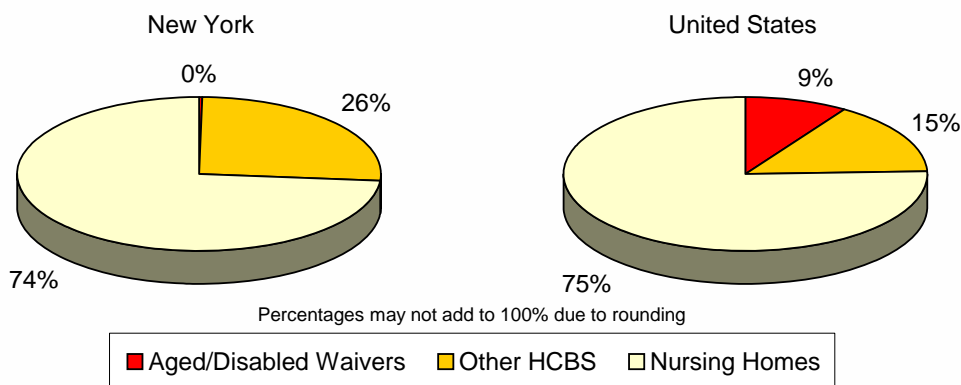
- dual-eligibles (persons eligible for both Medicare and Medicaid) who do not need nursing facility level of care;
- nursing home residents;
- participants in the state's disabled and elderly waiver program;
- participants in the state's Personal Care option under the Medicaid state plan; and
- certain persons with a brain injury not currently enrolled in a waiver program.

The state proposes to develop a "single blended rate" approach to capitation, with annual targets for decreases in use of nursing facility services. New Mexico intends to contract with at least two managed care organizations to deliver services. State officials say the program is needed because existing fragmentation of services leads to duplication, over- and underutilization of services, and inappropriate emergency room visits and in-patient hospitalizations.

Single Point of Entry. Access to services has been improved through creation of a statewide Aging and Disability Resource Center, which began full operation on January 1, 2005. This one-stop resource for older persons and people with disabilities integrates several Aging and Long-Term Services Department programs—its benefits and counseling program, prescription drugs, in-home and community-based care, housing, and caregiver support.

NEW YORK

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in New York and the U.S., 2006



Similar to the U.S. average, New York allocates a greater percentage (74 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, New York spent less than 1 percent on waiver services and 26 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	109,309	107,705	-1,604	\$1,897	\$2,496	+\$599
Nursing Homes	139,509*	200,446	+60,937	\$6,392	\$6,951	+\$559

From 1999 to 2004, the number of participants receiving home and community-based services (HCBS) decreased slightly, while the number of participants receiving nursing home services increased. From FY 2001 to FY 2006, Medicaid spending on both HCBS and nursing homes increased. FY 2006 expenditures for HCBS are most likely underreported and are likely to increase as the state submits more prior period adjustments.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

* The number of nursing home participants reported in 1999 was unusually low. It is likely that this is a reporting abnormality. From 2000 through 2004, the number of participants was approximately 200,000 per year.

Medicaid is not the only source of funding for LTC in New York. The Expanded In-Home Services for the Elderly Program served almost 43,000 older persons, with expenditures of \$52.5 million in FY 2007. Services include case management and personal care and homemaker services. Program participants may be required to pay a share of costs on a sliding-fee scale, depending on their income.

Major Initiative

New York has been working on an LTC restructuring initiative for several years. In 2003, then-Governor George Pataki called for comprehensive efforts to reform the state's LTC institutional system. He also convened a Health Care Reform Working Group to review the state's health care system, especially its hospitals and nursing homes.

Long-Term Care Restructuring Advisory Council

New York has been working to restructure its institutional LTC system, especially with hospitals and nursing homes. A Health Care Reform Working Group recommended closing 3,000 nursing home beds while creating more HCBS alternatives. The state allocated \$1 billion, plus \$1.5 billion from federal grants, to fund this restructuring and these nursing home closing costs.

Among its many recommendations, the Working Group proposed a reduction of 3,000 nursing homes beds, almost 3 percent of the state's supply, while creating home and community-based alternatives. The state allocated \$1 billion, combined with \$1.5 billion from the federal government, to fund system restructuring and facility closing costs.

New York's LTC restructuring initiatives include creating a Long-Term Care Restructuring Advisory Council in May 2006 to assist the Department of Health in balancing the scope and delivery of LTC services. In 2006, the department conducted sessions throughout the state to elicit citizen input about the LTC system and needed changes.

Another major project is NY Connects, a local link for consumers to LTC services and resources in every county in the state. Local offices for the aging and departments of social services are collaborating to develop the program.

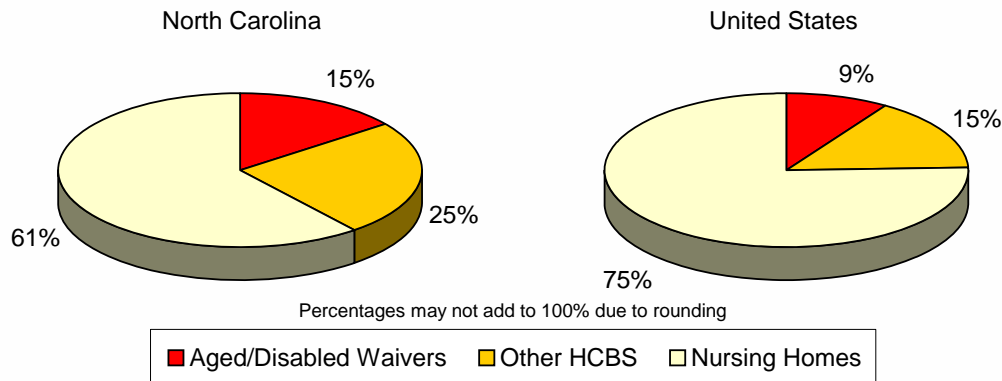
Other Developments

Diversion Program. In 2006, the state received federal approval of a Medicaid Nursing Facility Transition and Diversion program, with a goal of 1,000 community placements in the first year. The Department of Health contracts with nonprofit Regional Resource Development Centers to administer non-financial waiver eligibility determinations, conduct needs assessment, and approve service plans.

Money Follows the Person. In 2007, the state was awarded a \$27 million, five-year federal Money Follows the Person Demonstration grant to move 2,800 persons from nursing homes to community settings. State officials also planned to use the grant to establish a housing task force to address housing barriers to community integration, and to coordinate efforts with the NY Connects program to avoid unnecessary hospital discharges to nursing homes.

NORTH CAROLINA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in North Carolina and the U.S., 2006



Compared to the U.S. average, North Carolina allocates a much greater percentage (40 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to home and community-based services (HCBS). In FY 2006, North Carolina spent 15 percent on waiver services and 25 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	20,244	53,425	+33,181	\$423	\$717	+\$294
Nursing Homes	42,382	43,182	+800	\$876	\$1,108	+\$231

Recent Medicaid trends indicate that North Carolina has made significant progress in increasing the number of Medicaid HCBS participants and expenditures while holding the number of Medicaid participants in nursing homes fairly constant. More Medicaid participants received HCBS than received nursing home services in 2004. In fact, the number of participants receiving HCBS more than doubled from 1999 to 2004, while the number of participants in nursing homes increased only slightly. From FY 2001 to FY 2006, Medicaid spending on HCBS increased by \$294 million, compared to a \$231 million increase for nursing homes.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Major Initiative

In July 2006, the North Carolina General Assembly created the first-in-the-nation voluntary state licensure program for LTC providers who help develop high-quality direct-care workers through training and other incentive programs. Senate Bill 1277

established the North Carolina New Organizational Vision Award (NC NOVA) for home care agencies, assisted living facilities, and nursing homes.

“Voluntary State Licensure Program”

The voluntary state licensure program rewards LTC providers for developing the skill sets of direct care workers.

The Better Jobs/Better Care North Carolina project, in conjunction with the state’s Division of Health Service Regulation, developed the licensure program, which set standards in four areas: supportive workplace, training, career development, and balanced workload. As of June 2008, two home care agencies and three nursing homes have received the special licensure.

A federal Real Choice Systems Change grant for \$1.6 million has helped the state to address direct-care workforce issues. North Carolina has used the funds to help launch a public education campaign to help consumers understand the vital role direct-care workers play in LTC, and to establish a training institute for workers. The funds also helped with the establishment of a Direct-Care Workers Association.

Other Developments

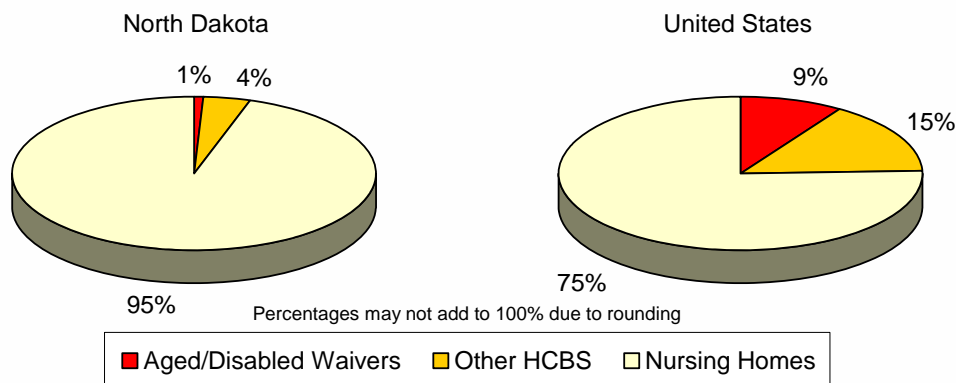
Coordination of Services. The state Department of Health and Human Services has a Communications and Coordination Initiative in local communities to develop and coordinate core LTC services and streamline access to such services for older persons and people with disabilities. Two pilot communities were selected to assess and evaluate their LTC systems and services with regard to how they enhance the quality of life of older adults, and then to identify and initiate strategies to strengthen those systems. Those communities developed and published their plans. The state agency also developed 22 tools to assist other North Carolina communities in developing this model.

Systems Transformation. The state received a \$2.3 million federal grant in 2006, which state officials said would help North Carolina to achieve “streamlined, integrated, and easy access” to LTC services and supports, to expand consumer self-direction and self-determination, to expand Aging and Disability Resource Centers, and to fully implement the state’s new information and assistance Web portal, NC Care Link.

Money Follows the Person. In 2007, the state was awarded a five-year, \$17 million Money Follows the Person Demonstration grant. Goals for the project include expanding the home and community-based waiver, developing optional state services, and creating regional case management teams.

NORTH DAKOTA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in North Dakota and the U.S., 2006



Compared to the U.S. average, North Dakota allocates a much greater percentage (95 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, North Dakota spent 1 percent on waiver services and 4 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	347	979	+632	\$4	\$9	+\$4
Nursing Homes	5,570	5,599	+29	\$151	\$168	+\$16

Although North Dakota has one of the country’s least balanced Medicaid LTC systems for older people and adults with physical disabilities, the state has made some progress in increasing the number of Medicaid home and community-based services (HCBS) participants in recent years. However, many more Medicaid participants received nursing home services than received HCBS. From FY 2001 to FY 2006, the increase in Medicaid spending on nursing homes was four times the increase in spending on HCBS. Medicaid, however, is not the only source of funding for LTC in the state. State-funded programs also provide HCBS to older people and people with physical disabilities (described on the next page).

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants’ type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Major Initiative

In 1983, the North Dakota legislature authorized the state-funded Service Payments for the Elderly and Disabled (SPED) program, which provides services to older persons and persons with physical disabilities. To be eligible, persons must be impaired in four activities of daily living, such as dressing and eating, or five other types of activities (such as laundry or housework). One of the covered services includes reimbursement for a family caregiver who lives with the beneficiary. Approximately 1,300 persons age 60 and older participated in SPED in 2007. In FY 2007, SPED expenditures totaled \$5.6 million.

In 1994, the legislature authorized an Expanded SPED program that pays for in-home services for people with disabilities who would otherwise be eligible for services in Basic Care Facilities, which are facilities licensed by the Department of Health to provide 24-hour supervision. Eligibility requires being impaired in three of four specific daily activities (meal preparation, housework, laundry, or taking medications) or having health, welfare, or safety needs that require supervision or a structured environment. In 2007, 78 people age 60 and older were enrolled in the program, whose expenditures totaled \$238,000.

“SPED” and “ExSPED”

These state-funded programs provide services—including payment to a family caregiver—to older people and people with disabilities. State expenditures for these programs totaled \$5.8 million in FY 2007 and served 1,300 people.

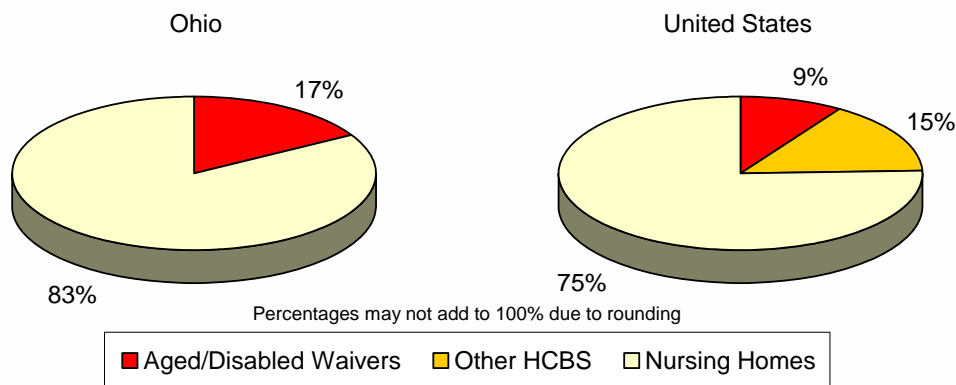
Other Developments

Money Follows the Person. In May 2007, North Dakota was awarded an \$8.9 million, five-year federal Money Follows the Person Demonstration grant to help 110 persons move from nursing homes to community settings. In its application, the state described caregiver support in sparsely populated rural areas as “fragile” and emphasized the need to address transportation and socialization needs in those areas.

Nursing Home Moratorium. North Dakota had a moratorium on expansion of nursing facility beds that expired in July 2007. The legislature extended the moratorium, however, until July 31, 2009.

OHIO

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Ohio and the U.S., 2006



Compared to the U.S. average, Ohio allocates a greater percentage (83 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Ohio spent 17 percent on waiver services.

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	26,135	34,576	+8,441	\$281	\$532	+\$251
Nursing Homes	92,133	98,232	+6,099	\$2,313	\$2,656	+\$342

Although Ohio has yet to achieve a balanced LTC system for older people and adults with physical disabilities, the state has made progress in increasing the number of Medicaid home and community-based services (HCBS) participants in recent years. More Medicaid participants received nursing home services than received HCBS in 2004, but the number of participants receiving HCBS increased 24 percent from 1999 to 2004, while the number of participants in nursing homes increased by only 6 percent. From FY 2001 to FY 2006, Medicaid spending on HCBS increased by \$251 million, compared to a \$342 million increase in spending for nursing homes.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Major Initiative

Ohio's PASSPORT program, a Medicaid HCBS Waiver program for persons age 60 and older, is one of the largest waiver programs in the United States, with about 33,000 participants. The program provides adult day services, care management, homemaker and chore services, home health, personal care services, respite, and hospice care.

In March 2007, Governor Ted Strickland issued a directive requiring the Department of Aging to expand access to PASSPORT services to include 1,100 individuals on a waiting list for the program. In addition, the 2007–08 budget bill (House Bill 119) approved by the legislature added 5,600 more slots to the program. The budget bill also authorized the development of a unified LTC budget that consolidates policy-making authority and budgets in a single entity, assures a cost-effective system, and provides consumers with choice and a continuum of services. The Implementation Committee, headed by the director of the Department of Aging and composed of state legislators, advocates, providers, and consumers, is expected to report its recommendations to the legislature in June 2008.

“PASSPORT and Global Budget”

Ohio's PASSPORT program was expanded by 5,600 slots to reduce the waiting list for Medicaid services. Legislation was enacted that authorizes the state to create a global budget while ensuring consumer choice in how and where they receive services.

Other Developments

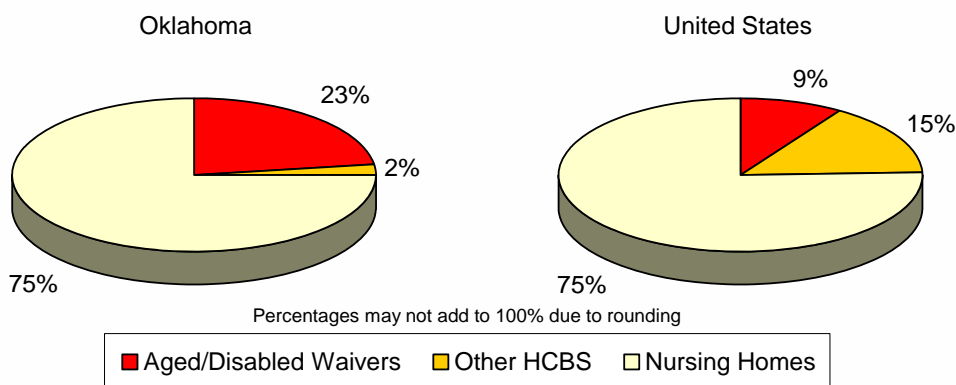
Workforce. In July 2007, Gov. Strickland issued an executive order that established collective bargaining rights for independent home health care workers, including nurses and direct-care professionals. The action gave about 7,000 workers in Ohio the opportunity to select a bargaining representative.

Assisted Living. The Ohio legislature authorized the Department of Aging to develop an Assisted Living Medicaid Waiver pilot program in 2006 to serve 1,800 persons. Provider participation was slow initially because the rate of reimbursement was lower than the average rate in licensed Residential Care Facilities. Although there are 279 assisted living facilities in the state that meet waiver requirements, only 70 facilities participated in the program as of October 31, 2007. At that time, 300 clients were enrolled, and there were slightly more than 400 persons on a waiting list. The Assisted Living option was made a permanent option of the HCBS program in Ohio in House Bill 119, which passed in June 2007. An outside consultant will conduct a rate study.

Money Follows the Person (MFP). Ohio was awarded \$2 million for FY 2007, as well as a five-year commitment of \$101 million, to implement the MFP program statewide and expand HCBS. MFP resources will be used to examine the preadmission process for institutional care. In addition, state officials plan to enhance the process of transition from institutions to the community by providing supplemental demonstration services, such as independent living skills, peer support, and benefit coordination. Approximately 2,231 individuals will transition into the community during this demonstration period.

OKLAHOMA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Oklahoma and the U.S., 2006



Similar to the U.S. average, Oklahoma allocates a greater percentage (75 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Oklahoma spent 23 percent on waiver services and 2 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	15,201	21,154	+5,953	\$75	\$152	+\$76
Nursing Homes	25,758	22,917	-2,841	\$426	\$455	+\$29

Although Oklahoma has yet to achieve a balanced LTC system for older people and adults with disabilities, the state has made significant progress in increasing the number of Medicaid home and community-based services (HCBS) participants and expenditures and decreasing the number of participants in nursing homes in recent years. In 1999, many more participants received nursing home services than received HCBS, but during the next five years, the number of Medicaid HCBS participants increased by 28 percent, while the number of participants in nursing homes decreased by more than 10 percent. From FY 2001 to FY

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

2006, the increase in Medicaid spending on HCBS was about 2.5 times the increase in spending on nursing homes.

Major Initiative

The Medicaid Reform Act of 2006 (House Bill 2842), signed into law on June 9, 2006, is primarily a new form of health insurance for Medicaid beneficiaries that allows the participants to own a “personal health account” to pay for medical expenses.

“The Medicaid Reform Act of 2006”

This Act requires the state to create community-based LTC options and provides incentives for LTC planning.

However, HB 2842 also provides authority for the Oklahoma Health Care Authority (OHCA) to develop LTC alternatives such as community-based options and a model of consumer-directed care. The legislation also provides incentives for LTC planning, such as purchasing private LTC insurance and creating a Long-Term Care Insurance Partnership program. (Senate Bill 1547, approved by the Oklahoma legislature in 2007, authorized the Partnership program.)

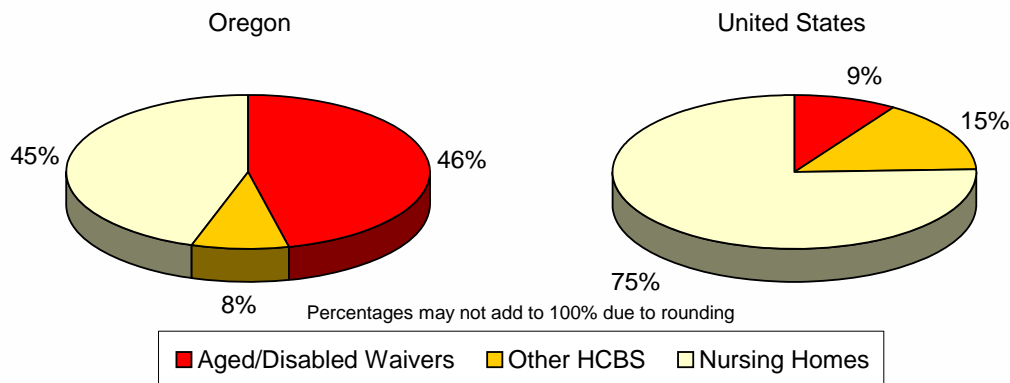
Other Developments

LTC Administration. The Oklahoma Health Care Authority created a new office in 2005, called Opportunities for Living Life (OLL), charged with developing, operating, and administering new initiatives that now include a Money Follows the Person grant and an LTC Insurance Partnership program with the Oklahoma Insurance Department.

Money Follows the Person. Oklahoma was awarded a \$41.8 million Money Follows the Person Demonstration grant in 2007, called the Oklahoma Long-Term Living Choice Project. The state plans to transition 2,100 persons from nursing homes to community settings, to identify barriers to community living, and to improve community-integrated services.

OREGON

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Oregon and the U.S., 2006



Oregon allocates the majority (54 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to home and community-based services (HCBS). In FY 2006, Oregon spent 46 percent on waiver services and 8 percent on other HCBS, including personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	27,675	31,628	+3,953	\$255	\$341	+\$86
Nursing Homes	12,031	10,610	-1,421	\$240*	\$280	+\$40

Oregon has the nation’s most balanced LTC system for older people and adults with physical disabilities, and recent trends indicate that the state is continuing to make even more progress toward balancing. About three times as many Medicaid participants receive HCBS than receive nursing home services. The number of participants receiving HCBS increased from 1999 to 2004, while the number of participants in nursing homes decreased by nearly 12 percent. From FY 2001 to FY 2006, the increase in Medicaid spending on HCBS was more than twice the increase in spending for nursing homes. Oregon is one of the few states that spend more on HCBS than on nursing homes.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants’ type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

* Expenditures for nursing homes were used from FY 2000—instead of FY 2001—because of state reporting irregularities.

Major Initiative

Since 1981, Oregon has led the nation in maintaining a lower institutionalization rate for older persons and adults with physical disabilities and has consistently provided a higher proportion of these populations with HCBS than

has any other state. This HCBS system is grounded in Oregon Revised Statutes 410, also enacted in 1981, which creates a system predicated on “honor, dignity...entitled to live lives of maximum freedom and independence.” It also builds on Oregon’s creation of Oregon Project Independence, funded exclusively with General Fund dollars, in 1977. However, since 1989, Oregon has experienced a net reduction in the proportion of General Revenue (and thus match to available federal Medicaid dollars) of 38 percent. This failure to reinvest from HCBS savings was exacerbated further when the state was forced to curtail services and restrict eligibility during a budget crisis in 2001 and 2004, when services were eliminated for almost 5,000 older persons and people with physical disabilities who did not meet the more limited eligibility criteria.

“Long-Term Care Workgroup”

The Long-Term Care Workgroup, created to address the future of Oregon’s LTC system, recommended a Livable Community Initiative to better integrate individuals in the community, provide local communities with a toolkit to plan better for the aging demographic, and develop a new investment strategy regarding prevention and Medicaid funding.

In February 2008, Governor Ted Kulongoski signed into law Senate Bill 1061, directing the Department of Human Services to oversee a long-range planning process. This follows previous Long-Term Task Force work conducted under governors John Kitzhaber and Kulongoski. Some preliminary ideas resulting from that previous work include:

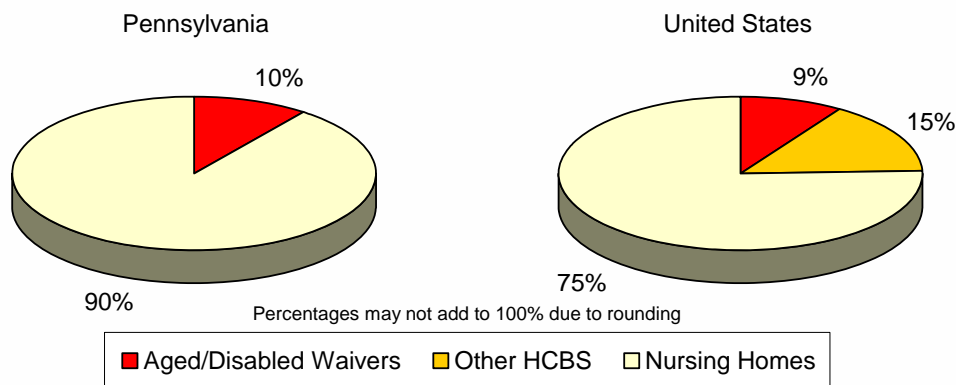
- DHS should consider integrating work by the Oregon Health Fund Board and its charge, especially regarding chronic care management and primary/medical care home models and LTC.
- DHS should implement a “Livable Community Initiative,” which would involve piloting integrated service planning for older persons and people with disabilities in one urban and one rural community.
- The governor, legislature, and DHS should develop and implement a “new model” investment strategy, including navigation and educational supports from establishment of an Adult & Disabilities Resource Network; preventive strategies to keep people from needing more expensive care; and a tiered approach to Medicaid-funded acute and LTC.

Other Developments

Money Follows the Person. Oregon was awarded one of the largest Money Follows the Person grants in May 2007—\$114.7 million over five years. In their proposal, state officials said they would use the grant to demonstrate that “long-term institutionalized populations of people with complex medical and LTC needs can be served in their communities with wrap-around packages of supports and services.” The 780 people whom the state will assist to move to the community account for 16.5 percent of Oregon’s institutionalized Medicaid population. Of the total, 300 are older people with end-stage dementia.

PENNSYLVANIA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Pennsylvania and the U.S., 2006



Compared to the U.S. average, Pennsylvania allocates a greater percentage (90 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Pennsylvania spent 10 percent on waiver services.

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	4,411	18,912	+14,501	\$100	\$440	+\$340
Nursing Homes	72,481	79,272	+6,791	\$3,684	\$3,862	+\$178

Although Pennsylvania has yet to achieve a balanced LTC system for older people and adults with physical disabilities, the state has made some progress in expanding access to home and community-based services (HCBS) in recent years. From 1999 to 2004, the number of participants receiving HCBS increased far more than did the number in nursing homes. However, many more Medicaid participants still received nursing home services than received HCBS. From FY 2001 to FY 2006, the increase in Medicaid spending on HCBS was nearly double the increase in spending on nursing homes, indicating a positive trend in reallocating spending.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Pennsylvania also has a large state-funded program. The OPTIONS program, funded by the state lottery, served 51,288 older people and adults with physical disabilities in 2006–07, with another 4,000 persons on a waiting list. The state expects the Aging 60+ Medicaid waiver program to serve about 23,000 people in 2007–08. As part of its Commonwealth Long-Term Living Project, the state has set a goal of 50 percent home-based care to 50 percent institutional care for all LTC populations by FY 2011–12.

Major Initiative

The Departments of Public Welfare and Aging created the Office of Long Term Living to consolidate all LTC programs and services for older persons and people with physical disabilities under a single management umbrella. This new organizational structure oversees all Medicaid institutional and HCBS for these populations. A deputy secretary for Long Term Living was hired in early 2007.

“Systems Change”
Pennsylvania has made progress in changing its LTC system by creating a single agency—the Office of Long Term Living—to consolidate and administer LTC programs and policies.

Other Developments

Recent LTC Initiatives. A December 2006 Medstat report found that Pennsylvania’s progress in balancing its system of LTC services for older people has come through initiatives, such as 1) a common budget in the Department of Public Welfare for nursing facilities and HCBS for older adults (the combined budget is a single line item in both the governor’s budget and the legislature’s appropriations bill); 2) a single-point-of-entry system through county-based Area Agencies on Aging (the state also has two pilot Aging and Disability Resource Centers); and 3) an expedited eligibility determination pilot program in 10 counties, called “Community Choice,” which helps applicants to receive services within 72 hours of initial application.

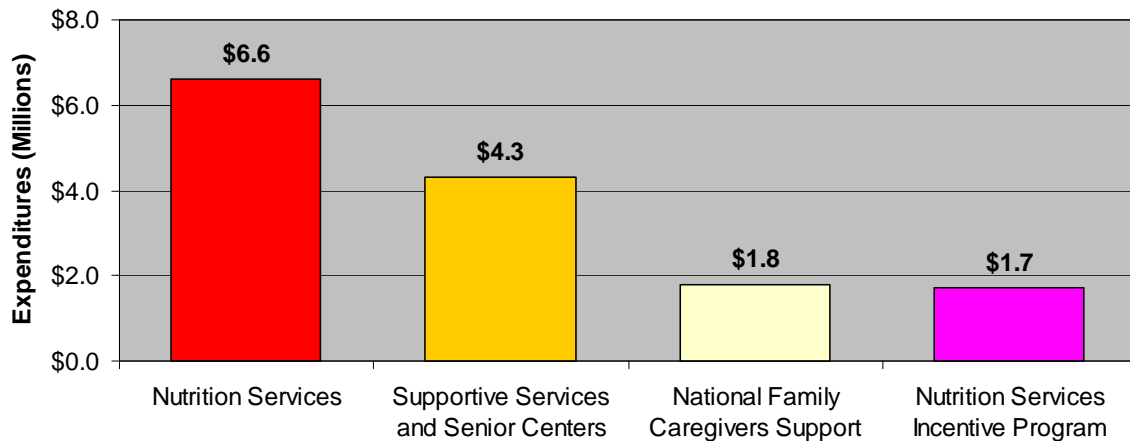
Assisted Living. In July 2007, the Pennsylvania legislature enacted Senate Bill 704 establishing licensing standards for assisted living residencies. The legislation stipulates that residents can sign informed consent agreements that acknowledge their own risk if they wish to remain in the facility, even if their condition over time warrants more assistance than the facility had offered when the resident moved in. The facilities are to make “reasonable accommodation” for aging in place. New regulations are being drafted that could have a significant impact on how the informed consent and aging-in-place provisions are interpreted.

Nursing Home Transition. In 2000, Pennsylvania received one of the original nursing home transition grants from the U.S. Centers for Medicare & Medicaid Services. The one-year, \$500,000 grant evolved into a three-year demonstration in four of the state’s 67 counties. The program was expanded statewide in 2005, and transition services were added to six HCBS waiver programs. Further expansion took place in 2006. From January 2005 to June 2006, 474 transitions took place in 54 counties.

PUERTO RICO

In 2005, Puerto Rico’s population age 65 and older totaled 489,819, accounting for 12.5 percent of the total population. Poverty is a major problem for older Puerto Ricans; more than 44 percent of persons age 65 and older live at or below the federal poverty level.

Puerto Rico Spending on Home and Community-Based Services, in Millions, 2006



Puerto Rico spent more than \$15 million on non-Medicaid home and community-based services in 2006, which included \$6.6 million for nutrition services; \$4.3 million for supportive services and senior centers; \$1.8 million for National Family Caregivers support; and \$1.7 million for a Nutrition Services Incentive Program.

Major Initiatives

Puerto Rico’s unit on aging is the Governor’s Office of Elderly Affairs. Major initiatives in Puerto Rico include a federal grant for support and services for people with Alzheimer’s disease, caregiver support, and managed care for people who are both Medicare- and Medicaid-eligible.

Alzheimer’s Grant. The Office of Elderly Affairs received a three-year federal demonstration grant in 2003 for Home and Community-Based Support Services for Hispanic Cultured Persons with Alzheimer’s Disease and Their Caregivers. The grant provides \$300,000 each year for respite, home health care, companionship, homemaker services, and case management. The grant has two primary goals: to develop and provide a comprehensive home-based support model for this population, and to improve the

receptiveness of senior centers and the long-term care service network in Puerto Rico to persons with Alzheimer's disease and related disorders.

Caregiver Support. Efforts to provide caregiver support in Puerto Rico have included pooling funds with Area Agencies on Aging to develop promotional materials and brochures for island-wide use, and developing a video, *Testimonials by Caregivers*, to disseminate to area agencies and nonprofit organizations. The program also targets program assistance to the island's rural and functionally illiterate population.

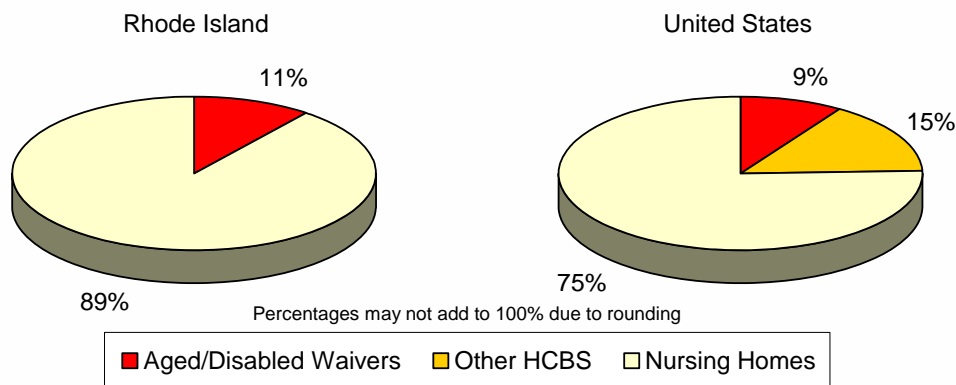
Managed Long-Term Care. Puerto Rico has a Special Needs Plan (SNP) for Medicaid services for persons eligible for both Medicare and Medicaid ("dual-eligibles"), with an enrollment of approximately 147,000 dually eligible persons in 2007. A Special Needs Plan allows a state or territory to integrate care and benefits for certain populations.

"Puerto Rico Initiatives"

Major initiatives in Puerto Rico include a federal grant for support and services for people with Alzheimer's disease, caregiver support, and managed care for people who are both Medicare- and Medicaid-eligible.

RHODE ISLAND

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Rhode Island and the U.S., 2006



Compared to the U.S. average, Rhode Island allocates a greater percentage (89 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Rhode Island spent 11 percent on waiver services.

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	2,362	2,705	+343	\$27	\$35	+\$8
Nursing Homes	13,297	11,754	-1,543	\$244	\$298	+\$54

Recent Medicaid trends indicate that Rhode Island still has an unbalanced LTC system for older people and adults with physical disabilities. In 2004, the number of Medicaid participants in nursing homes was more than four times the number of participants receiving home and community-based services (HCBS). However, the number of Medicaid participants in nursing homes decreased, while the number of participants receiving HCBS increased slightly from 1999 to 2004. From FY 2001 to FY 2006, the increase in Medicaid spending on nursing homes was nearly seven times the increase in spending on HCBS.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Major Initiative

Major issues of resident safety in Rhode Island's assisted living facilities and nursing homes were the focus of legislative and executive action in 2004 and 2005, leading to passage of the Long-Term Care Reform Act of 2005. The legislation, enacted after the disclosure of poor care and financial problems at an insolvent nursing home, gives the state stronger authority to protect patient safety and to assure facilities are financially solvent.

“Long-Term Care Reform Act”

As a result of safety concerns for residents in nursing and assisted living facilities, the state legislature and the governor's office created the Long-Term Care Reform Act to address issues with poorly performing nursing homes as well as methods for ensuring the safety and quality of care of residents.

The death of an assisted living resident in 2005, allegedly at the hands of another resident, led to a study of the industry in Rhode Island, the appointment of an interagency Assisted Living Task Force, and steps to improve state oversight of the facilities. Health and Human Services announced plans to adopt 23 recommendations resulting from a four-month study, including requiring licensed assisted living facilities to use a standardized comprehensive screening instrument before admission, improving consumer information, and providing service coordination at six-month intervals.

Other Developments

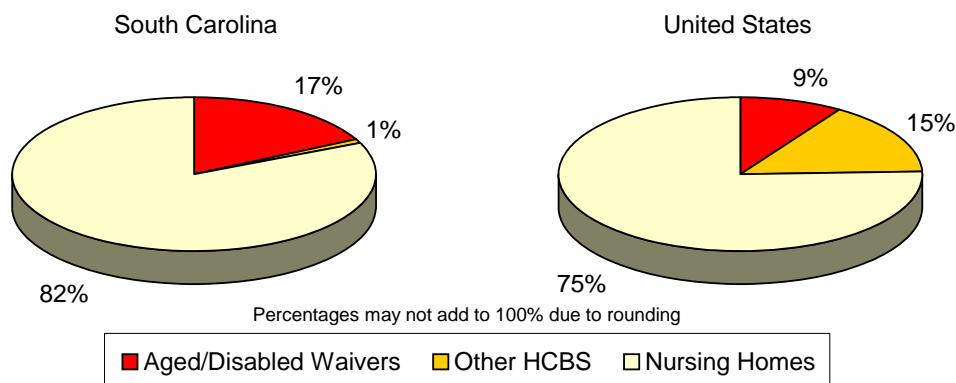
Long-Term Care Administration. By executive order, Governor Donald Carcieri established the Executive Office of Health and Human Services in 2004 to facilitate coordination and collaboration among five state departments administering health and social services, including the Department of Elderly Affairs. Statute subsequently established the office as part of the FY 2007 state budget.

Systems Reform. The Long-Term Care Service and Finance Reform Act (House Bill 7686), signed by the governor on July 3, 2006, directs the Department of Human Services (DHS) to develop a new model for provision and delivery of LTC that supports consumer choice and independence. The legislation specifically directs the state to fund care “in the least restrictive setting” appropriate to individual needs and preferences, and provides for “global budgeting” by requiring DHS to use the savings from reducing nursing home days to strengthen community-based alternatives.

Aging and Disability Resource Centers. The state received a \$749,000 grant in 2003 to implement the Elder and Adult Disabled Resource Center. With these funds, state officials are creating up to three satellite mini-centers to provide consumers with information and assistance regarding LTC options. An Executive Order by the governor created a Long-Term Care Cabinet to ensure that services in the LTC system were provided in an efficient, cost-effective, and consumer-centered manner.

SOUTH CAROLINA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in South Carolina and the U.S., 2006



Compared to the U.S. average, South Carolina allocates a greater percentage (82 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, South Carolina spent 17 percent on waiver services and 1 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	14,393	13,643	-750	\$94	\$104	+\$10
Nursing Homes	17,458	17,618	+160	\$374	\$463	+\$89

Recent Medicaid trends indicate that South Carolina still has an unbalanced LTC system for older people and adults with physical disabilities. The number of Medicaid participants receiving home and community-based services (HCBS) decreased, while the number receiving nursing home services remained relatively constant from 1999 to 2004. From FY 2001 to FY 2006, the increase in Medicaid spending on nursing homes was nearly nine times the increase in spending on HCBS (specifically, HCBS spending decreased slightly from FY 2001 to FY 2004, then increased from FY 2004 to FY 2006).

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Major Initiative

South Carolina has provided HCBS to older persons under the Community Long Term Care (CLTC) program since 1983. CLTC administers and operates four Medicaid waiver programs, one of which is the Community Choices waiver for older persons and persons with disabilities. The program had 15,740 participants in SFY 2006.

Another 2,800 persons were on the waiting list, however, and the legislature added 500 new slots, effective July 2006. These were the first additions to the CLTC program in more than seven years. An additional 500 CLTC slots were added in 2007. In recent years, the state has added three additional services to Community Choices: adult foster care, transition nursing services, and adaptive devices.

“Community Choices”

Community Choices provides HCBS to older persons under a Medicaid waiver. The waiver program also provides adult foster care, transition nursing services, and adaptive devices.

South Carolina has used federal Systems Change grants since 2001 to develop several major LTC initiatives: a Web-based service directory (SC Access), expansion of consumer direction, and creation of centralized, one-stop entry points into the state’s LTC support system (SC Access Plus). Another grant activity, state officials said, would be identifying appropriate housing options through work with the South Carolina State Housing Authority.

South Carolina has also pioneered development of an electronic monitoring system, Care Call, that home care workers (including those providing nursing services, personal care, attendant care, and companion services) are required to use to verify delivery of services. The program was launched in a pilot region in 2002, went statewide in January 2003, and is now used in all HCBS waiver programs. In 2004, it was expanded to include adult day care and case management.

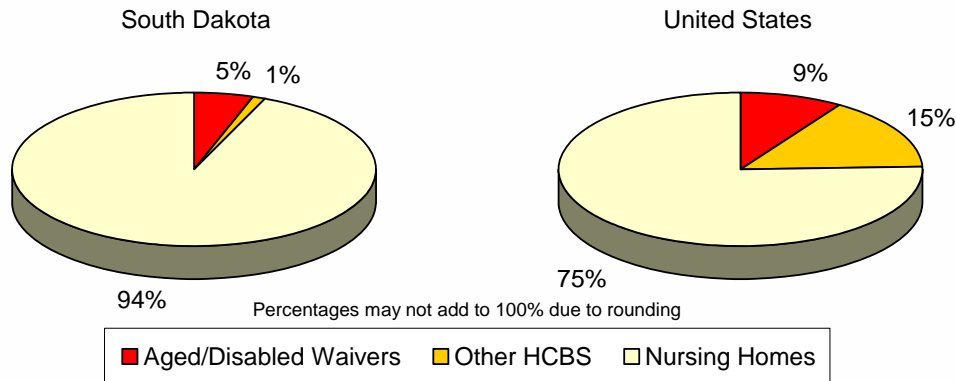
Other Developments

Money Follows the Person. South Carolina was awarded a \$5.8 million, five-year Money Follows the Person Demonstration grant in 2007 to increase service levels and expand services in its waiver programs, and to explore the possibility of establishing a global budget for all Medicaid LTC services. State officials estimate they will transition up to 200 individuals over the life of the project.

Managed Long-Term Care. South Carolina was one of the first states to develop a PACE (Program of All-Inclusive Care for the Elderly) replication site in 1990, modeled after the original California project, On Lok. With a rural PACE grant, the state plans to expand to a second site in 2008. The new PACE provider includes both a continuing care retirement community and a Medicaid-contracted nursing facility.

SOUTH DAKOTA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in South Dakota and the U.S., 2006



Compared to the U.S. average, South Dakota allocates a much greater percentage (94 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, South Dakota spent 5 percent on waiver services and 1 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	1,729	2,327	+598	\$4	\$9	+\$5
Nursing Homes	5,950	5,694	-256	\$103*	\$134	+\$30

Although South Dakota still has an unbalanced LTC system for older people and adults with physical disabilities, Medicaid trends indicate an increase in the number of Medicaid participants receiving home and community-based services (HCBS) in recent years. Specifically, the number of waiver beneficiaries increased, while the number of participants in nursing homes decreased slightly. From FY 2001 to FY 2006, however, the increase in Medicaid spending on nursing homes was six times the increase in spending on HCBS.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

* Expenditures for nursing homes were used from FY 2000—instead of FY 2001—because of state reporting irregularities.

Major Initiative

The 2006 legislature requested a comprehensive review of the state's LTC system (House Bill 1156). In response, the South Dakota Department of Social Services hired Abt Associates to conduct an assessment and evaluation of the system. In a November 2007 report, the consultants noted that HCBS "are limited in South Dakota, due to the difficulty of providing community-based services in very sparsely populated areas where there are few communities and a limited workforce."

The consultants recommended that the state "set goals and adopt policies" to expand HCBS across the state. Their recommendations included developing single points of entry to provide information, assessment, and referral to services; continuing expansion of the Long-Term Care Partnership Program; and implementing other initiatives to improve consumers' financial planning.

Long-Term Care System Review

The South Dakota legislature called for a comprehensive review of the state's LTC system in 2006. A consultant evaluation of the system recommended expanding HCBS across the state and developing a single point of entry to help consumers with information and referral to services.

Other Developments

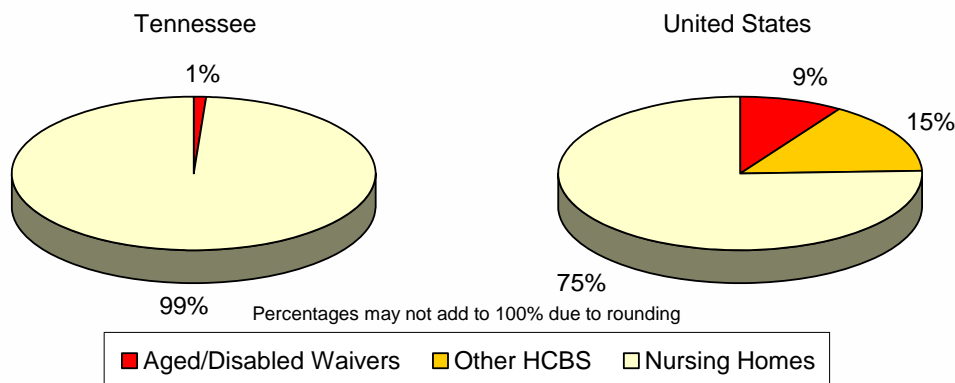
2010 Initiative. In 2003, Governor Michael Rounds launched a 2010 Initiative to stimulate economic growth and promote quality of life. One of the goals of the Initiative is to address shortages of health care professionals and direct-care workers. In its 2006 report, the South Dakota Department of Health, which conducts an annual survey of the direct-care workforce, identified the position of certified nursing assistant as having the highest percentage of turnover (37 percent), followed by case manager (33 percent).

Own Your Future. In November 2006, South Dakota joined the campaign to raise awareness about LTC planning, promote a range of planning options, and inform the general public about state resources that are available to help residents and family members better navigate the LTC system. In addition to mailing pamphlets, state and local officials ran public service announcements on both radio and television stations and hosted public education events and activities.

Long-Term Care Partnership Program. South Dakota's State Plan amendment to create a LTC Partnership Program was approved in July 18, 2007. This partnership provides consumers with LTC insurance that will allow them to receive services and support without having to deplete all of their assets.

TENNESSEE

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Tennessee and the U.S., 2006



Compared to the U.S. average, Tennessee allocates a greater percentage (99 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Tennessee spent 1 percent on waiver services.

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	511	512	+1	\$4	\$11	+\$7
Nursing Homes	37,311	35,324	-1,987	\$785	\$943	+\$158

Tennessee has one of the most unbalanced LTC systems for older people and adults with physical disabilities in the nation. Many more Medicaid participants receive nursing home services than receive home and community-based services (HCBS). The number of participants receiving HCBS remained the same from 1999 to 2004, while the number of participants in nursing homes decreased. From FY 2001 to FY 2006, the increase in Medicaid spending on nursing homes was more than 22 times the increase on HCBS (most of the increase in HCBS expenditures occurred from FY 2004 to FY 2006).

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Medicaid is not the only source of funding for LTC in Tennessee. The state-funded OPTIONS program, which provides homemaker services, personal care, and meals, had 2,073 enrollees in FY 2007 and expenditures of \$4.5 million in FY 2006. It also had a waiting list of about 4,000.

Major Initiative

In his 2008 State of the State address, Governor Phil Bredesen outlined his plan—the Long-Term Care Community Choices Act—to

“Long-Term Care Community Choices Act”

The Act restructures the state’s LTC system by providing enhanced HCBS options for people seeking LTC services.

restructure the state’s LTC system and provide options for those needing HCBS. The Long-Term Care Community Choices Act of 2008 (Senate Bill 4181/House Bill 4144) seeks to increase the number of people receiving HCBS and to simplify access to those services. Key components of the legislation include:

- A statewide fully integrated risk-based LTC system by July 1, 2009;
- Consumer-directed care options following approval of a waiver amendment;
- Strategies to encourage cost-effective HCBS in lieu of institutional placement;
- A streamlining of the eligibility process for faster enrollment and service delivery; and
- A single point of entry for access to LTC services.

The legislation also includes an additional \$4 million for the OPTIONS program. In addition, new funding will open 2,700 additional slots in the TennCare waiver program, which will bring the total to 6,000.

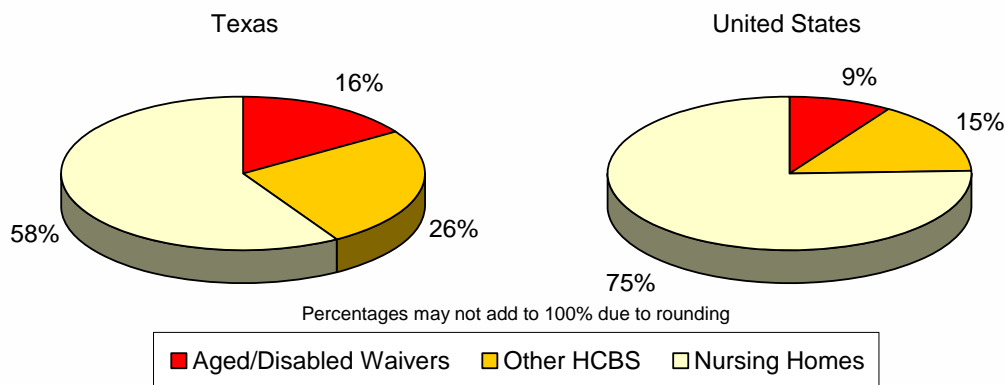
Other Developments

Waiver Expansion. In 2004, Tennessee implemented a statewide Medicaid waiver program for older adults and adults with physical disabilities after operating a more limited program in several counties for years. The new HCBS program started with 18 enrollees and gradually built up to 2,325 enrollees as of November 2007. With a five-year renewal of the HCBS waiver program in 2006, the state received federal approval to increase the number of slots in the program from 2,871 to 3,700. Since the state expected to fill all those slots by summer 2008, it plans to request federal approval to reach a total of 7,000 slots by 2012. Several additional services have been added to the program, including personal care assistant, adult day care, in-home respite, care in assisted living facilities, and assistive technology.

Systems Transformation. The state received a \$291,000 federal balancing grant in 2004 from the Centers for Medicare & Medicaid Services to develop a comprehensive client assessment instrument and a process for using the tool. Tennessee also received an \$800,000 federal grant in 2005 to pilot Aging and Disability Center models in two areas of the state.

TEXAS

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Texas and the U.S., 2006



Compared to the U.S. average, Texas allocates a much greater percentage (42 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to home and community-based services (HCBS). In FY 2006, Texas spent 16 percent on waiver services and 26 percent on other HCBS, including personal care services (PCS) and Community Attendant Services (CAS), a program which provides personal care services to individuals who are not eligible to receive other Medicaid services.

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS*	95,739	108,698	+12,959	\$828	\$1,301	+\$473
Nursing Homes	95,812	111,437	+15,625	\$1,604	\$1,833	+\$229

Texas serves nearly as many older people and adults with physical disabilities with HCBS as it does with nursing home services in its Medicaid program, and recent Medicaid trends indicate that the state is making progress in funding more HCBS. From FY 2001 to FY 2006, the increase in Medicaid spending on HCBS was more than double the increase in spending on nursing homes. The number of participants receiving HCBS and nursing home

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

* Because of differences in the data sources used for participants and expenditures, participants in Community Attendant Services are *not* included in the HCBS participant totals, but spending for this program *is* included in HCBS spending. The average monthly CAS enrollment increased from 21,274 in 1999 to 40,256 in 2004.

services both increased from 1999 to 2004. Participant and expenditure numbers are underreported because they do not include Texas STAR+PLUS, a Medicaid managed care program; the participant numbers also exclude CAS.

Despite the state's progress, a substantial number of Medicaid participants with disabilities still have unmet need. As of December 31, 2007, more than 39,800 people were on an "interest list" (waiting list) in Texas for HCBS waiver services; about 8,800 of them are in counties served by STAR+PLUS. The Texas legislature appropriated an additional \$71.5 million for waitlist reduction in 2007; however, this funding is projected to reduce the waiting list by only 10 percent.

Major Initiative

Texas STAR+PLUS is a managed care program that integrates acute and LTC under a combination of 1915(b) and (c) waivers from the federal government. LTC services include health services,

personal and home health attendant services, home-delivered meals, adaptive aids, adult foster care, adult day services, assisted living, and minor home modifications. Enrollment is required for persons who have a physical or mental disability and qualify for Supplemental Security Income or Medicaid due to low income, and for persons who qualify for the Medicaid Community Based Alternatives (CBA) waiver program. Texas began STAR+PLUS as a pilot program in Harris County (Houston) in 1998. The program had 65,000 enrollees in that county by the time the state announced an expansion to four additional regions in January 2007, with enrollment beginning in February 2007. Several provider and staff problems arose in the first few months of 2007, however. At one point, too few physicians were willing to accept new patients in the Austin area, and there were not enough trained staff in the San Antonio service area to complete LTC needs assessments in a timely manner. Nonetheless, by February 2008, this program had more than 155,000 Medicaid clients enrolled (55,268 aged; 1,736 blind; and 98,239 people with disabilities).

"Texas STAR+PLUS"

This Medicaid managed LTC program integrates acute and LTC services for people with disabilities. Although the program has experienced several problems, it has expanded and now serves more than 155,000 Medicaid clients with disabilities.

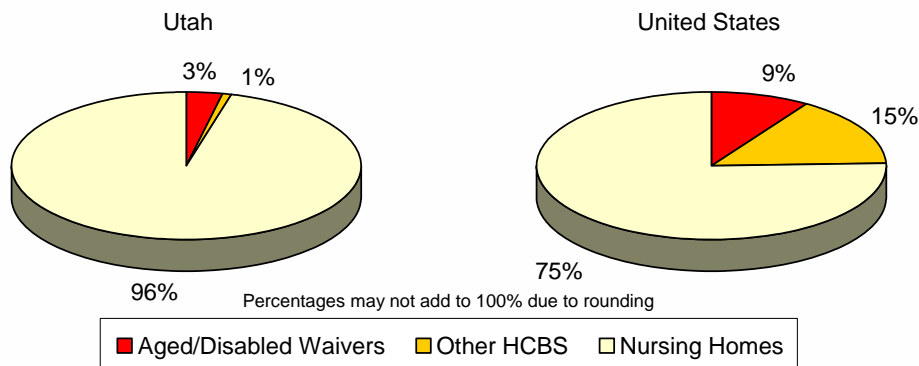
Other Developments

Money Follows the Person (MFP). Texas was awarded a \$17.9 million federal Money Follows the Person demonstration grant in January 2007 to help provide transition services for approximately 3,000 people leaving nursing homes for community settings. Texas pioneered the MFP model, which the Texas legislature authorized initially through "riders" (amendments) to appropriations, and then codified in 2005. From September 2001 to 2006, more than 12,000 persons were transitioned.

Consumer Direction. Legislation signed into law in June 2007 defines a consumer-direction model for community services as a service delivery payment program under which the consumer exercises control over his or her service plan or over the person delivering the services. The legislation charges the Consumer Direction (CD) Work Group with developing recommendations to expand CD services, expand access to support advisors, and provide outreach assistance.

UTAH

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Utah and the U.S., 2006



Compared to the U.S. average, Utah allocates a much greater percentage (96 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Utah spent 3 percent on waiver services and 1 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	3,624	2,731	-893	\$5	\$6	+\$2
Nursing Homes	5,513	5,403	-110	\$92	\$145	+\$52

Utah has one of the nation’s most unbalanced LTC systems based on funding for older people and adults with physical disabilities, and Medicaid trends indicate that little progress has occurred in the state in recent years. The number of participants receiving home and community-based services (HCBS) decreased, while the number of participants in nursing homes remained relatively constant between 1999 and 2004. From FY 2001 to FY 2006, the increase in Medicaid spending on nursing homes was \$52 million, roughly 26 times the increase in spending on HCBS. In fact, the *increase* in Medicaid spending on nursing homes was more than eight times the *total* HCBS spending for older people and adults with disabilities.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants’ type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Major Initiative

Utah has the sixth-fastest growth rate in the nation for persons age 65 and older. One study noted that, in Utah, one person will turn age 65 every 23 minutes in 2015. By 2030, Utah's 65 and over age group is projected to increase by 155 percent compared to the number of older persons in 2000.

In 2005, the state began a project called "The Utah Aging Initiative," a collaborative effort of Utah state agencies led by the Department of Human Services (DHS). The program seeks to raise state government awareness of the challenges presented by Utah's increasingly older population, and to stimulate planning efforts by these agencies.

"The Utah Aging Initiative"

The Utah Aging Initiative was created to examine the changing demographics in Utah and how the state can best accommodate the service needs of an increasing older population.

DHS has brought other state agencies together with the University of Utah Center for Public Policy and Administration to prepare plans for the aging of the Utah population. The Center held focus groups to gauge public attitudes about the issues the state should address, and, after these efforts and interviews with state agency officials, DHS and the Utah Center jointly published three reports in 2004 and 2005 (see References for titles and websites in the full report).

Other Developments

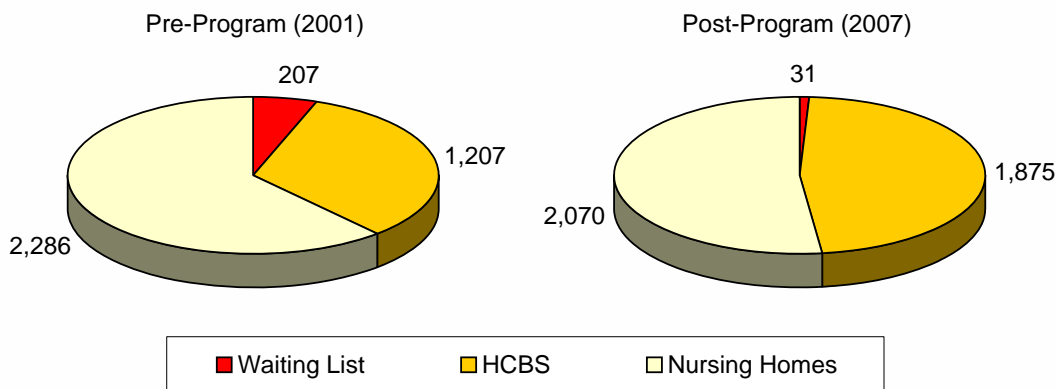
Long-Term Care Planning. In another move to facilitate the state's planning efforts for its aging population, the Utah legislature created the 21-member Commission on Aging in 2005. Although the Commission originally had only a two-year mandate, the 2007 legislature extended its work for another two years to July 1, 2009 (Senate Bill 26).

The Commission is facilitating "Utah 2030," a process through which every state agency is addressing and planning for the impact of the growing older population. All departments have designated a liaison to participate in the effort, with each department to develop a two-year plan. A report was scheduled for release in March 2008.

The Commission also supported the legislature's 2007 passage of the Utah Advance Health Care Directive Act and worked to assure that the 211 Information and Referral system provided effective service to older persons. Other initiatives included publishing a guide to financial security and guidelines for employers of caregivers.

VERMONT

Medicaid Long-Term Care Participants in Vermont, Before and After Implementation of the Choices for Care Program



Since 2005, Vermont has provided its Medicaid long-term care (LTC) services under a unique 1115 waiver that combines Medicaid home and community-based services (HCBS) waiver funds with the state’s nursing home appropriation in a “global budget,” called “Choices for Care.” Prior to implementation of the Choices for Care Program (described in more detail on the next page), 2,286 people were in nursing homes, 1,207 were receiving HCBS, and 207 people were on a waiting list.

Type of Service	Medicaid Participants		Spending on Services
	2001	2007	% Growth, 2000 to 2005
HCBS	1,207	1,875	+154%
Nursing Homes	2,286	2,070	+32%

As of December 2007, the number of residents in nursing homes decreased from 2,286 to 2,070, while the number of people receiving HCBS increased from 1,207 to 1,875. As of April 2008, 31 people are on a waiting list for services. Spending for HCBS in Vermont grew by 154 percent between 2000 and 2005, compared to 32 percent for nursing homes. However, in 2007, Vermont still provided services to more people in nursing homes than in to people receiving HCBS.

Major Initiative

Vermont uses a Section 1115 Medicaid waiver demonstration program, called “Choices for Care,” which restructures Medicaid LTC services by offering eligible older persons a choice between nursing home care and HCBS. It is the only state in which eligible individuals are entitled to HCBS on the same basis as they are to nursing home care.

Three beneficiary groups have been created under the program: Highest Need, High Need, and Moderate Need, with only the Highest Need category entitled to either nursing home or HCBS care. The High Need group receives services as funds are available, but with no entitlement to such services. The Moderate Need group includes people who are at risk of nursing home admission, but do not meet nursing home or HCBS waiver criteria; they receive services only if funding is available. The waiver limits the amount of federal funding available to the state over five years, but does give the state more flexibility in spreading the LTC funds between institutional and community care.

“Choices for Care”

Choices for Care—a Section 1115 Medicaid waiver demonstration—puts nursing home services on equal footing with HCBS by allowing consumers to choose where services are delivered.

Other Developments

Managed Long-Term Care. The Vermont Department of Disabilities, Aging and Independent Living received a \$2.1 million federal Real Choice Systems Change grant (Health and Long Term Care Integration Project) in 2005 to help develop a capitated, integrated Medicare-Medicaid system for acute, primary, and LTC for older persons and adults with physical disabilities. The Department has made planning grants available to several provider organizations to develop the model further.

Supportive Housing. The state received a \$900,000 supportive housing planning grant in 2004 under the Real Choice Systems Change grant program to preserve, develop, and enhance 10 supportive housing projects.

PACE. The state also used the \$900,000 grant described in the paragraph above to open its first Program of All-Inclusive Care for the Elderly (PACE) center in 2006 and was planning to open another such facility in the fall of 2007. PACE is a managed care program with capitated benefits that integrates Medicare and Medicaid financing. PACE participants must be 55 years old or older, live in the PACE area, and be nursing home-eligible.

Cash and Counseling. Vermont’s Cash & Counseling Program, Flexible Choices, began enrollment in summer 2006. The Flexible Choices program seeks to expand HCBS options to consumers by providing them with an allowance to manage and budget their LTC services. The program enrolled 50 participants during its first year and is projected to have 250 participants.

VIRGIN ISLANDS

The Department of Human Services (DHS) is the state Area Agency on Aging in the Virgin Islands. The Department operates two Homes for the Aged with a total of 65 residential beds, and plans are being developed to expand bed capacity and services in the near future.

Major Initiative

Home and Community-Based Services. DHS administers Older Americans Act programs, which include:

- Meals on Wheels,
- Homemaker Services,
- Family Caregiver Support Program,
- Information and Referral Services, and
- Socio-Recreational programs.

In addition, several community and faith-based organizations provide meals, homemaker services, in-home personal care, and companionship programs. The Corporation for National and Community Service funds Retired Senior Volunteer and Foster Grandparents programs.

Nursing Home and Residential Care. One privately owned and operated nursing home, Sea View, is on the island of St. Thomas. In addition, nonprofit community organizations and governmental agencies operate several Independent Living Facilities.

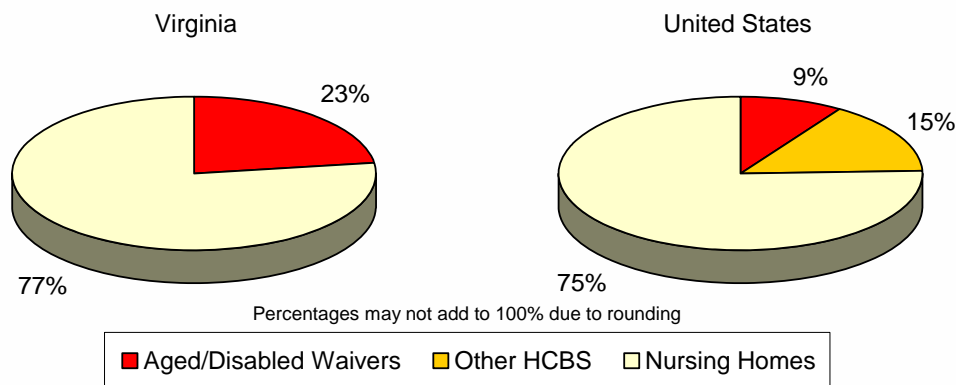
Other Developments & Future Outlook

Federal Grant. The Department of Human Services received a three-year grant from the U.S. Administration on Aging to recruit and train volunteers for a Senior Medicare Patrol to educate Medicare and Medicaid beneficiaries and their caregivers about how to protect themselves from fraud and any abusive health care practices. The program will receive \$75,000 a year through May 2009.

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VIRGINIA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Virginia and the U.S., 2006



Similar to the U.S. average, Virginia allocates a greater percentage (77 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Virginia spent 23% on waiver services.

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	12,070	11,439	-631	\$107	\$208	+\$101
Nursing Homes	27,746	27,902	+156	\$528	\$709	+\$181

Recent Medicaid trends indicate that Virginia still has an unbalanced LTC system for older people and adults with physical disabilities. Many more Medicaid participants received nursing home services than received home and community-based services (HCBS) in 2004. While the number of participants receiving nursing home services remained relatively constant from 1999 to 2004, the number of participants receiving HCBS decreased slightly. From FY 2001 to FY 2006, Medicaid spending on HCBS increased by \$101 million, while spending on nursing homes increased by \$181 million (specifically, the expenditures on HCBS waivers increased from FY 2003 to FY 2005).

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Major Initiative

Virginia Governor Tim Kaine took two major actions early in his administration affecting the state's LTC system: 1) In January 2006, he directed the Department of Medical Services (DMS), the state's Medicaid agency, "to develop a plan which will serve as the blueprint for moving towards an integrated acute and LTC delivery system for elderly and disabled Medicaid recipients," and 2) in July 2006, he created the Health Reform Commission (Executive Order 31), charged with improving access to competent, affordable health care. The Commission was also directed to address LTC and affordability.

While engaged in long-term planning for integration of acute and LTC services, DMS planned to develop two different model delivery systems more immediately. DMS was to develop a local "community model" with an Area Agency on Aging, and the other model would be developed by an existing Medicaid managed care organization ("regional model"). The legislature appropriated \$1.5 million in start-up funds in 2006 for six potential Program of All-Inclusive Care for the Elderly (PACE) sites.

"Managed Long-Term Care"

Virginia is designing and implementing a Medicaid integrated acute and LTC delivery system for older people and adults with disabilities. The system will use two models: one based on a community model and the other based on an existing Medicaid managed care organization.

A draft report issued in September 2007 included the following recommendations for the state's LTC system:

- Obtain funding to implement a Money Follows the Person program.
- Continue support of integration of Medicaid acute and LTC services through the PACE program and managed care models.
- Add assisted living as a service under the Medicaid Elderly and Disabled waiver program.
- By 2010, expand the "No Wrong Door" (see below) access to LTC services model statewide.

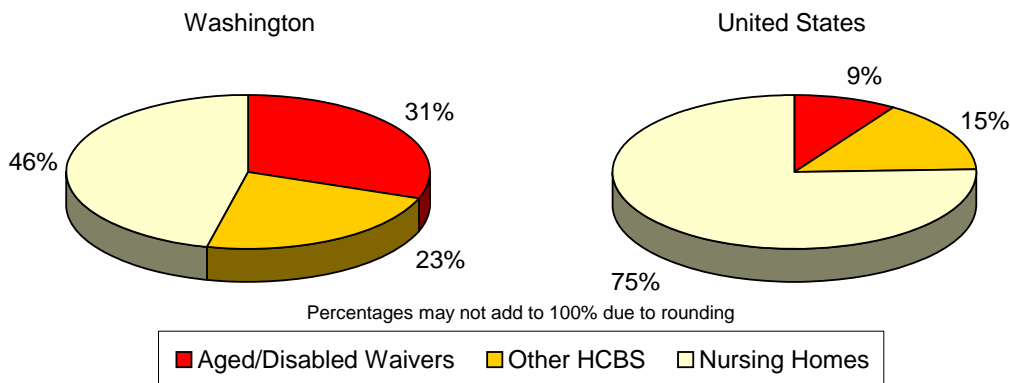
Other Developments

No Wrong Door. In June 2007, the American Council for Technology (ACT) named the Virginia Department of Aging's "No Wrong Door" initiative a national winner of the 2007 ACT Intergovernmental Solutions Award. "No Wrong Door" is a Web-based initiative using a one-stop service approach to simplify and improve service delivery for the state's older population and adults with disabilities.

Legislative Activity. The 2005 General Assembly gave the Department of Social Services (DSS) new enforcement authority for assisted living facilities (ALFs); directed the Department of Health Professions to license facility administrators and medication aides; and increased the auxiliary grant rate, a financial subsidy to ALF residents with low-incomes. DSS regulations detailing ALF minimum standards became effective in December 2006; the Board of Nursing regulations for medication aides took effect July 1, 2007.

WASHINGTON

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Washington and the U.S., 2006



Compared to the U.S. average, Washington allocates a much greater percentage (54 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to home and community-based services (HCBS). In FY 2006, Washington spent 31 percent on waiver services and 23 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	33,343	53,218	+19,875	\$439	\$642	+\$203
Nursing Homes	24,620	22,555	-2,065	\$614	\$558	-\$56

Washington has one of the nation’s most balanced LTC systems for older people and adults with physical disabilities, and recent trends indicate the state is continuing to make even more progress toward balancing. Many more Medicaid participants received HCBS than received nursing home services in 2004. While the number of participants receiving HCBS increased significantly, the number of participants in nursing homes decreased from 1999 to 2004. From FY 2001 to FY 2006, Medicaid spending on HCBS increased significantly, while spending on nursing homes decreased. Washington is one of the few states that spend more on HCBS than on nursing homes.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants’ type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Major Initiative

Washington has a long record of success in providing HCBS to older persons with LTC needs. In 2006, beds in assisted living facilities and adult family homes outnumbered institutional beds—39,637 residential care beds compared to 25,011 institutional beds. The state also helped to pioneer a presumptive Medicaid financial eligibility process: A caseworker can “presume” an applicant’s eligibility based on certain information, so the applicant can receive in-home or residential services quickly while the more detailed paperwork process proceeds. This process and expedited eligibility determination have reduced the average time for Medicaid approval from 37 days to 17.

The state was able to initiate presumptive eligibility in part because of its electronic assessment tool, called CARE (Comprehensive Assessment Reporting and Evaluation), a computerized assessment tool used to determine a person’s functional eligibility for Medicaid services and the development of care plans. A Case Management Information System, added to the CARE system in January 2008, includes an advanced tickler system to provide case managers with prompts regarding deadline and program requirements.

Other Developments

Money Follows the Person. Washington was awarded a \$27 million federal Money Follows the Person Demonstration in 2007 for a “Roads to Community Living” project to help move 660 nursing home residents to the community.

Task Force. The Washington legislature passed House Bill 1220 in 2005 establishing a joint legislative and executive Long Term Care Task Force to focus on LTC financing and chronic care management. The task force issued a report in January 2008 recommending:

- Expand the Aging and Disability Resource Center approach beyond the initial pilot site in Pierce County, and expand the campaign to educate the public on the importance of planning for LTC needs.
- Increase funding for and access to adult day services, respite, support groups, training, and other caregiver supports; review the funding needs of rural areas; and implement a comprehensive falls-prevention education program.
- Pursue an LTC Partnership insurance option through legislation.
- Implement an evidence-based, comprehensive chronic care program.

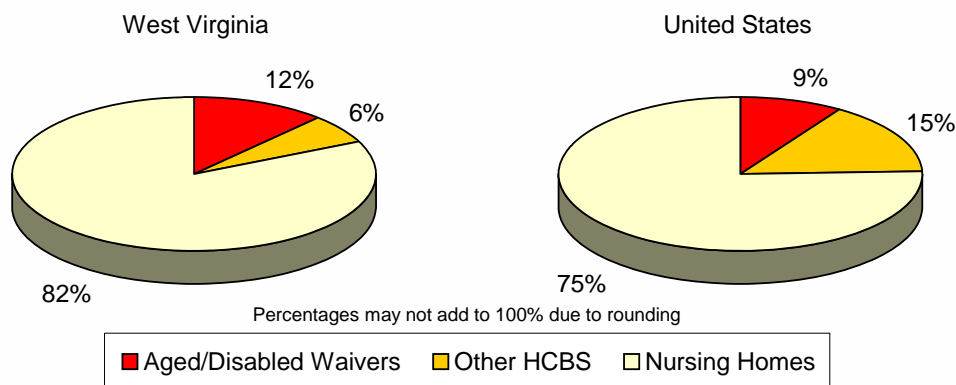
In 2008, the legislature enacted House Bill 2668, giving a 12 percent increase in the existing respite program and a Senior Falls Prevention Program to help prevent slips and falls through an education and exercise program. Another 2008 bill (HB 2666) established National Association of Insurance Commissioners standards for private LTC policies, another Task Force recommendation.

“Presumptive Eligibility and CARE Assessment Tool”

Presumptive eligibility and the CARE assessment tool have allowed caseworkers to presume the eligibility of a Medicaid applicant as a means of expediting home and residential services to consumers while their paperwork is being processed.

WEST VIRGINIA

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in West Virginia and the U.S., 2006



Compared to the U.S. average, West Virginia allocates a greater percentage (82 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, West Virginia spent 12 percent on waiver services and 6 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	10,970	9,684	-1,286	\$68	\$88	+\$21
Nursing Homes	11,788	11,534	-254	\$293	\$402	+\$109

Recent Medicaid trends indicate that West Virginia has an unbalanced LTC system for older people and adults with physical disabilities. The number of participants receiving nursing home services remained relatively flat from 1999 to 2004, while the number of participants receiving home and community-based services (HCBS) decreased (specifically, there was a decrease in the number of personal care beneficiaries from 1999 to 2002). From FY 2001 to FY 2006, the increase in Medicaid spending on nursing homes was more than five times the increase in spending for HCBS. In fact, the *increase* in Medicaid spending on nursing homes

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

was larger than the *total* HCBS spending for older people and adults with disabilities in FY 2006.

Major Initiative

On October 12, 2005, West Virginia Governor Joe Manchin III, through an executive order, approved implementation of a plan for the state to comply with the 1999 Supreme Court *Olmstead* ruling that persons with disabilities be provided services in the least restrictive setting. One of the state's first actions under the directive was to require nursing homes to make residents aware of their *Olmstead* rights and the community options available to them.

The state's *Olmstead* plan, "Building Inclusive Communities," spells out 189 specific activities or tasks under 10 categories, including "Informed Choice," which directs the state to develop a resource guide and interactive website to help consumers find community LTC resources. Other categories include "Transition" and "Diversion" to aid consumers in avoiding institutionalization or by returning to the community from a nursing home stay.

"Building Inclusive Communities"

West Virginia has laid out 189 activities, ranging from providing consumers with resources to make better LTC decisions to implementing transition and diversion programs to assist consumers who want to receive services in a community setting. The state plans to move at least 50 people back into the community by the end of the effort's first year.

West Virginia also developed a Transition Initiative in the spring of 2007 to provide transition services for nursing home residents who want to return to the community. The plan seeks to move at least 50 people the first year with the assistance of Transition Navigators and Coordinators.

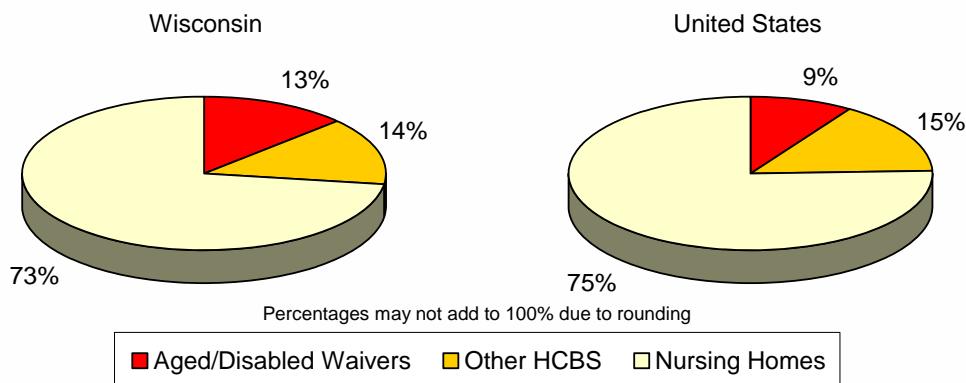
Other Developments

Systems Change grants. West Virginia has received more than \$4 million in federal grants through the Real Choice Systems Change grant program and other sources to implement the *Olmstead* plan. An Aging and Disability Resource Center grant in 2003 is being used to develop centers in two counties and to evaluate the feasibility of establishing a statewide network of such centers. Funds have also been used to commission a Money Follows the Person study, due to be completed in early summer 2008.

Cash and Counseling. Another *Olmstead* plan recommendation on self-directed services and supports came to fruition in the spring of 2007 when the Medicaid Aged and Disabled waiver program added a self-direction option, "Personal Options." The program gives consumers age 60 and older, as well as adults with physical disabilities, the option to direct their own services. There are currently 400 participants in the Personal Options program who receive an individualized budget based on a needs assessment. Consumers are responsible for hiring and managing their own workers and arranging for their own services and supports.

WISCONSIN

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Wisconsin and the U.S., 2006



Similar to the U.S. average, Wisconsin allocates a greater percentage (73 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Wisconsin spent 13 percent on waiver services and 14 percent on personal care services (PCS).

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	24,967	32,315	+7,348	\$283	\$326	+\$43
Nursing Homes	41,341	35,533	-5,808	\$960	\$876	-\$84

Recent Medicaid trends indicate that Wisconsin has made progress in balancing its LTC system for older people and adults with physical disabilities. While the number of participants receiving home and community-based services (HCBS) increased, the number of participants receiving nursing home services decreased from 1999 to 2004. From FY 2001 to FY 2006, Medicaid spending on HCBS increased by \$43 million, whereas spending on nursing homes decreased by \$84 million. In addition, participant and expenditure numbers are underreported because they do not include the Partnership program or Family Care, two Medicaid managed care programs for people with LTC needs.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Major Initiative

The heart of LTC reform in Wisconsin has been development and implementation of the Family Care program, a managed care pilot program that operates under a combination of 1915(b) and 1915(c) Medicaid waivers. Created in 1999 as a redesign of the state's LTC system, Family Care operated as a demonstration project in only five of the state's 72 counties until 2006, largely because of state fiscal problems. In his January 2006 State-of-the-State address, Governor Jim Doyle proposed statewide expansion of the program, which the legislature approved (2005–06 Act 386) in the spring of 2006.

Family Care provides older adults and persons with disabilities with an entitlement to a wide range of service options. Services are tailored to each enrollee's needs and preferences, and participants can remain in their homes and self-direct their services. Care Management Organizations (CMOs) in each Family Care county help arrange for and manage services for persons eligible for them. (CMOs receive a monthly per person payment to manage and purchase care for their members.)

“Family Care”

The heart of LTC reform in Wisconsin is the Family Care program, a managed care pilot program for older adults and persons with disabilities.

The program was operating in eight counties as of February 2008, with enrollment totaling 12,141 persons. Older persons accounted for 71.5 percent (8,677 persons) of the total Family Care population. In 2006, the Wisconsin Department of Health and Family Services (DHFS) awarded a total of \$1.4 million in planning grants to communities around the state that wanted to develop Family Care.

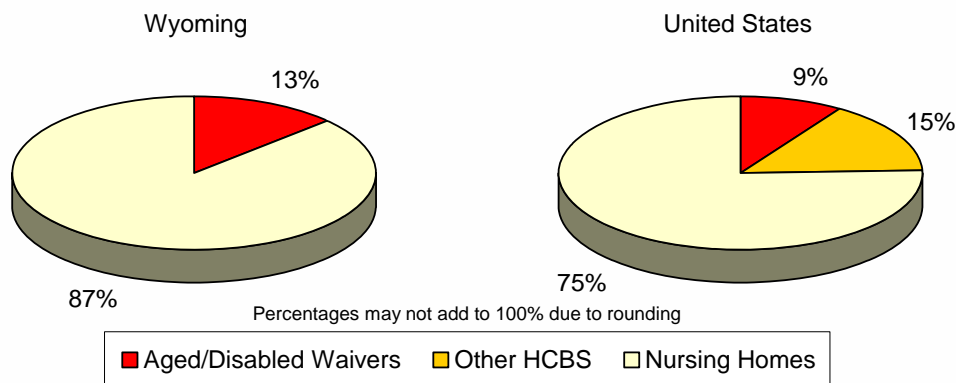
An independent study by APS Healthcare Inc. concluded that the cost of Family Care services per member per month in the pilot counties (except for Milwaukee County) in 2003 and 2004 (the fourth and fifth years of operation) was \$452 less than for a comparable fee-for-service population. Also, waiting lists for services were eliminated in the pilot counties. (The waiting list for the Community Options Program totaled about 12,000 persons in February 2008, which included 4,122 older persons. State officials predict that the numbers on this waiting list will drop as Family Care moves into additional Wisconsin counties because the program will provide services to this population.)

Other Developments

Aging and Disability Resource Center (ADRC). State officials estimate that, by 2009, expansion of Family Care will allow for about 75 percent of Wisconsin's population to be covered by ADRCs Centers and 62 percent by CMOs. In addition to the counties with Family Care programs that also include ADRCs, at least 10 other ADRCs were operating around the state by 2008, with about 14 other centers planned to open in 2008. Ten planning consortia were being developed around the state to develop multi-county Family Care programs through formation of Long-Term Care Districts.

WYOMING

Medicaid Long-Term Care Spending for Older People and Adults with Physical Disabilities in Wyoming and the U.S., 2006



Compared to the U.S. average, Wyoming allocates a greater percentage (87 percent) of its Medicaid long-term care (LTC) spending for older people and adults with physical disabilities to nursing homes, even though most people prefer to remain in their own homes and communities. In FY 2006, Wyoming spent 13 percent on waiver services.

Type of Service	Medicaid Participants ¹			Expenditures (millions)		
	1999	2004	Change	2001	2006	Change
HCBS	982	1,356	+374	\$0	\$10	+\$10
Nursing Homes	2,609	2,659	+50	\$39	\$64	+\$24

Recent Medicaid trends indicate that Wyoming has made some progress in expanding access to home and community-based services (HCBS) for Medicaid participants, but the state still has an unbalanced LTC system for older people and adults with physical disabilities. More Medicaid participants received nursing home services than received HCBS in 2004. However, the number of participants receiving HCBS increased, while the number of participants receiving nursing home services remained relatively flat from 1999 to 2004. Funding for the waiver program began in FY 2002. From FY 2001 to FY 2006, the increase in Medicaid spending on nursing homes was more than twice as much as the increase in spending on HCBS.

¹ This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other LTC populations. Participants and expenditures for HCBS include all 1915(c) waivers for older people and adults with physical disabilities, and the personal care services option, if the state offers it. All participants and expenditures for nursing homes are included, regardless of the participants' type of disability or reason for admission. Excluded are participants and expenditures for intermediate care facilities for mental retardation (ICF/MR), HCBS waivers for other populations such as MR/DD, home health, and individuals receiving LTC services through managed care programs. Participant numbers include all persons receiving services during the year, not the average number on a given day; the number of nursing home participants is greater than the number of nursing home beds in each state. The average number of Medicaid nursing home residents on any given day for each state appears in the *Tables* tab at the end of the full report.

Medicaid is not the only source of funding for LTC. The state-funded Community-Based In-Home Services program had \$3.8 million in funding and 2,800 participants in 2007.

Major Initiative

In February 2007, the Wyoming Legislature enacted the Long-Term Care Choices Act (SF 89), which included the following provisions:

- Expand the capacity of the Medicaid HCBS waiver program by 300 slots and the Assisted Living Waiver by 22 slots.
- Authorize the Wyoming Department of Health to license an adult foster care home pilot project.
- Fund transition services for people leaving nursing homes or avoiding placement in an institutional setting.
- Authorize three pilot grants, with a 25 percent local match, to study the feasibility of innovation in LTC facilities.

“Long-Term Care Choices Act”

This Act expands the HCBS waiver program by 300 slots, establishes a licensed adult foster care home pilot project, provides funding for transition efforts, and authorizes three pilot grants to examine innovations in LTC facilities.

The legislation refers to “alternative elder care homes,” which are defined as fully detached houses with no more than 10 residents, “providing the highest level of care permitted under the state’s applicable health care facility rules” and modeled on the “Green House” concept. An elder care home must provide a “residential home environment to Medicaid-supported residents,” the legislation says. The bill, which also authorizes a feasibility grant to fund the exploration of one elder care home, was signed into law on March 15, 2007.

Other Developments

Home and Community-Based Services. The Wyoming legislature clarified and expanded the duties of the Wyoming Advisory Council on Aging in 2007 (House Bill 0149) by including assisted living, adult day care, boarding homes, and personal care as issues on which the Council should advise the Division on Aging. In another piece of legislation (House Bill 0016), the legislature added personal care services to the Community-Based In-Home Services Program.

Aging and Disability Resource Centers (ADRC). State officials received an \$800,000 ADRC grant in 2005 to develop a single-point-of-entry demonstration in central Wyoming. Since the opening of the Resource Centers in August 2006, more than 500 consumers have either received information or gained access to LTC services. In addition, 21 consumers were transitioned, through the nursing home transition/diversion program, into HCBS settings in FY 2006–07.

**Table A1:
Medicaid Long-Term Care Balancing (% HCBS)**

State	Percent of 2001 Medicaid LTC Expenditures going to HCBS				Percent of 2006 Medicaid LTC Expenditures going to HCBS			
	All Medicaid Beneficiaries		Older People & Adults with Physical Disabilities		All Medicaid Beneficiaries		Older People & Adults with Physical Disabilities	
	Percent	Rank	Percent	Rank	Percent	Rank	Percent	Rank
Oregon	67%	1	51%	1	72%	1	55%	1
New Mexico	55%	2	34%	4	67%	2	54%	2
Washington	47%	6	42%	3	60%	4	54%	3
Alaska	54%	3	32%	7	63%	3	51%	4
California	47%	7	43%	2	51%	9	47%	5
Texas	33%	22	34%	5	40%	18	42%	6
Minnesota	40%	12	19%	17	60%	5	40%	7
North Carolina	35%	16	33%	6	41%	16	39%	8
Idaho	28%	27	26%	9	42%	14	38%	9
Kansas	43%	9	26%	10	53%	7	34%	10
Nevada	22%	35	14%	24	42%	13	32%	11
Missouri	33%	21	24%	11	39%	21	30%	12
Wisconsin	34%	17	23%	14	44%	10	27%	13
New York	32%	23	23%	13	39%	19	26%	14
Montana	38%	14	29%	8	42%	15	25%	15
Oklahoma	33%	19	15%	21	41%	17	25%	16
Maine	39%	13	13%	26	52%	8	24%	17
Dist. of Columbia	1%	50	1%	48	22%	47	23%	18
Virginia	29%	26	17%	20	36%	28	23%	19
Massachusetts	30%	24	15%	22	39%	23	22%	20
Arkansas	25%	30	23%	12	26%	40	21%	21
Colorado	46%	8	17%	19	43%	12	21%	22
New Jersey	20%	37	14%	23	34%	29	19%	23
Illinois	15%	44	10%	31	28%	35	19%	24
South Carolina	29%	25	20%	15	32%	31	18%	25
West Virginia	33%	18	19%	18	37%	25	18%	26

**Table A1:
Medicaid Long-Term Care Balancing (%HCBS)**

State	Percent of 2001 Medicaid Expenditures going to HCBS				Percent of 2006 Medicaid Expenditures going to HCBS			
	All Medicaid Beneficiaries		Older People & Adults with Physical Disabilities		All Medicaid Beneficiaries		Older People & Adults with Physical Disabilities	
	Percent	Rank	Percent	Rank	Percent	Rank	Percent	Rank
Hawaii	25%	33	13%	25	37%	26	17%	27
Ohio	13%	47	11%	29	26%	39	17%	28
Nebraska	25%	29	9%	34	33%	30	16%	29
Michigan	25%	32	12%	28	31%	34	15%	30
Louisiana	14%	46	2%	47	26%	41	15%	31
Wyoming	50%	5	0%	50	54%	6	13%	32
Iowa	16%	43	5%	42	32%	33	13%	33
New Hampshire	40%	11	9%	33	39%	22	12%	34
Maryland	24%	34	5%	40	38%	24	11%	35
Georgia	17%	42	11%	30	23%	45	11%	36
Mississippi	8%	49	8%	36	11%	49	11%	37
Rhode Island	41%	10	10%	32	44%	11	11%	38
Pennsylvania	18%	40	3%	45	27%	38	10%	39
Delaware	25%	31	8%	35	32%	32	9%	40
Florida	22%	36	7%	37	27%	37	9%	41
Connecticut	26%	28	6%	39	27%	36	8%	42
Kentucky	19%	39	12%	27	22%	46	8%	43
Alabama	17%	41	7%	38	25%	43	7%	44
South Dakota	33%	20	4%	43	36%	27	6%	45
North Dakota	20%	38	3%	44	24%	44	5%	46
Utah	38%	15	5%	41	39%	20	4%	47
Indiana	11%	48	2%	46	18%	48	2%	48
Tennessee	15%	45	1%	49	25%	42	1%	49
Arizona	*		*		*		*	
Vermont	53%	4	20%	16	*		*	
United States	29%		19%		37%		25%	

Notes: Because of lack of comparable data between 2001 and 2006, U.S. totals exclude Arizona and Vermont. 2000 nursing home data are used instead of 2001 for Iowa, Kansas, Louisiana, Missouri, New Jersey, Oregon, and South Dakota.

* Data omitted because of lack of comparable data to the rest of the states.

**Table A2:
Medicaid Long-Term Care Balancing (Expenditures)**

State	Medicaid HCBS Expenditures (millions)				Medicaid Nursing Home Expenditures (millions)			
	2001	2006	Change		2001	2006	Change	
Alabama	\$48	\$60	+\$12	+26%	\$674	\$839	+\$165	+25%
Alaska	\$33	\$131	+\$98	+295%	\$72	\$123	+\$52	+72%
Arizona	*	*			*	*		
Arkansas	\$111	\$136	+\$24	+22%	\$370	\$522	+\$152	+41%
California	\$1,923	\$3,348	+\$1,425	+74%	\$2,598	\$3,761	+\$1,163	+45%
Colorado	\$75	\$119	+\$44	+59%	\$360	\$462	+\$102	+28%
Connecticut	\$68	\$112	+\$43	+63%	\$1,024	\$1,226	+\$201	+20%
Delaware	\$10	\$17	+\$7	+67%	\$111	\$160	+\$49	+45%
Dist. of Columbia	\$2	\$52	+\$50	+2563%	\$159	\$173	+\$15	+9%
Florida	\$124	\$230	+\$106	+86%	\$1,703	\$2,396	+\$693	+41%
Georgia	\$90	\$157	+\$67	+74%	\$760	\$1,287	+\$526	+69%
Hawaii	\$22	\$39	+\$17	+76%	\$148	\$195	+\$47	+32%
Idaho	\$42	\$85	+\$43	+101%	\$119	\$137	+\$18	+15%
Illinois	\$170	\$350	+\$180	+106%	\$1,500	\$1,502	+\$3	+0%
Indiana	\$18	\$32	+\$14	+78%	\$818	\$1,289	+\$472	+58%
Iowa	\$24	\$64	+\$40	+169%	\$505**	\$441	-\$65	-13%
Kansas	\$121	\$164	+\$43	+35%	\$349**	\$321	-\$27	-8%
Kentucky	\$77	\$62	-\$15	-20%	\$565	\$734	+\$169	+30%
Louisiana	\$10	\$109	+\$100	+1043%	\$515**	\$637	+\$122	+24%
Maine	\$29	\$78	+\$48	+166%	\$201	\$247	+\$46	+23%
Maryland	\$36	\$121	+\$85	+237%	\$697	\$939	+\$243	+35%
Massachusetts	\$249	\$475	+\$226	+91%	\$1,423	\$1,673	+\$249	+18%
Michigan	\$234***	\$253	+\$20	+8%	\$1,744	\$1,448	-\$296	-17%
Minnesota	\$209	\$566	+\$358	+172%	\$901	\$853	-\$48	-5%
Mississippi	\$35	\$79****	+\$44	+127%	\$416	\$648	+\$232	+56%
Missouri	\$228	\$320	+\$92	+40%	\$726**	\$763	+\$37	+5%
Montana	\$44	\$49	+\$5	+11%	\$111	\$147	+\$36	+32%

**Table A2:
Medicaid Long-Term Care Balancing (Expenditures)**

State	Medicaid HCBS Expenditures (millions)				Medicaid Nursing Home Expenditures (millions)			
	2001	2006	Change		2001	2006	Change	
Nebraska	\$37	\$67	+\$29	+78%	\$370	\$347	-\$23	-6%
Nevada	\$15	\$69	+\$54	+372%	\$92	\$150	+\$58	+62%
New Hampshire	\$21	\$38	+\$17	+79%	\$210	\$291	+\$82	+39%
New Jersey	\$269	\$428	+\$160	+59%	\$1,646**	\$1,777	+\$131	+8%
New Mexico	\$87	\$227	+\$140	+161%	\$166	\$196	+\$30	+18%
New York	\$1,897	\$2,496	+\$599	+32%	\$6,392	\$6,951	+\$559	+9%
North Carolina	\$423	\$717	+\$294	+70%	\$876	\$1,108	+\$231	+26%
North Dakota	\$4	\$9	+\$4	+91%	\$151	\$168	+\$16	+11%
Ohio	\$281	\$532	+\$251	+89%	\$2,313	\$2,656	+\$342	+15%
Oklahoma	\$75	\$152	+\$76	+102%	\$426	\$455	+\$29	+7%
Oregon	\$255	\$341	+\$86	+34%	\$240**	\$280	+\$40	+17%
Pennsylvania	\$100	\$440	+\$340	+340%	\$3,684	\$3,862	+\$178	+5%
Rhode Island	\$27	\$35	+\$8	+31%	\$244	\$298	+\$54	+22%
South Carolina	\$94	\$104	+\$10	+11%	\$374	\$463	+\$89	+24%
South Dakota	\$4	\$9	+\$5	+104%	\$103**	\$134	+\$30	+29%
Tennessee	\$4	\$11	+\$7	+175%	\$785	\$943	+\$158	+20%
Texas	\$828	\$1,301	+\$473	+57%	\$1,604	\$1,833	+\$229	+14%
Utah	\$5	\$6	+\$2	+36%	\$92	\$145	+\$52	+57%
Vermont	\$20	*			\$84	\$92	+\$8	+10%
Virginia	\$107	\$208	+\$101	+95%	\$528	\$709	+\$181	+34%
Washington	\$439	\$642	+\$203	+46%	\$614	\$558	-\$56	-9%
West Virginia	\$68	\$88	+\$21	+31%	\$293	\$402	+\$109	+37%
Wisconsin	\$283	\$326	+\$43	+15%	\$960	\$876	-\$84	-9%
Wyoming	\$0***	\$10	+\$10	***	\$39	\$64	+\$24	+62%
United States	\$9,355	\$15,466	+\$6,111	+65%	\$40,773	\$47,589	+\$6,815	+17%

Notes: Because of lack of comparable data between 2001 and 2006, U.S. totals exclude Arizona and Vermont.

* Data are not included because states provide these services almost entirely through managed care programs.

** 2000 nursing home data are used instead of 2001 for Iowa, Kansas, Louisiana, Missouri, New Jersey, Oregon, and South Dakota because of irregularities in state reporting.

*** Michigan's reported expenditures for HCBS in 2001 include HCBS waiver spending for 2002 instead of 2001 because of data availability. Wyoming's waiver funding began in 2002; there were no expenditures in 2001.

**** Mississippi reported total waiver spending for 2006, but not individual waiver spending. The spending on waiver programs for older people and adults with physical disabilities uses the historical proportion of total waiver spending in the state (70%) going to this population.

**Table A3:
Medicaid Long-Term Care Balancing (Participants)**

State	Medicaid HCBS Participants				Medicaid Nursing Home Participants			
	1999	2004	Change		1999	2004	Change	
Alabama	6,161	8,215	+2,054	+33%	24,576	26,723	+2,147	+9%
Alaska	2,299	4,838	+2,539	+110%	929	967	+38	+4%
Arizona	*	*			*	*		
Arkansas	26,814	24,207	-2,607	-10%	20,699	28,854	+8,155	+39%
California	185,493	327,160	+141,667	+76%	117,843	119,252	+1,409	+1%
Colorado	11,481	15,425	+3,944	+34%	18,918	16,474	-2,444	-13%
Connecticut	9,176	11,335	+2,159	+24%	38,862	36,868	-1,994	-5%
Delaware	734	1,304	+570	+78%	3,109	3,736	+627	+20%
Dist. of Columbia	1,624	2,701	+1,077	+66%	4,359	6,089	+1,730	+40%
Florida	25,322	37,459	+12,137	+48%	91,985	114,134	+22,149	+24%
Georgia	14,018	15,418	+1,400	+10%	39,720	43,349	+3,629	+9%
Hawaii	923	2,043	+1,120	+121%	4,274	5,425	+1,151	+27%
Idaho	3,196	10,838	+7,642	+239%	5,014	5,075	+61	+1%
Illinois	29,783	50,279	+20,496	+69%	81,791	77,370	-4,421	-5%
Indiana	2,338	3,979	+1,641	+70%	47,988	42,952	-5,036	-10%
Iowa	3,994	8,501	+4,507	+113%	21,882	20,155	-1,727	-8%
Kansas	10,523	12,105	+1,582	+15%	17,644	17,804	+160	+1%
Kentucky	13,391	12,744	-647	-5%	27,739	26,736	-1,003	-4%
Louisiana	872	3,210	+2,338	+268%	35,508	32,306	-3,202	-9%
Maine	3,184	9,557	+6,373	+200%	9,236	9,116	-120	-1%
Maryland	4,759	8,464	+3,705	+78%	27,920	27,109	-811	-3%
Massachusetts	8,850	17,715	+8,865	+100%	60,044	60,273	+229	+0%
Michigan	49,722	64,130	+14,408	+29%	44,180	50,431	+6,251	+14%
Minnesota	18,574	34,385	+15,811	+85%	38,925	39,016	+91	+0%
Mississippi	2,667	11,747	+9,080	+340%	23,909	22,678	-1,231	-5%
Missouri	57,407	73,160	+15,753	+27%	39,762	39,606	-156	-0%
Montana	4,279	4,805	+526	+12%	5,549	5,204	-345	-6%

**Table A3:
Medicaid Long-Term Care Balancing (Participants)**

State	Medicaid HCBS Participants				Medicaid Nursing Home Participants			
	1999	2004	Change		1999	2004	Change	
Nebraska	3,219	6,265	+3,046	+95%	16,487	11,109	-5,378	-33%
Nevada	1,857	4,416	+2,559	+138%	3,821	4,504	+683	+18%
New Hampshire	1,489	2,510	+1,021	+69%	7,147	7,290	+143	+2%
New Jersey	24,581	25,639	+1,058	+4%	51,747	48,404	-3,343	-6%
New Mexico	1,404	12,118	+10,714	+763%	7,074	6,895	-179	-3%
New York	109,309	107,705	-1,604	-1%	139,509	200,446	+60,937	+44%
North Carolina	20,244	53,425	+33,181	+164%	42,382	43,182	+800	+2%
North Dakota	347	979	+632	+182%	5,570	5,599	+29	+1%
Ohio	26,135	34,576	+8,441	+32%	92,133	98,232	+6,099	+7%
Oklahoma	15,201	21,154	+5,953	+39%	25,758	22,917	-2,841	-11%
Oregon	27,675	31,628	+3,953	+14%	12,031	10,610	-1,421	-12%
Pennsylvania	4,411	18,912	+14,501	+329%	72,481	79,272	+6,791	+9%
Rhode Island	2,362	2,705	+343	+15%	13,297	11,754	-1,543	-12%
South Carolina	14,393	13,643	-750	-5%	17,458	17,618	+160	+1%
South Dakota	1,729	2,327	+598	+35%	5,950	5,694	-256	-4%
Tennessee	511	512	+1	+0%	37,311	35,324	-1,987	-5%
Texas	95,739	108,698	+12,959	+14%	95,812	111,437	+15,625	+16%
Utah	3,624	2,731	-893	-25%	5,513	5,403	-110	-2%
Vermont	1,014	3,331	+2,317	+229%	3,745	3,997	+252	+7%
Virginia	12,070	11,439	-631	-5%	27,746	27,902	+156	+1%
Washington	33,343	53,218	+19,875	+60%	24,620	22,555	-2,065	-8%
West Virginia	10,970	9,684	-1,286	-12%	11,788	11,534	-254	-2%
Wisconsin	24,967	32,315	+7,348	+29%	41,341	35,533	-5,808	-14%
Wyoming	982	1,356	+374	+38%	2,609	2,659	+50	+2%
United States	935,160	1,337,010	+401,850	+43%	1,615,695	1,707,572	+91,877	+6%

Notes: Because of lack of comparable data between 2001 and 2006, U.S. totals exclude Arizona.

* Data are not included because state provides these services almost entirely through managed care programs.

**Table A4:
Medicaid Nursing Home Residents on a Given Day**

State	Medicaid Nursing Home Residents			
	1999	2004	Change	
Alabama	16,962	17,079	+117	+1%
Alaska	519	496	-23	-4%
Arizona	6,751	8,504	+1,753	+26%
Arkansas	15,045	13,277	-1,768	-12%
California	68,620	70,916	+2,296	+3%
Colorado	10,331	9,613	-718	-7%
Connecticut	20,353	18,226	-2,127	-10%
Delaware	1,977	2,308	+331	+17%
Dist. of Columbia	2,237	2,294	+57	+3%
Florida	44,052	44,317	+265	+1%
Georgia	28,343	27,638	-705	-2%
Hawaii	2,702	2,752	+50	+2%
Idaho	2,846	2,822	-24	-1%
Illinois	54,079	49,129	-4,950	-9%
Indiana	28,247	25,955	-2,292	-8%
Iowa	14,751	13,963	-788	-5%
Kansas	12,368	11,280	-1,088	-9%
Kentucky	17,116	15,353	-1,763	-10%
Louisiana	26,327	23,015	-3,312	-13%
Maine	5,375	4,715	-660	-12%
Maryland	12,016	15,523	+3,507	+29%
Massachusetts	36,196	31,042	-5,154	-14%
Michigan	29,145	27,717	-1,428	-5%
Minnesota	24,721	20,635	-4,086	-17%
Mississippi	13,290	12,726	-564	-4%
Missouri	25,713	23,841	-1,872	-7%
Montana	3,494	3,165	-329	-9%

**Table A4:
Medicaid Nursing Home Residents on a Given Day**

State	Medicaid Nursing Home Residents			
	1999	2004	Change	
Nebraska	8,100	7,274	-826	-10%
Nevada	2,469	2,598	+129	+5%
New Hampshire	4,518	4,833	+315	+7%
New Jersey	27,005	29,175	+2,170	+8%
New Mexico	4,345	4,298	-47	-1%
New York	81,352	82,920	+1,568	+2%
North Carolina	27,250	26,922	-328	-1%
North Dakota	3,504	3,324	-180	-5%
Ohio	54,854	52,490	-2,364	-4%
Oklahoma	14,738	14,057	-681	-5%
Oregon	6,527	5,099	-1,428	-22%
Pennsylvania	54,024	51,843	-2,181	-4%
Rhode Island	6,746	5,081	-1,665	-25%
South Carolina	11,402	11,462	+60	+1%
South Dakota	4,157	3,873	-284	-7%
Tennessee	25,838	22,886	-2,952	-11%
Texas	65,905	61,728	-4,177	-6%
Utah	3,425	3,143	-282	-8%
Vermont	1,956	2,224	+268	+14%
Virginia	18,301	18,119	-182	-1%
Washington	13,791	12,408	-1,383	-10%
West Virginia	7,601	7,185	-416	-5%
Wisconsin	26,359	23,117	-3,242	-12%
Wyoming	1,671	1,501	-170	-10%
United States	999,414	955,861	-43,553	-4%

Federal Grant Initiatives to Improve System Balance

Under the **New Freedom Initiative**, CMS began making a series of grants to states and non-profit agencies to enable them to develop infrastructure and programs to make enduring changes in their long-term care systems to support balancing.

Since 2001, CMS has awarded 334 **Real Choice Systems Change** grants totaling \$270 million to 50 states and the District of Columbia in seven different funding cycles.¹ These grants were designed to enable states and non-profit agencies to build infrastructure to create enduring improvements in community-integrated services and long term services and supports systems. States are using these grants to address: expansions of personal assistance services, transitions from institutions to community living, quality improvement, person-centered planning, consumer-directed services, improving access to long-term services and supports, resources centers and connections to housing.

In 2001, CMS awarded Real Choice Systems Change grants to 23 states. The Real Choice Systems Change grant projects were designed to enable states to implement programs or infrastructure to create enduring systems change. The initial states were: Alabama, Alaska, Delaware, Hawaii, Idaho, Illinois, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, North Carolina, Oregon, South Carolina, Tennessee, Vermont, and Virginia.

Also beginning in 2001, CMS awarded two types of **Nursing Facility Transition** grants. One set of grants went to state programs and the other set went to Independent Living Center Partnerships. The grants were designed to help states and Independent Living Centers establish the infrastructure necessary for transition programs or to established and operate transition programs. The programs would identify Medicaid clients in nursing facilities or other institutions and help them to transition to community living. The initial states were: Alabama, Alaska, Colorado, Connecticut, Georgia, Indiana, Maryland, Massachusetts, Michigan, New Hampshire, Texas, Washington, West Virginia, and Wisconsin.

The following year (2002), CMS awarded fourteen more Nursing Facility Transition grants to states and another 25 Real Choice Systems Change grants.

In 2003, CMS awarded nine grants to develop or support **Money Follows the Person** initiatives. The programs were designed to improve the balance of funding spent on home and community based services. Seven of the states used the funding to develop Money Follows the Person infrastructure. These states were: California, Idaho, Maine, Michigan, Nevada, Pennsylvania and Washington. Two states, Texas and Wisconsin, used their

¹ This total was current as of March, 2008; detailed state information that appears in the Table titled, "Federal Long-Term Care Grants to States" was current as of May 30, 2007 and, therefore, has a somewhat lower total.

funding to strengthen existing MFP programs. Design and implementation of these programs was evaluated with an eye to informing states that might utilize the Money Follows the Person demonstration program authority in the Deficit Reduction Act of 2005.²

Also in 2003, CMS awarded **Community-Integrated Personal Assistance Services and Supports** (C-PASS) grants to eight states. The grants were to assist states to improve personal assistance services that are consumer-directed. Personal assistance services are the most frequently used service that enables individuals with disability or long term illness to live in the community. States are taking a leadership role in providing personal assistance services that affords consumer maximum control over selection and direction of direct service workers. The eight states were: Arizona, Connecticut, Louisiana, Massachusetts, Nebraska, Oregon, Texas and Virginia.

In 2003, CMS awarded **Independence Plus** grants to 12 states to establish and improve self-directed services options for persons of all ages with disabilities and chronic illnesses. These grant projects were evaluated, with the results reported in *Increasing Options for Self-Directed Services, Initiatives of the 2003 Independence Plus Grantees*.³

Beginning in 2003, CMS partnered with the Administration on Aging to begin awarding a series of **Aging & Disability Resource Center** (ADRC) grants.⁴ These centers offer one-stop, single entry access to long-term care services and supports. They include physical locations with staff trained to answer questions about affordable public and private services, and they provide assistance in obtaining these services, assessing people's needs, and determining eligibility for public programs. As of February 2008, more than 140 ADRC pilot sites operated in 43 states and territories (see map Figure B1). States have also set up telephone and web-based systems to provide consumers with easy access to information and assistance. Many of the states also have developed standardized assessment and eligibility tools.

In 2003, CMS awarded grants for **Quality Assurance and Quality Improvement** in home and community-based services to 19 states. They followed with nine other Quality Assurance/Quality Improvement grant awards in 2004. The descriptions of each initiative can be found in *Real Choice Systems Change Grants Compendium, Sixth Edition*.⁵

In 2004, CMS awarded **Mental Health: Systems Transformation Research and Demonstration** grants to 12 states. The grants were to allow states to develop initiatives and infrastructure to improve services to Medicaid eligible individuals with mental illness. The 12 states were: Delaware, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, and Virginia.

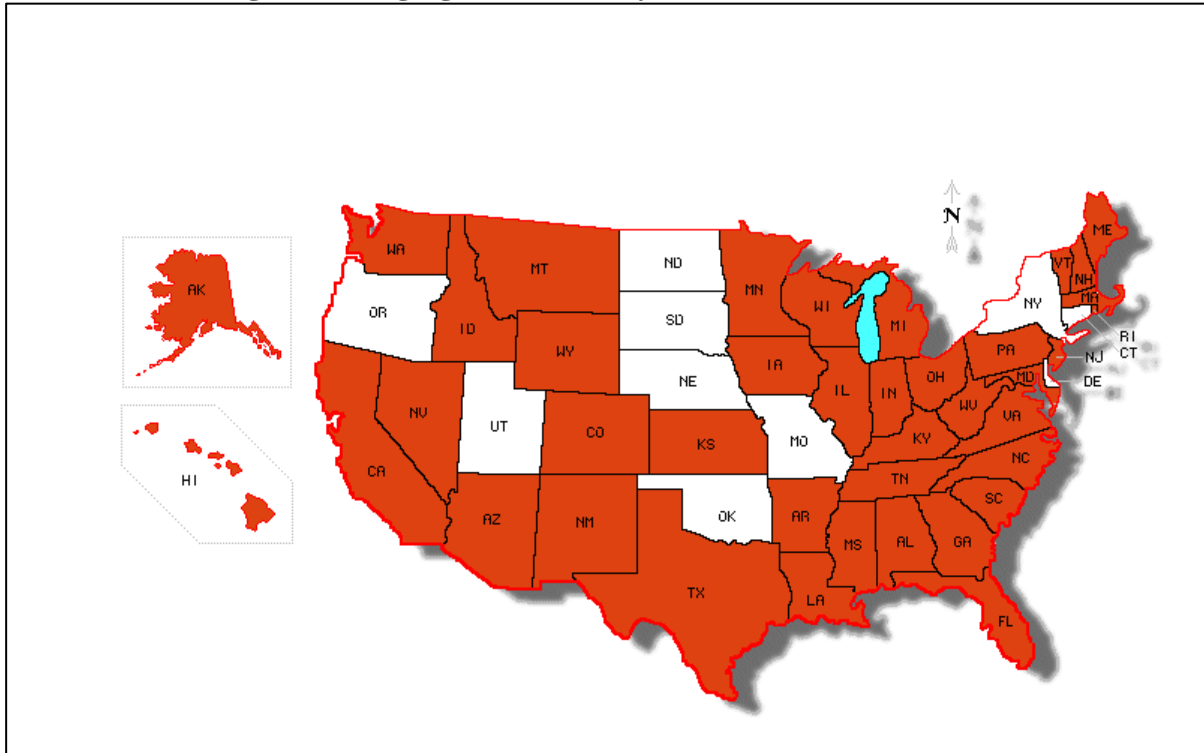
² Wayne Anderson, et al, *Money Follows the Person Initiatives of the Systems Change Grantees*, RTI International, July 2006. www.cms.hhs.gov/RealChoice/

³ Janet O'Keeffe, et al, "Increasing Options for Self-Directed Services, Initiatives of the 2003 Independence Plus Grantees," RTI International, December 2007. www.cms.hhs.gov/RealChoice/

⁴ Specific names vary by state, although CMS and the Administration on Aging call them "Aging and Disability Resource Centers." In California, they are called "CommunityLink Resource Centers," for example, and "Gateway" in Georgia.

⁵ *Real Choice Systems Change Grants Compendium, Sixth Edition. Centers for Medicare and Medicaid Services, March 2007.* www.cms.hhs.gov/RealChoice/

Figure B1: Aging and Disability Resource Center Grants



Source: Administration on Aging. (March 2007). Aging and Disability Resource Centers Fact sheet. Accessed at http://www.aoa.gov/prof/aging_dis/statemap.asp.

CMS also awarded eight grants for **Integrating Long-Term Supports with Affordable Housing** in 2004. The purpose of these grants is to remove barriers that prevent Medicaid-eligible individuals with disabilities of all ages from residing in the community. The grants will assist states to create the infrastructure to increase access to and capacity of affordable and accessible housing. The states were: Arkansas, Mississippi, New Hampshire, North Carolina, Oregon, Pennsylvania, Vermont and the District of Columbia.

Also in 2004, CMS gave grants to seven states for **Rebalancing Initiatives**. The purpose of this initiative is to enable states to develop and implement strategies to reform the financing and services designs of state long-term support systems in order to decrease reliance on institutional care and increase the utilization of community based long term supports. States are encouraged to develop a targeted rebalancing plan to increase access to home and community-based services and transitioning individuals out of institutions. The states are: Illinois, Louisiana, Mississippi, North Carolina, North Dakota, Tennessee, and Virginia. CMS also funded two states for **Comprehensive Systems Reform**. Vermont received \$2 million to design an integrated care system to coordinate both primary/acute and long term care services for elderly and physically disabled adults. Wisconsin received \$5.5 million to address system barriers, develop enhanced tools and apply managed care strategies to expand their Family Care and Partnership managed care programs statewide.

CMS continued their grant making activities in 2005 and 2006. Eighteen (Real Choice Systems Change) **Comprehensive Systems Transformation Grants** were given in 2005 to: Arkansas, Iowa, Louisiana, Maine, Massachusetts, Missouri, New Hampshire, New Mexico, Oregon, and South Carolina. In 2006, eight more grants were given to: California, Virginia, Michigan, North Carolina, New York, New Jersey, Rhode Island, and Kansas. These grants are designed to create better systems of long-term care by breaking down internal barriers to home and community based services and supports by developing infrastructure to create enduring systems transformation.

Most recently, CMS awarded \$13.9 million in Real Choice Systems Change grants in September 2007. Grants were awarded for two different purposes. The grants to 16 states for **Person-Centered Planning Implementation** are designed to change the basic model of care planning from one that is directed by the needs of the institution or agency to one that responds to the needs of the individual. The states are: Alaska, Arkansas, Arizona, Connecticut, Florida, Guam, Idaho, Louisiana, Massachusetts, Missouri, New Hampshire, North Carolina, Tennessee, Washington, Wisconsin, and Virginia. **State Profile Tool** grants are designed to support a comprehensive assessment of a state's long term care system. Standard templates to be completed by grantees will help create a national picture of long-term care service delivery. Grantee states are: Arkansas, Florida, Iowa, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Nevada, and Virginia.

The Administration on Aging (AoA) also awarded grants with its **Nursing Home Diversion Modernization Grants** program in 2007. The program is designed to assist individuals at risk of nursing home placement and spend down to Medicaid to receive home and community based services that enable them to continue to live in the community. The program also encourages the aging services network to transform some of their funding into flexible, consumer-directed service dollars. The programs are administered through State Units on Aging, in partnership with Area Agencies on Aging, to work with community aging services and other long term care service providers. Grant awards were given to twelve states in September 2007.

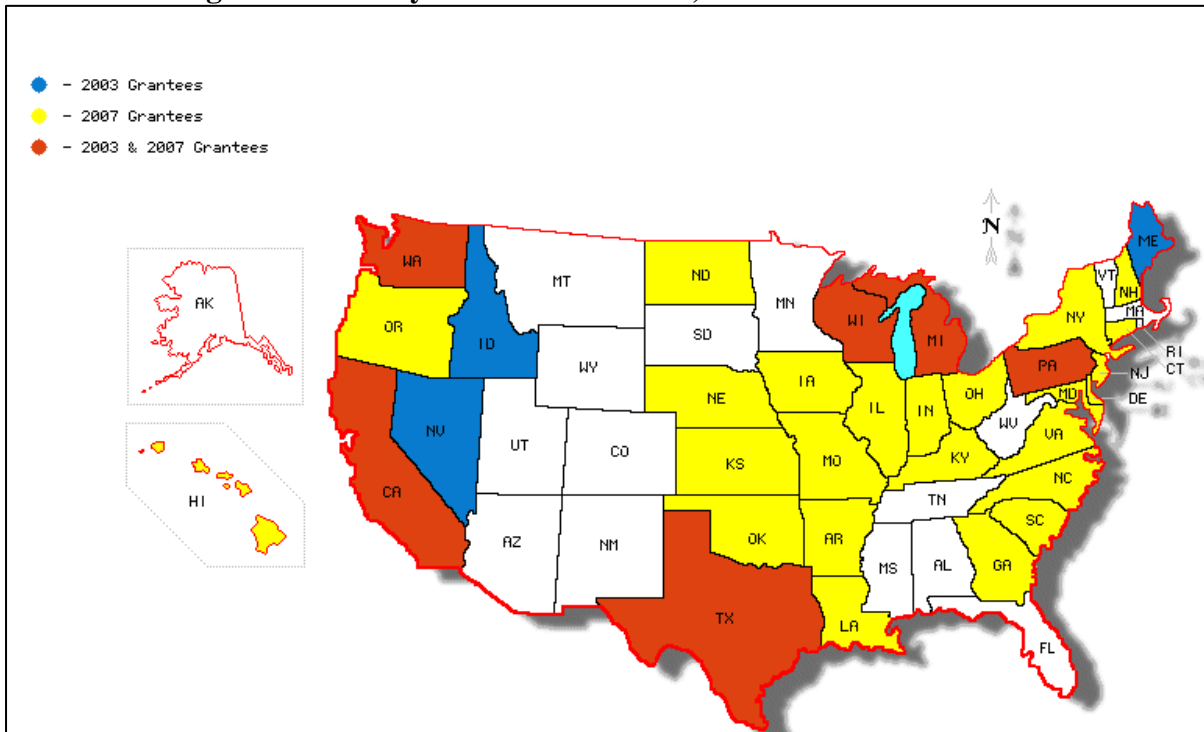
Another AoA grant program, designed to complement the existing Aging & Disability Resource Center program, is the **Medicare Senior Risk Reduction Demonstration**. Three-year demonstration grants were given to agencies in ten states in December 2007. The purpose of these grants is to test whether health promotion and health management programs can be tailored to and work well with Medicare beneficiaries to improve their health and reduce avoidable health care utilization. Five demonstration organizations will work with ten local Area Agencies on Aging, including several Aging and Disability Resource Centers, to link participants with health promotion programs in their communities.

A second wave of **Money Follows the Person** demonstration grants was authorized by the Deficit Reduction Act of 2005 (DRA). Under these grants, states are eligible for an enhanced Medicaid match for HCBS services provided to individuals who transition from an institution to the community. Transitioned individuals must have resided in the nursing home for at least 6 months prior to transition. The enhanced match is for a 12-month period from the date of discharge from the facility. It covers from 75 percent to 90 percent of total

expenditures for HCBS for each person making the transition. States must maintain the services after the demonstration period for as long as the participant continues to qualify for them. States are permitted to allow participants to self direct their services.

As of February 2008, the U.S. Centers for Medicare and Medicaid Services (CMS) had awarded \$1.4 billion in Money Follows the Person (MFP) demonstration grants to 31 states, making it the largest demonstration in the history of Medicaid. In total, the states proposed transitioning 37,731 individuals out of institutional settings to the community over the five years of the grant period. Both the 2003 and 2007 state MFP grantees are displayed on the map in Figure B2, and a detailed description of these state MPF demonstrations follows.

Figure B2: Money Follows the Person, 2003 and 2007 Grantees



Source: Kitchener, M., Micky Willmott, Alice Wong and Charlene Harrington. Federal Systems Change Grants to States and Territories: 2001-2005. CMS-MFP Award Summary Fact sheet, June 1, 2007. Accessed at http://www.cms.hhs.gov/DeficitReductionAct/Downloads/MFP_FactSheet.pdf.

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Money Follows the Person State Summaries

Money Follows the Person (MFP) grants will allow states to further balance their long-term care systems by providing services to individuals who transition from institutions to community settings. In 2003, the U.S. Centers for Medicare and Medicaid Services (CMS) initially awarded, through the Systems Change MFP Initiative, \$6.5 million to nine states: California, Idaho, Maine, Michigan, Nevada, Pennsylvania, Texas, Washington, and Wisconsin.

As result of the Deficit Reduction Act of 2005 (DRA), CMS awarded \$1.4 billion in MFP grants to 31 states, making it the largest demonstration in the history of Medicaid. Approximately 37,731 individuals will either be diverted or transitioned from institutional settings back into the community over the course of this demonstration project. Of the 37,731 individuals who will be transferred, 16,694 are older adults, 7,422 are individuals with mental retardation or developmental disabilities, 10,899 are people with physical disabilities, 2,282 are individuals with a mental illness, and 434 are duals.

Each state's MFP grant initiative is described below.

Arkansas

Arkansas was awarded \$140,000 for the 2007 fiscal year and received a five-year, \$21 million commitment. Through the ARHome waiver and three other existing waivers, qualified nursing home residents will have an opportunity to transition back into the community and direct their own care. The MFP grant will allow Arkansas officials to help transition 305 people (92 of whom are older adults and 146 are individuals with physical disabilities) who prefer to live in a home-based setting from an institution. State officials will also provide the following services to help sustain each transferred person for one year: telemedicine, a 24-hour helpline, intensive transition assistance, and a personal attendant to help the individual navigate through the state's medical transportation system.

California

California was awarded \$750,000 in 2003 through the Systems Change MFP Grant Initiatives. State officials used the grant to create a preference assessment instrument to identify the needs of potential residents who may wish to transition from a nursing facility back into the community. The state also used funds to assess the possibility of transitioning 220 consumers in eight nursing facilities to HCBS programs. In June 2007, California was awarded \$90,000 for the 2007 fiscal year and received a five-year, \$130 million commitment. Creation of the California Community Transition demonstration will allow state officials to create consumer-directed home and community-based programs for individuals receiving

institutionalized care. Local communities will have an opportunity to develop transition models and manage community transition teams that will specifically address local long-term care needs and assist with the transition process. Approximately 2,000 residents who prefer to live in a home-based setting (400 of whom are older adults and 899 are individuals with physical disabilities) will receive assistance in making this transition.

Connecticut

Connecticut was awarded \$1.3 million for the 2007 fiscal year, as well as a five-year, \$24 million commitment, to enhance current home and community-based programs and address any service gaps that may exist in the long-term care system. State officials will also expand home and community-based options to include individuals who would like to receive LTC services in a community setting. The MFP grant will allow state officials to enhance their current quality management system by implementing a consumer satisfaction survey to track the quality of care people are receiving through this demonstration project. Over the course of five years, 700 people who prefer to live in a home-based setting (280 of whom are older adults and 140 are individuals with physical disabilities) will receive assistance in making this transition.

Delaware

Delaware was awarded \$133,000 for the 2007 fiscal year and received a five-year, \$5.4 million commitment. Through the *Finding a Way Home* demonstration project, the grant will consolidate existing transition projects and narrow any community-service gaps that may exist. It will also allow the state to expand consumer-directed care by empowering individuals to purchase and manage their own care. In addition, state officials will create a number of budgetary/financial strategies to reduce intergovernmental barriers. Such an approach will establish a global budget and create a seamless system where funds will be able to move between agencies and actually follow the person. Approximately 100 people who prefer to live in a home-based setting (32 of whom are older adults and 28 are individuals with physical disabilities) will receive assistance in making this transition.

District of Columbia

The District of Columbia was awarded \$2.5 million for the 2007 fiscal year, along with a five-year, \$26 million commitment, to increase the District's LTC infrastructure by expanding home and community-based options and consumer choice. It will also increase the District's ability to promote a consumer-centered approach to LTC. Approximately 1,110 people who prefer to live in a home-based setting (215 of whom are older adults and 645 are individuals with physical disabilities) will receive assistance in making this transition. Officials also hope to improve the overall management of the District's LTC system while increasing the awareness of alternative choices in such care.

Georgia

Georgia was awarded \$480,000 for the 2007 fiscal year, as well as a five-year, \$34 million commitment, to address housing, employment, and transportation issues with a focus on self-direction, quality management, and the enhancement of the LTC system. To reduce complexity and confusion, transition coordinators and peer counselors will assist consumers with the various LTC services. As a result of MFP funding, 1,347 people who prefer to live in a home-based setting (375 of whom are older adults and 375 are individuals with physical disabilities) will receive assistance in making this transition.

Hawaii

Hawaii was awarded \$231,000 for the 2007 fiscal year in addition to a five-year, \$10 million commitment. Through the demonstration project, titled *Building a Home around the Individual*, the MFP grant will assist individuals who are currently institutionalized but desire to return to their communities. Funds will also be allocated to assist individuals with disabilities locate affordable and accessible housing and to expand the number of community home providers, develop training programs, provide support services, and create a measuring tool to accurately capture the cost savings associated with sustaining an individual in the community. Approximately 415 people who prefer to live in a home-based setting (115 of whom are older adults and 242 are individuals with physical disabilities) will receive assistance in making this transition.

Idaho

Idaho was awarded \$750,000 in 2003 through the Systems Change MFP Grant Initiatives. State officials used the grant to support current diversion activities within the state, created an antistigma marketing campaign, examined the feasibility and practicality of increasing home and community services, and developed a community-based effectiveness study to assess the living standards of 15 to 45 individuals who returned to the community.

Illinois

Illinois was awarded \$6.9 million for the 2007 fiscal year, as well as a five-year, \$56 million commitment, to help support the transition efforts of 3,357 individuals who prefer to live in a home-based setting (1,517 of whom are older adults and 1,000 are individuals with physical disabilities). State officials will also use MFP resources to examine right-sizing and conversion strategies of nursing homes, increase HCBS, and evaluate states policies that hinder community integration. MFP funds will also go toward creating a comprehensive housing strategy to make affordable housing more accessible.

Indiana

Indiana was awarded \$860,000 for the 2007 fiscal year, along with a five-year, \$21 million commitment, to increase and expand transition efforts, develop a transition training

curriculum to standardize the transition process, and create counseling materials and procedures to foster consumer choice and integration of LTC services. State officials will also use MFP funds to support a full-time program director who will participate in system change activities and help coordinate transition efforts. These funds will provide 1,039 people who prefer to live in a home-based setting (768 of whom are older adults and 200 are individuals with physical disabilities) with assistance in making this transition.

Iowa

Iowa was awarded \$308,000 for the 2007 fiscal year and a five-year, \$51 million commitment to support Iowa's Real Choice Systems Transformation initiatives by providing more opportunities for individuals to receive LTC services. State officials will also use the MFP grant to expand affordable and accessible housing options by partnering with the Iowa Finance Authority to promote the Housing Registry and the HCBS Rent Subsidy program. In addition, the grant will strengthen the HCBS system by providing more consumer-directed services. Approximately 528 people with mental retardation or developmental disabilities (MR/DD) who prefer to live in a home-based setting will receive assistance in making this transition. Transition service coordinators will also support and guide consumers who desire to transition from an institution.

Kansas

Kansas was awarded \$102,000 for the 2007 fiscal year, along with a five-year, \$37 million commitment. The MFP grant will be used as an incentive to close 191 of 267 private ICF/MR-licensed beds in the state. Through the state's *Community Choice* demonstration grant, resources will provide 934 people who prefer to live in a home-based setting (242 of whom are older adults and 406 are individuals with physical disabilities) assistance in making this transition. State officials expect to save \$12 million in LTC cost by providing the same number of people with HCBS rather than institutional care.

Kentucky

Kentucky was awarded \$5 million for the 2007 fiscal year, as well as a five-year, \$50 million commitment to help transition 431 people who prefer to live in a home-based setting (108 of whom are older adults and 107 are individuals with physical disabilities) from an institution. MFP resources will also go toward collaboration with stakeholders in the public, private, and nonprofit sectors to design a comprehensive transition process that reduces consumers' burden while providing them with more home and community-based options.

Louisiana

Louisiana was awarded \$524,000 for the 2007 fiscal year and received a five-year, \$31 million commitment to develop strategies that address resistance toward rebalancing the LTC system. Funds will also be used to bridge service gaps in the accessibility of HCBS while strengthening the infrastructure within local communities. Approximately 760 people who

prefer to live in a home-based setting (364 of whom are older adults and 76 are individuals with physical disabilities) will receive assistance in making this transition.

Maine

Maine was awarded \$750,000 in 2003 through the Systems Change MFP Grant Initiatives. State officials used the grant to create new Medicaid rates for consumers receiving HCBS. This system will allow state officials to create budgets based on individual needs for services rather than the reimbursement needs of the provider.

Maryland

Maryland was awarded \$1 million for the 2007 fiscal year and a five-year, \$67 million commitment to help transition 3,091 people who prefer to live in a home-based setting (1,617 of whom are older adults and 1,149 are individuals with physical disabilities) from an institution. The state will create transitional teams to visit various facilities throughout the state and identify individuals who desire to return to their respective communities. Funds will be used to provide transition services, create an outreach strategy that will increase awareness of home and community-based options, and, among many other services, provide assistance with affordable and accessible housing options.

Michigan

Michigan was awarded \$750,000 in 2003 through the Systems Change MFP Grant Initiatives, which state officials used to create a single point of entry and managed care plan pilot program to divert consumers from institutionalized LTC facilities to HCBS. Funds were also used to divert more individuals on the Michigan Choice waiver and provide rental and housing assistance to LTC consumers. In 2007, Michigan was also awarded \$2 million for the 2007 fiscal year, along with a five-year, \$68 million commitment, to complement current reform efforts in Michigan's LTC system by developing a standardized protocol for transferring residents. MFP resources will also go toward assisting individuals with housing options. Approximately, 2,500 people who prefer to live in a home-based setting (1,500 of whom are older adults and 1,000 are individuals with physical disabilities) will receive assistance in making this transition.

Missouri

Missouri was awarded \$3.4 million for the 2007 fiscal year, and a five-year, \$18 million commitment to transition at least 250 people who prefer to live in a home-based setting (50 of whom are older adults and 50 are individuals with physical disabilities) from an institution. Resources will also be use to improve access to LTC services by expanding HCBS to consumers. State officials also plan to use these funds to collaborate with other agencies to integrate the state's transformation efforts while enhancing quality management systems with a consumer-oriented model.

Nebraska

Nebraska was awarded \$203,000 for the 2007 fiscal year and a five-year, \$28 million commitment, to transfer 900 individuals who prefer to live in a home-based setting (400 of whom are older adults and 300 are individuals with physical disabilities) from an institution. The state will also use MFP resources to increase HCBS, invest in remote technology, and design a “rural solution” program to address the needs of individuals who want to live in rural or frontier communities. The state also plans to develop a “no wrong door” portal to respond to the immediate needs of the elderly and/or individuals with disabilities.

Nevada

Nevada was awarded \$750,000 in 2003 through the Systems Change MFP Grant Initiatives, which state officials used to create a global budget to ensure that programs, policies, and the financing structure for LTC were not hindering the transition efforts of individuals who desire to live in the community. Funds were used to increase home and community-based programs and access to affordable housing. In addition, MFP funds went to support the transition efforts of 160 persons back into the community.

New Hampshire

New Hampshire was awarded \$298,000 for the 2007 fiscal year, as well as a five-year, \$11 million commitment, to expand a transition model statewide. State officials will also use these funds to hire four outreach coordinators, who will be responsible for assisting individuals throughout the transition program. As a result of the MFP grant, 370 individuals who prefer to live in a home-based setting (325 of whom are older adults and 45 are individuals with physical disabilities) will receive assistance in making this transition.

New Jersey

New Jersey was awarded \$230,000 for the 2007 fiscal year, along with a five-year, \$30 million commitment. Through the MFP grant, New Jersey and its partners will pilot a coordination model to enhance consumer awareness and self-direction. Funds will also be used to expand transition services by increasing the accessibility of LTC services among all cultural and disability groups and assisting individuals with housing issues. Approximately 590 individuals who prefer to live in a home-based setting (174 of whom are older adults and 87 are individuals with physical disabilities) will receive assistance in making this transition.

New York

New York was awarded \$193,000 dollars for the 2007 fiscal year and a five-year, \$83 million commitment, to enhance HCBS while reducing the institutional bias toward Medicaid. MFP resources will be allocated for pre-implementation activities such as examining the barriers that may hinder the transition of individuals from institutions back into the community. State officials will also evaluate the practicality and feasibility of

various solutions for reducing the state's reliance on institutional care. Approximately 2,800 individuals who prefer to live in a home-based setting (1,190 of whom are older adults and 1,190 are individuals with physical disabilities) will receive assistance in making this transition.

North Carolina

North Carolina was awarded \$16,000 for the 2007 fiscal year, along with a five-year, \$17 million commitment, to expand the state's current home and community-based waiver, develop statewide optional services, and help transition 552 individuals (22 of whom are older adults and 202 are individuals with physical disabilities) who prefer to live in a home-based setting. State officials also plan to create regional case management teams to provide individuals with information regarding the state's LTC system.

North Dakota

North Dakota was awarded \$18,000 for the 2007 fiscal year and a five-year, \$9 million commitment, to create a statewide transition program and the mechanism for identifying individuals who desire to return to the community. To support transition efforts, MFP funds will also be used to coordinate support services within the community and increase the accessibility and affordability of housing options. Approximately 110 people who prefer to live in a home-based setting (46 of whom are older adults and 34 are individuals with physical disabilities) will receive assistance in making this transition.

Ohio

Ohio was awarded \$2 million for the 2007 fiscal year and a five-year, \$101 million commitment to implement the MFP program statewide and expand current HCBS. MFP resources will also be allocated to examining the pre-admission process for institutional care. In addition, state officials plan to enhance the transition process from institutions to the community by providing supplemental demonstration services, such as independent living skills, peer support, and benefit coordination. Approximately 2,231 individuals who prefer to live in a home-based setting (1,428 of whom are older adults and 158 are individuals with physical disabilities) will receive assistance in making this transition.

Oklahoma

Oklahoma was awarded \$3.5 million for the 2007 fiscal year, and a five-year, \$42 million commitment, to enhance the LTC integrated system and expand HCBS by strengthening relationships between agencies and community providers. Such an approach will ensure that consumers receive accurate information and coordinated services. Approximately 2,100 individuals who prefer to live in a home-based setting (1,575 of whom are older adults and 300 are individuals with physical disabilities) will receive assistance in making this transition.

Oregon

Oregon was awarded \$82,000 for the 2007 fiscal year and received a five-year, \$115 million commitment, which state officials will use to expand current HCBS by providing comprehensive LTC services. Approximately 780 people who prefer to live in a home-based setting (300 of whom are older adults and 301 are individuals with physical disabilities) will receive assistance in making this transition.

Pennsylvania

Pennsylvania was initially awarded \$698,000 in 2003 through the Systems Change MFP Grant Initiatives, which state officials used to pilot three MFP programs that covered the state's urban, suburban, and rural areas. Funds were also used to reduce utilization rates in nursing facilities and decrease the number of nursing facility beds and facilities in the state. In 2007, Pennsylvania was awarded \$130,609 for the 2007 fiscal year, and a five-year, \$98 million commitment to enhance the state's rebalancing goals by hiring a MFP director who will lead and coordinate demonstration objectives. Funds will also be used to hire a statewide housing coordinator who will develop a housing strategy and hire additional housing coordinators who will assist state and local staff identify housing resources for individuals who are transitioning back into the community. Housing coordinators will also provide training and technical assistance to transition consultants, and funds will be used to strengthen community infrastructures and invest in right-sizing activities. Approximately 2,600 individuals who prefer to live in a home-based setting (1,400 of whom are older adults and 600 are individuals with physical disabilities) will receive assistance in making this transition.

South Carolina

South Carolina was awarded \$35,000 for the 2007 fiscal year and a five-year, \$5.8 million commitment, to create adult foster care services and a transition nursing service. Resources will also be used to create the adaptive device demonstration service, which will ensure a smoother transition into a community setting. Approximately 192 individuals who prefer to live in a home-based setting (152 of whom are older adults and 40 are individuals with physical disabilities) will receive assistance in making this transition.

Texas

Texas was initially awarded \$730,000 in 2003 through the Systems Change MFP Grant Initiatives to support transition efforts and address barriers to HCBS. Funds were also used to train various stakeholders regarding home and community options within the state. In 2007, Texas was awarded \$143,000 dollars for the 2007 fiscal year and received a five-year, \$143 million commitment to enhance the state's current MFP initiatives by improving HCBS and increasing awareness of LTC options. Resources will also be used to transition residents out of community-operated intermediate care facilities. In particular, the state will transition individuals out of a 14-plus-bed community and close a nine-plus-bed community. The state

will help transition 2,616 individuals who prefer to live in a home-based setting (780 of whom are older adults and 420 are individuals with physical disabilities) from institutions and back into the community.

Virginia

Virginia was awarded \$14,000 for the 2007 fiscal year and a five-year, \$29 million commitment, to rebalance the state's LTC system by providing individuals with more choices regarding living arrangements and LTC services. The state will also develop a home modification assistance program while enhancing HCBS. Funds will be used as well to help transition 1,041 individuals who prefer to live in a home-based setting (325 of whom are older adults and 358 are individuals with physical disabilities) from institutions.

Washington

Washington was initially awarded \$608,000 in 2003 through the Systems Change MFP Grant Initiatives, which state officials used to assess individuals in LTC facilities who desire to return to the community. Funds were also used to analyze the differences in the needs of consumers on a waiting list and those receiving services. In June 2007, Washington was awarded \$108,500 for the 2007 fiscal year and a five-year, \$20 million commitment to enhance transition efforts by identifying individuals who want to live in the community. Resources will also be used to create a transition supports program that will assist these individuals throughout the transition process. The state plans to develop an educational outreach and resource development strategy to ensure that individuals are receiving appropriate information to direct their own care. Approximately 660 individuals who prefer to live in a home-based setting (348 of whom are older adults and 172 are individuals with physical disabilities) will receive assistance in making this transition.

Wisconsin

Wisconsin was initially awarded \$744,000 in 2003 through the Systems Change MFP Grant Initiatives, which state officials used to transition individuals from nursing facilities back into the community. Funds were also used to downsize the number of nursing facility beds and track LTC expenditures on individual level. In June 2007, Wisconsin was awarded \$8 million for the 2007 fiscal year, along with a five-year, \$56 million commitment to expand availability of HCBS to more individuals. Funds will also go toward assisting with the creation of a comprehensive managed LTC system, which is intended to reduce the complexity and confusion of ascertaining whether consumers receive LTC services. Approximately 1,322 individuals who prefer to live in a home-based setting (554 of whom are older adults and 229 are individuals with physical disabilities) will receive assistance in making this transition.

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State Long-Term Care Initiatives and Innovations Overview

LTC Partnership Program

The original long-term care insurance (LTCI) partnership program was developed in four states in the 1980s. Its purpose was to encourage people who might otherwise turn to Medicaid to finance their long-term care (LTC) to instead purchase LTCI. The Deficit Reduction Act of 2005 expanded the ability of *all* states to develop these programs. People who purchase qualified policies will be allowed special asset protection, should they subsequently become eligible for Medicaid. Under the new partnership programs, purchasers may receive “dollar-for-dollar” asset protection. This means, for example, a purchaser who used \$75,000 of LTCI would be allowed to disregard \$75,000 of assets when applying for Medicaid. If the purchaser meets all other Medicaid eligibility criteria, the excluded assets will not be considered during eligibility determination or subsequent estate recovery. States must have an approved Medicaid State Plan amendment to implement partnership programs. Qualified LTCI policies must meet specified inflation and consumer protection guidelines.

Own Your Future

The Own Your Future long-term care campaign is a federal- state initiative created to raise public awareness about the importance of planning for LTC as one grows older. The primary activity of the campaign is a mailing to all households in the state with members age 45 to 70 informing them about available resources and information. Consumers may request a free LTC Planning Kit with practical steps on how to plan for future LTC needs.

Aging and Disability Resource Centers (ADRC)

The Aging and Disability Resource Center (ADRC) program was created to help states reduce the complexity and fragmentation of their LTC delivery systems. The ADRC model creates a single-point of entry or “one-stop shop” at the community level. Through state and local partnerships, ADRCs help individuals navigate the LTC system by providing them with information and resources. The ADRCs are designed to empower consumers to make better and more informed decisions about their LTC needs and exercise their service delivery preferences.

Cash and Counseling

The Cash and Counseling program was created to allow people receiving Medicaid home and community-based services (HCBS) greater choice and control over service delivery. Participants can manage their individual service budgets, choose the services that best meet their needs, determine when services are provided, and select who delivers those services.

Service budgets also may be used to purchase items or services that enhance independence, such as home modifications. The Cash and Counseling program was piloted in 3 states, and recently was expanded to 12 additional states. It is sponsored by the Robert Wood Johnson Foundation, the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services (ASPE/DHHS), and the Administration on Aging (AoA).

Independence Plus

The Independence Plus program was created in 2002 to assist states in their efforts to provide person-centered planning and consumer directed services. In particular, this initiative provides states with model waiver and demonstration application templates as a means of simplifying the process by which states can apply for and receive approval of programs that promote self-direction, control and consumer choice.

Program of All Inclusive Care for the Elderly (PACE)

The Program of All Inclusive Care for the Elderly (PACE) was initially developed as a demonstration pilot modeled after the On Lok Senior Health Services in San Francisco, California in the mid-1980s. The Balanced Budget Act of 1997 (BBA) provided permanent authority for the PACE program to provide a capitated benefit within a comprehensive service delivery system that integrated Medicare and Medicaid financing.

PACE provides preventive, primary, acute and long-term care services to adults age 55 and older. The PACE program has demonstrated reduced use of nursing home services among participants, many of whom receive adult day health services.

**Table B1:
Federal Long-Term Care Grants to States**

State/Territory	Money Follows the Person (MFP) Awards			System Change Grants
	FY 2003 Award	FY 2007 Award	5-Yr Demo. Award	
Alabama				\$4,170,000
Alaska				\$4,503,000
American Samoa				\$50,000
Arizona				\$2,000,000
Arkansas		\$139,519	\$20,923,775	\$8,058,000
California	\$750,000	\$90,000	\$130,387,500	\$6,872,000
Colorado				\$4,486,000
Connecticut		\$1,313,823	\$24,207,383	\$3,669,000
Delaware		\$132,537	\$5,372,007	\$2,739,000
Dist. of Columbia		\$2,546,569	\$26,377,620	\$4,101,000
Florida				\$3,872,000
Guam				\$1,823,000
Georgia		\$480,193	\$34,091,671	\$4,169,000
Hawaii		\$231,250	\$10,263,736	\$2,925,000
Idaho	\$750,000			\$3,366,000
Illinois		\$6,879,166	\$55,703,078	\$2,050,000
Indiana		\$860,514	\$21,047,402	\$4,359,000
Iowa		\$307,933	\$50,965,815	\$4,521,000
Kansas		\$102,483	\$36,787,453	\$5,159,000
Kentucky		\$4,973,118	\$49,831,580	\$3,000,000
Louisiana		\$524,000	\$30,963,664	\$6,896,000
Maine	\$750,000			\$7,372,000
Maryland		\$1,000,000	\$67,155,856	\$3,459,000
Massachusetts				\$7,624,000
Michigan	\$750,000	\$2,034,732	\$67,834,348	\$8,558,000
Minnesota				\$4,792,000
Mississippi				\$3,287,000
Missouri		\$3,398,225	\$17,692,006	\$6,048,000
Montana				\$3,306,000

**Table B1:
Federal Long-Term Care Grants to States**

State/Territory	Money Follows the Person (MFP) Awards			System Change Grants
	FY 2003 Award	FY 2007 Award	5-Yr Demo. Award	
Nebraska		\$202,500	\$27,538,984	\$4,220,000
Nevada	\$750,000			\$3,741,000
New Hampshire		\$297,671	\$11,406,499	\$8,425,000
New Jersey		\$230,000	\$30,300,000	\$6,380,000
New Mexico				\$5,120,000
New York		\$192,981	\$82,636,864	\$5,019,000
North Carolina		\$16,055	\$16,897,391	\$8,062,000
North Dakota		\$18,089	\$8,945,209	\$1,400,000
Northern Marianas				
Ohio		\$2,079,488	\$100,645,125	\$4,159,000
Oklahoma		\$3,526,428	\$41,805,358	\$2,585,000
Oregon		\$80,785	\$114,727,864	\$6,927,000
Pennsylvania	\$698,000	\$130,609	\$98,196,439	\$4,230,000
Puerto Rico				\$50,000
Rhode Island				\$5,515,000
South Carolina		\$34,789	\$5,768,496	\$7,011,000
South Dakota				\$200,000
Tennessee				\$4,088,000
Texas	\$730,000	\$143,401	\$142,700,353	\$4,630,000
Utah				\$1,985,000
Vermont				\$8,558,000
Virgin Islands				
Virginia		\$13,793	\$28,626,136	\$3,471,000
Washington	\$608,000	\$108,500	\$19,626,869	\$3,778,000
West Virginia				\$3,664,000
Wisconsin	\$744,000	\$8,020,388	\$56,282,998	\$10,472,000
Wyoming				\$1,450,000
United States	\$6,530,000	\$40,109,539	\$1,435,709,479	\$242,374,000

Table B2:
State Long-Term Care Initiatives and Innovations

State/Territory	LTCI Partnership Program	Own Your Future	Aging and Disability Resource Centers	Cash and Counseling	Independence Plus	PACE
Alabama			X	X		
Alaska			X			
American Samoa						
Arizona			X			
Arkansas	In Progress	X	X	X		
California	Original State		X		X	X
Colorado	Approved State Plan		X			X
Connecticut	Original State				X	
Delaware					X	
Dist. of Columbia			X			
Florida	Approved State Plan		X	X	X	X
Guam			X			
Georgia	Approved State Plan	X	X			
Hawaii			X			
Idaho	Approved State Plan	X	X			
Illinois	In Progress		X	X		X
Indiana	Original State		X			
Iowa	Approved State Plan		X	X		
Kansas	Approved State Plan	X	X			X
Kentucky	In Progress		X	X		
Louisiana			X		X	X
Maine	In Progress		X			
Maryland	In Progress	X	X		X	X
Massachusetts	In Progress		X			X
Michigan	In Progress	X	X	X		X
Minnesota	Approved State Plan		X	X		
Mississippi			X			
Missouri	Approved State Plan	X				X
Montana	In Progress		X			

**Table B2:
State Long-Term Care Initiatives and Innovations**

State/Territory	LTC Partnership Program	Own Your Future	Aging and Disability Resource Centers	Cash and Counseling	Independence Plus	PACE
Nebraska	Approved State Plan	X				
Nevada	Approved State Plan	X	X			
New Hampshire	In Progress		X		X	
New Jersey	In Progress	X	X	X	X	
New Mexico			X	X		X
New York	Original State					X
North Carolina			X		X	X
North Dakota	Approved State Plan					
Northern Marianas			X			
Ohio	Approved State Plan		X			X
Oklahoma	In Progress					
Oregon	Approved State Plan					X
Pennsylvania	Approved State Plan		X	X		X
Puerto Rico						
Rhode Island	In Progress	X	X	X		X
South Carolina			X		X	X
South Dakota	Approved State Plan	X				
Tennessee	In Progress	X	X			X
Texas	In Progress	X	X			X
Utah						
Vermont	In Progress		X	X		X
Virgin Islands						
Virginia	Approved State Plan	X	X			X
Washington		X	X	X		X
West Virginia			X	X		
Wisconsin	In Progress		X			X
Wyoming			X			
United States	36 states	16 states	43 states	15 states	10 states	24 states

About the Data: Methodology & References

The authors collected data from a wide variety of sources: state and federal websites, state legislative and agency reports, interviews with key state officials and stakeholders, Medicaid long-term care expenditures collected by Brian Burwell and his colleagues at Thomson Reuters, and caseload information from Charlene Harrington and her colleagues at the University of California, San Francisco. We convened a national advisory committee comprising the following individuals: Lisa Alexih of the Lewin Group; Brian Burwell of Thomson Reuters; Donna Folkemer of the National Conference of State Legislatures; Charlene Harrington of the University of California, San Francisco; Robert Mollica of the National Academy for State Health Policy; and Charley Reed of the AARP Board of Directors. In addition, staff from state AARP offices and the following AARP national office staff provided valuable advice and helpful comments: Elaine Ryan, JoAnn Lamphere, Ilene Henshaw, and Rhonda Richards from Government Relations and Advocacy; Kieun Oh from the Office of Social Impact; Ellen O'Brien from the Public Policy Institute; and Kathy Tefft-Keller from State Operations.

No single, consistent source of data provides the information required for this analysis. In addition, methodological issues and concerns need to be addressed for every source used in this report. We have attempted to explain these concerns and address why we made the decisions we did in this analysis. Although there are no perfect solutions to some of the methodological issues, we believe that, by presenting a series of data points, we are able to convey a reasonably accurate picture of the status of Medicaid long-term care balancing in the states and in the nation as a whole.

Methodology

Each state profile includes data on Medicaid expenditures and participants for the most recent five-year period for which such data are available. For expenditures, this period is 2001 to 2006; for participants, this period is 1999 to 2004. Because of the two-year difference in these periods, as well as changes in expenditures per beneficiary, the expenditure and participant trends may diverge. The authors do not recommend constructing per beneficiary expenditures from these data because of the difference in data years, and because they use different data sources for spending and participants. In particular, states may decrease or hold constant the number of nursing home residents but still increase spending on nursing homes for a variety of reasons, including requirements that capital costs be spread over fewer residents, health care cost inflation, provider taxes, and other factors.

This analysis separates Medicaid participation and spending data for older people and adults with physical disabilities from the population with mental retardation/development disabilities (MR/DD) and other long-term care populations. The number of Medicaid

participants receiving home and community-based services (HCBS) who are classified as “older people and adults with physical disabilities” includes all enrollees in 1915(c) waiver programs for older people and adults with physical disabilities (sometimes referred to as “aged and disabled” waivers), as well as all participants in the personal care services (PCS) option, if offered under that state’s Medicaid plan. While it is possible to separate waiver services by population, adequate data were not available to do so for PCS participants or spending. Therefore, *all* participants and spending for PCS are included in the category “older people and adults with physical disabilities.”

It is likely that the majority of participants in and spending for PCS is for older people and adults with physical disabilities. For example, an analysis of 2005 Medicaid Statistical Information System (MSIS) data reveals that 57 percent of PCS spending was for people age 65 and older (who comprised 54 percent of participants), with an additional 22 percent for people ages 45 to 64 (who comprised 23 percent of participants). See Table C1 for details. Some of these individuals may have MR/DD; however, people under age 21 represented only 5 percent of PCS participants and accounted for only 5 percent of spending.

Table C1: Personal Care Participants and Expenditures, by Age of Participant, 2005

Age	% of PCS Participants	% of PCS Expenditures
0–20	5%	5%
21–44	12%	13%
45–64	23%	22%
65+	54%	57%
Unknown	6%	3%

Source: Burwell, B. and Sredl, K., Thomson Reuters. Analysis of 2005 Medicaid Statistical Information System (MSIS) data. E-mail communication to Jean Accius, May 5, 2008.

All beneficiaries receiving nursing home services are included as older people and adults with physical disabilities, regardless of the type of disability or reason for admission. The counts exclude residents in intermediate care facilities for mental retardation (ICF/MR), recipients of HCBS waiver services for other populations such as MR/DD, and individuals receiving services through managed care programs that provide long-term care services.

As with participants, expenditures for HCBS include all waiver services for older people and adults with physical disabilities and the PCS program. Nursing homes include all expenditures for nursing home services, regardless of type of disability or reason for admission. Excluded are expenditures for ICF/MR, HCBS waivers for other populations such as MR/DD, and individuals receiving services through managed care programs that provide long-term care services.

A special caveat must be mentioned regarding the exclusion of home health spending and participation. A large proportion of home health services are provided to persons recovering from acute incidents (postacute services) who do not receive long-term care. In most states, this is not a major issue for expenditures, as home health expenditures are generally much lower than PCS or waivers. But there is a substantial impact on the number of participants. After consultation with our national advisory committee, the authors decided to exclude participants and spending for Medicaid home health, since home health programs in many states provide primarily or entirely postacute care, not long-term care, and it is impossible to distinguish the spending and participants receiving postacute care from those receiving longer-term services. Postacute services provided under Medicaid home health can contribute to better chronic care management and may prevent the need for institutional services. However, on balance, the authors decided that the characterization of state balancing is better served by excluding home health participants and spending from this analysis. In particular, including home health participants would overstate the number of long-term care participants in many states and misstate the change in the number of Medicaid long-term care beneficiaries from 1999 to 2004 in others. Because the data used in this report exclude Medicaid home health and separate the population of older people and adults with physical disabilities from other long-term care populations, they differ from those reported elsewhere.

It is important to recognize that the HCBS participant data include some degree of duplication. There is no way to determine accurately how many individuals receive services from more than one Medicaid HCBS program. For example, an individual may receive services from both the PCS program and an HCBS waiver. In addition, many short-term nursing home users receive postacute care, not long-term care (LTC). Thus, the comparison to HCBS participants is not perfectly parallel, because of the exclusion of home health, much of which comprises postacute services. *The effect of these data features, and the inclusion of all PCS participants, may be to slightly overstate or understate the extent of balancing that states have achieved for older people and adults with physical disabilities.*

It is also important to note that the data in this report do not include all state-administered programs that provide LTC. For example, consistent with other national analyses, the data in this report do not include Medicaid spending for adult day care or case management when they are provided as part of a state's Medicaid state plan. Also, because the report includes only Medicaid spending and participants, it does not include state efforts to provide HCBS to older people and adults with physical disabilities through general revenue funds. Some of the state profiles note these programs when they play a major role in providing HCBS. However, it was beyond the scope of this report to provide a comprehensive review of all state-funded HCBS programs.

Expenditures

Data come from Brian Burwell, Kate Sredl, and Steve Eiken, *Medicaid Long Term Care Expenditures FY 2006*. Thomson Reuters, 2007. Data are based on Centers for Medicare & Medicaid Services (CMS) 64 reports and include total spending by both the state and

federal government. Expenditures are grouped by date of payment, not date of service. Thus, year-to-year changes may reflect changes in state payment policies as well as real changes in service utilization. In addition, CMS 64 reports represent claims to the federal government for matching funds; some claims may be disallowed, which are then adjusted on future CMS 64 reports, but the adjustments are not reported by type of service.

HCBS expenditures include all expenditures for personal care services; 1915(c) waiver services designated as aged, aged/disabled, or physically disabled; and some additional services in six states (Arkansas, Colorado, Florida, New Jersey, Oregon, and Texas). These amounts were calculated as the sum of the values in tables C, I, J, and T of the report. The authors included all expenditures reported for these services, regardless of the type of disability or reason for eligibility for Medicaid, as the data do not permit parsing by population. Excluded from the total are HCBS waiver services for other LTC populations (such as waivers for HIV/AIDS or traumatic brain injury) and all expenditures for HCBS under managed care programs.

Nursing home expenditures include all fee-for-service spending, as reported in Table A of the report. Data for several states include expenditures for Medicaid Upper Payment Limit programs. The authors excluded expenditures for ICF/MR and expenditures for institutional long-term care services under managed care programs.

Expenditure data for most states were calculated using the above methodology for FY 2001 and FY 2006. However, there were some exceptions:

- **Arizona.** Essentially all of Arizona's Medicaid LTC is provided through a managed care program. Comparable expenditure data could not be obtained.
- **Michigan.** Data for Michigan's aged/disabled waiver were not available for 2001, so 2002 waiver spending was substituted.
- **Mississippi.** Mississippi reported total waiver spending for 2006 but did not report spending by individual waivers on CMS 64 reports. The authors estimated that 70 percent of the state's total waiver spending went to services for older people and adults with physical disabilities, consistent with the proportion of such spending in previous years.
- **Vermont.** In 2006, the vast majority of Vermont's Medicaid HCBS was provided through a managed care program. The authors could not obtain comparable expenditure data.
- **Alabama, Louisiana.** Alabama and Louisiana reported a significant portion of 2006 HCBS waiver expenditures under 1115 waivers for Hurricane Katrina evacuees. CMS 64 reports for the 1115 waivers did not include target population information.
- **Iowa, Kansas, Louisiana, Missouri, Oregon, New Jersey, South Dakota.** There were irregularities in the total Medicaid nursing home expenditure for these seven states in 2001 and 2002, so the authors substituted FY 2000 expenditures.

All national trends exclude Arizona and Vermont because of a lack of comparable data in 2001 and/or 2006.

Participants

The number of HCBS participants for 2004 comes from Martin Kitchener, Terence Ng, Charlene Harrington, and Molly O’Malley, *Medicaid Home and Community-Based Service Programs: Data Update*, Kaiser Commission on Medicaid and the Uninsured, 2007. Home health and personal care participants for 1999 come from the same source. Aged, aged/disabled, and physically disabled HCBS waiver participants for 1999 come from Charlene Harrington and Martin Kitchener, *Medicaid 1915(c) Home and Community-Based Waivers: Program Data 1992–1999*, University of California, San Francisco, 2001. Home health, personal care, and the included HCBS waiver participants are added together for 1999. Data were not available for some states in some years, so the authors substituted data from the most recent year for which data were available.

The data are calculated as the sum of the values in tables 1C and 5 in Kitchener et al. (2007) for 2004, and tables 1C in Kitchener et al. (2007) and table 1 in Harrington and Kitchener (2001) for 1999. Beneficiaries are unduplicated within service and within waiver program, but not between services or waivers—that is, if an individual receives both personal care services and waiver services in a given year, that person is counted twice. HCBS participants include all personal care beneficiaries, as the data do not permit parsing by population; they exclude users of MR/DD and other non-aged or physically disabled waiver services.

The number of people receiving nursing home services in 2004 comes from table 13.25 in the *2007 Medicare & Medicaid Statistical Supplement (CMS)*. Caseloads for 1999, taken from table 109 in the *2001 Medicare & Medicaid Statistical Supplement*, do not include beneficiaries receiving nursing home services only through managed care programs for either year. Nursing home counts are unduplicated.

All national trends exclude Arizona because of a lack of comparable data for 1999 and 2004.

To facilitate comparison with HCBS participant numbers, the data reported for nursing home participants are the unduplicated counts of the number of people who use nursing homes over the course of a year, *not* the average number of residents on a given day. Most nursing home stays are for less than a full year, or begin or end during the year; therefore, the number of users over the course of a year is usually substantially higher than the average number of residents on a given day.

Readers should not interpret the inclusion of the higher number of nursing home users as an indicator of the number of nursing home beds in each state. The average daily census is a better indicator of usage related to a state’s nursing home bed inventory. Table A4 in the *Tables* tab presents the average daily census of Medicaid nursing home residents in 1999 and 2004 as an important alternative measure. This number is significantly lower than the total number of users over the course of a year. This is an important distinction because it provides a more accurate picture of recent trends in nursing home use. While there was a 6 percent increase from 1999 to 2004 in the number of Medicaid nursing

home participants at any time during the year, the average daily census actually shows a 4 percent *decrease* during these years. The explanation for this difference is that fewer people are long-term nursing home residents. The data in Table A4 come from an analysis of CMS On-line Survey Certification and Reporting System (OSCAR) data by Helen Carrillo and Charlene Harrington at UCSF, and represent the number of residents with Medicaid as a primary payer.

Pace of Change

Figure 2 of the report shows the proportion of LTC spending going to HCBS for older people and adults with physical disabilities, MR/DD, and all LTC populations for the years 1995 to 2006. For the MR/DD population, HCBS spending consists of HCBS waivers for the MR/DD population, and institutional spending consists of spending for ICF/MR. These proportions do not exclude Arizona and Vermont. In Arizona, reported LTC expenditures are extremely low since essentially all LTC is provided through managed care programs, so including Arizona numbers has no effect on the national trend. In Vermont, HCBS numbers are consistent with other states for 1995–2005 and are underreported for all populations for 2006 only.

Figure 6 presents historical and projected HCBS and nursing home spending for older people and adults with physical disabilities. This projection assumes that the average rate of spending growth from 1995 to 2006 continues going forward. For each pair of consecutive years (1995–1996, 1996–1997, etc.), the authors computed the percent increase in spending, and the average percent increase over the 11 pairs of consecutive years was applied to each year after 2006. Thus, consistent with the spending trend since 1995, we project HCBS spending to increase by about 13.2 percent per year, and nursing home spending to increase by 4.3 percent per year. Note that these increases are somewhat greater than the average annual percentage increases between 2001 and 2006. As with the data underlying Figure 2, these projections and historical trends do not exclude Arizona and Vermont. The source data for figures 2 and 6 come from Brian Burwell, Kate Sredl, and Steve Eiken, *Medicaid Long Term Care Expenditures FY 2006*, Thomson Reuters, 2007 and Brian Burwell, *Medicaid HCBS Waiver Expenditures, FY1995–2001*, Thomson Reuters, 2002.

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