AARP Public Policy Institute

On the Verge: The Transformation of Long-Term Services and Supports

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Research Report

AARP®

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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.

The views expressed herein are for information, debate, and discussion, and do not necessarily represent official policies of AARP.

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Executive Summary

This report presents the findings from a state survey conducted in the fall of 2011. State aging and disability agencies and Medicaid agencies responded with long-term services and supports (LTSS) information on programs for older individuals and adults with physical disabilities. Forty-eight states and the District of Columbia responded to the survey.

Findings

State LTSS Transformations

Many states are on the verge of transforming the financing and delivery of LTSS. On the heels of the Great Recession, state policymakers are looking at solutions that include moving toward capitated, risk-based managed care for Medicaid enrollees with LTSS needs and focusing on better care and cost containment for people who are dually eligible for both Medicare and Medicaid coverage, the so-called "dual eligibles."

Many states either have implemented or plan to implement Medicaid Managed LTSS for individuals with LTSS needs, with 12 states having existing programs and another 11 with plans for implementation in 2012 and 2013. About half of the 11 states that indicated that they are implementing Medicaid Managed LTSS have definite plans to implement statewide. At least 28 states are focusing on improved integration of Medicare and Medicaid services for the dual eligibles.

Budget Cuts and Increased Demand

The lagging economy remains a sustained and growing concern for state agencies. States have used many administrative tools to curtail expenditures. At the same time, demand for publicly funded services has grown, and resources, including staff, are stretched thin.

Although fewer states made cuts to LTSS in fiscal year (FY) 2011 compared to FY 2010, 14 states made cuts to aging and disability services programs (non-Medicaid) in FY 2011. Eleven states were expecting to cut these programs in FY 2012. It is important to remember that even in the states that did not impose reductions in this fiscal year, many states have sustained three years of consecutive budget cuts. Fewer states made cuts to Medicaid programs; most Medicaid cuts targeted provider rates. A handful of states, however, imposed restrictions on some Medicaid services, most notably personal care services.

Requests for services increase during an economic downturn because people have less income and assets and therefore qualify for government programs. While enrollment typically increases with more families and children qualifying, more than half of the states reported increased demands for Aging and Disability Resource Center (ADRC) services, information and referrals, and respite care in FY 2011.

Balancing Prioritized

Many states are using the economic downturn as an opportunity to balance services from institutional to noninstitutional settings. States continued to serve a greater number

of Medicaid recipients with LTSS needs in their homes or communities. Of 37 responding states, 27 reported that the home and community-based (HCBS) census increased from FY 2010 to FY 2011, and 31 expected increases from FY 2011 to FY 2012. Concurrently, 20 states reported that they expected the number of Medicaid nursing facility residents to decline, and 9 states expected the number to remain unchanged from FY 2010 to FY 2011. Only seven of the responding states expected the nursing facility census to increase. Surprisingly, many states were able to preserve their small but important non-Medicaid, state-only funded programs, which often serve people who do not qualify for Medicaid.

Staffing Changes and Reductions

There was a record number of new state officials in 2011, with 26 new governors, 40 new state aging and disability directors (78 percent turnover), and 11 new Medicaid directors (20 percent turnover). Reducing overall state aging and disability staff rather than cutting services continues to top the list of current and planned savings strategies.

Uncertainty of the Affordable Care Act

The recent health care reform law provides states with options to expand home and community-based services, yet many states are reluctant to commit to some of these programs because of litigation pending before the U.S. Supreme Court. States also are waiting for final federal implementation guidance.

Conclusion

Many states are undergoing or are about to undergo a dizzying array of LTSS transformations. The lagging economy and the increased demand for publicly funded LTSS have put pressure on state policymakers to redefine the way LTSS are financed and delivered in order to maximize access and system capacity. The next few years will be critical, as the transformations discussed in this report go from policy and demonstrations to full implementation and affect the lives of some of our most vulnerable citizens.

Introduction

Many states are on the verge of transforming the financing and delivery of long-term services and supports (LTSS). On the heels of the Great Recession,[1] state policymakers have been looking for cost-effective solutions to meet growing demand driven both by economic conditions and increases in the number of older adults and people with disabilities.

These solutions include moving toward capitated, risk-based managed care for Medicaid enrollees with LTSS needs; focusing on better care and cost containment for people who are dually eligible for both Medicare and Medicaid coverage; balancing Medicaid services toward more home and community-based services (HCBS) and away from institutional care; preserving non-Medicaid, state-only funded LTSS to serve the near poor; and continuing staff reductions and other administrative budget cuts to aging and disability agencies in order to preserve services.

This report represents the most comprehensive analysis of Medicaid and non-Medicaid LTSS financing across the states. In addition, it provides a point-in-time projection of the likelihood that states will pursue some of the LTSS provisions in the Affordable Care Act (ACA).

Methodology

The AARP Public Policy Institute commissioned the National Association of States United for Aging and Disabilities (NASUAD) and Health Management Associates (HMA) to undertake this project. The study builds on NASUAD's and HMA's experience in surveying states on public policy during the economic downturn and is a follow-up to our 2011 study entitled *Weathering the Storm: The Impact of the Great Recession on Long-Term Services and Supports*. The members of NASUAD represent the nation's 56 officially designated state and territorial agencies on aging, often referred to as state aging and disability agencies (SADAs). This is NASUAD's sixth survey of its membership on the economy. HMA has a long history of conducting studies on general Medicaid policy, enrollment, and financing.

The survey primarily focuses on state fiscal year (SFY) 2011 budgets and the outlook for SFY 2012 budgets, which for most states began on July 1, 2011.[2] Programs supporting older people and people with physical disabilities were the subject of the study. The intellectual and developmental disabilities (ID/DD) population was not included.[3]

Through this three-way collaboration of the AARP Public Policy Institute, NASUAD, and HMA, both the state aging and disability agency and the Medicaid agency in each state completed an electronic survey in fall 2011. NASUAD conducted telephone interviews with each stage aging and disability agency (SADA) after it completed its

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1 The Great Recession is the longest downturn in our nation's history since the Great Depression. The recession, which began in December 2007, officially ended in June 2009, lasting 18 months.

2 States that do not have fiscal years beginning on July 1 include Alabama, Michigan, New York, and Texas, and the District of Columbia.

3 ID/DD state expenditure information is regularly collected and reported by the University of Colorado. For more information, please visit http://sos.arielmis.net.

survey; each interview was approximately an hour long. The state aging and Medicaid officials also received their state profile to verify the state data. Forty-eight states and the District of Columbia responded to this survey.[4]

Finally, the report provides a summary of trends observed across state responses, for both Medicaid and non-Medicaid LTSS programs. It also identifies major issues and state actions taken in response to the economic environment. Altogether, the survey response provides a comprehensive snapshot of the status of LTSS for older Americans and adults with physical disabilities.

Overall Findings

While every state is unique in its response to the economic crisis, six clear patterns emerged.

1. ***Transformation of the Financing and Delivery of LTSS.*** Last year, states' primary strategy for addressing significant fiscal strain was to reduce programs—benefits and/or reimbursement rates in non-Medicaid programs and Medicaid-financed LTSS. This year, however, fewer states are making these types of reductions, and the cuts are not as deep as those in 2010. Instead, states are fundamentally restructuring service delivery systems to achieve efficiencies, reduce duplication, and continue to function with greatly reduced state staffing levels.

   - **Medicaid Managed LTSS in FY 2011, FY 2012, and FY 2013.** A significant number of states either have or plan to implement Medicaid Managed LTSS, with 12 states reporting existing programs and another 11 reporting plans for implementation in 2012 and 2013. About half of them (11) have definite plans to implement statewide. Many states (13) have or will require mandatory enrollment in Medicaid Managed LTSS, while some states (4) have not yet determined whether the enrollment will be voluntary or mandatory.
   - **Dual Eligibles.** States have a keen interest in integrating care for the 9 million people who are dually eligible for Medicaid and Medicare services. These individuals typically are poorer and sicker than other Medicare beneficiaries, use more health care services, and thus account for a disproportionate share of Medicare and Medicaid spending. At least 28 states report focusing on better integrating Medicare and Medicaid services for the so-called "dual eligibles." The focus of integrating services will be to deal with the current system, which is fragmented, has misaligned payments and incentives, and offers a lack of continuity of care for consumers. Ultimately, the vision for an integrated care model would be that the consumer would receive appropriate, high-quality long-term services and supports regardless of payer.
   - **Consolidation of Medicaid Home and Community-Based Services Waivers.** Most states have multiple Medicaid waivers—more than 300 such waivers in the United States—to provide home and community-based services (HCBS) to

[4] States and territories that chose not to participate in the survey included Nebraska, Wisconsin, Puerto Rico, and the Virgin Islands. Of the responding states, all SADAs—except Florida, Mississippi, and New Jersey—reported data. Six state agencies did not provide Medicaid data: Colorado, Louisiana, Montana, North Carolina, South Carolina, and Virginia.

targeted populations. In response to a proposed federal rule, as well as states' efforts to improve efficiency, 15 states are considering the consolidation of HCBS waivers in order to simplify administrative and programmatic design.

2. ***Continuing Impact of the Great Recession.*** The force behind many of these reforms is the continuing aftermath of the recession. States have used many administrative tools to curtail expenditures. At the same time, demand for publicly funded services has grown as the impact of the recession lingers. Although fewer states made cuts to LTSS in SFY 2011 compared to SFY 2010, many states continued to cut non-Medicaid LTSS funded services. Fourteen states cut aging and disability services programs (non-Medicaid) in SFY 2011. Eleven states were expecting to reduce aging and disability services programs (non-Medicaid) in SFY 2012. However, during the survey period, an additional 10 states did not yet know the composition of their SFY 2012 budgets. It is also important to note that many states have made cuts for three consecutive years. Fewer states made cuts to Medicaid programs, with most reducing provider rates. A handful of states, however, imposed cuts to Medicaid LTSS, most notably personal care services.

3. ***Increasing Demand for Publicly Funded Services.*** Although revenues slightly increased in some states, the vast majority of state agencies remain concerned about their budgets and their capacity to maintain services as the numbers of older adults and people with disabilities grow. As such, the second force behind many reforms is increasing demand for publicly funded LTSS due to rising numbers of people in need of these services. Requests for services increase during an economic downturn because people have less income and assets and therefore qualify for government programs. For example, more than 25 states reported increased demands for Aging and Disability Resource Center (ADRC) services, information and referrals, and respite care in SFY 2011.

4. ***Continued Commitment to Home and Community-Based Services and Maintaining Current Service Levels.*** Many states continue to use the economic downturn as an opportunity to balance services from institutional to noninstitutional settings. States continued to serve an increasing number of Medicaid recipients with LTSS needs in their homes or communities. Of the 37 states responding to Medicaid caseload questions, 27 reported that HCBS census increased from FY 2010 to FY 2011 and 31 reported expected increases from FY 2011 to FY 2012. Concurrently, 29 states increased Medicaid expenditures for HCBS from FY 2010 to FY 2011. At the same time, 20 states reported that the number of Medicaid nursing facility residents declined, and 9 states reported that the number remained unchanged from FY 2010 to FY 2011. Only seven states expected the nursing facility census to increase. A similar trend is expected in FY 2012, with 32 out of 37 reporting states expecting nursing home census to decline or remain the same. Also, after many years of cutting, many states were able to preserve their small but important non-Medicaid, state-only funded HCBS programs, which serve the near poor.

5. ***Changes in LTSS State Leadership, Agency Structure, and Staffing.*** A record number of new state officials took policy leadership positions in 2011: 26 new

governors, 40 new state aging and disability directors (78 percent turnover), and 11 new Medicaid directors (20 percent turnover). In some states, the state aging and disability director has changed more than once in the past 12 months. More than half of the state aging and disability agencies have or will be reorganizing their operations in response to personnel reductions, state reforms, and administrative simplification, according to NASUAD's State of the States 2011 report. Staff reductions continue to be the most frequently used savings strategy.

6. ***Uncertainty Surrounding Many Affordable Care Act (ACA) LTSS Provisions.*** The federal health care reform law provides states with new options and financial incentives to expand HCBS. However, pending litigation on the constitutionality of the ACA, which will be heard in 2012 by the U.S. Supreme Court, and a lack of final federal implementation guidance at the time of the survey on some options makes adoption challenging. The exceptions to this finding are the Money Follows the Person Rebalancing Demonstration Program (which existed prior to passage of the ACA and with which some states already had experience) and the duals integration initiative (described above). In addition, tight state resources—financial and staffing—present challenges to state policymakers as they consider future initiatives.

On the Verge

Struggling State Budgets

Most states (28) still project 2012 tax revenues below 2007 prerecession levels, but a growing number (22) are now projecting collections above 2007 levels.

States continue to struggle fiscally from the lingering impact of the recession.[5] Unemployment, a lagging indicator of economic decline and recovery, was at its highest in October 2009, at 10.1 percent. Two years later in October 2011, the unemployment rate remained stubbornly high at 9.0 percent. Unemployment, with the concurrent loss of income tax revenue, directly affects states' fiscal condition. Enrollment in the Medicaid program also serves as an important indicator of economic recovery and is also a lagging indicator. Higher overall enrollment in Medicaid generally accompanies economic downturns. Most economists agree that Medicaid enrollment lags 18 months past the first sign of economic recovery.[6] Recent Medicaid enrollment growth shows signs of tapering off, with 5.5 percent growth in FY 2011 slowing to a projected 4.1 percent in FY 2012, another sign of easing of economic pressures.[7]

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5 The recession began December 2007 and officially ended in June 2009, lasting 18 months.

6 Kaiser Commission on Medicaid and the Uninsured, *Medicaid and State Budgets: From Crunch to Cliff* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2009).

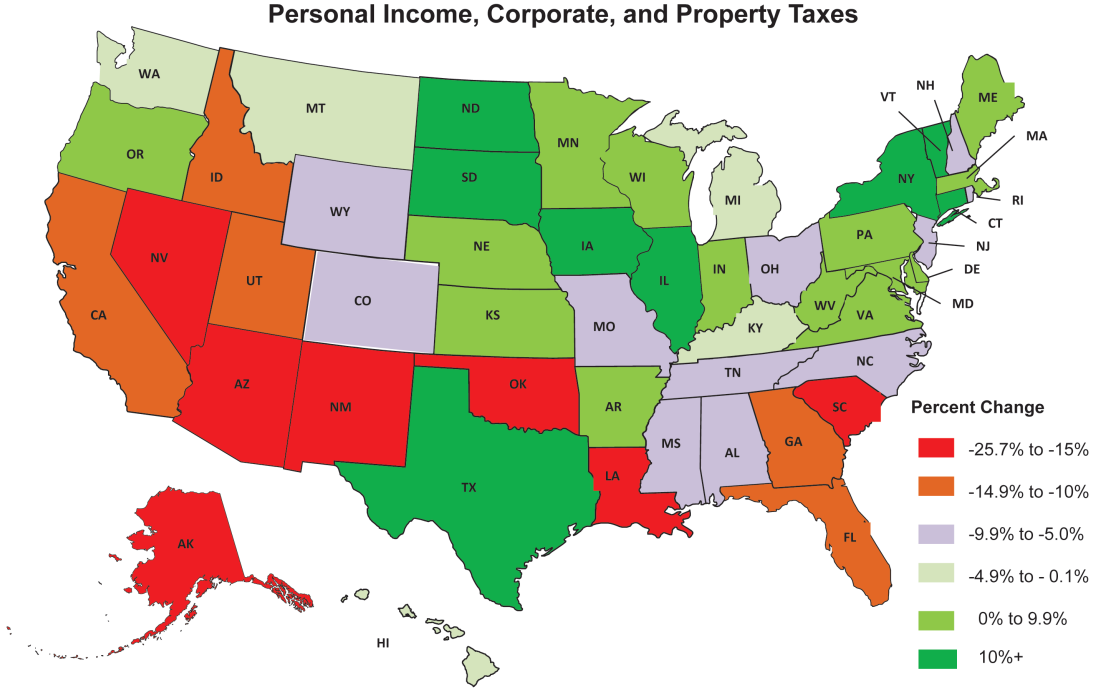
7 Vernon K. Smith, Kathleen Gifford, Eileen Ellis, Robin Rudowitz, and Laura Snyder Kaiser, *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage, and Policy Trends. Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2011).

However, according to the National Governors Association (NGA) and the National Association of State Budget Officers (NASBO) Fall 2011 Fiscal Survey of the States, aggregate state general fund revenue and state spending levels remained below 2008 levels in 2011. An analysis of the NGA/NASBO data indicates that in 2012, 22 states project general fund collections above 2007 levels. Many states, however, expect to remain significantly below the 2007 level, with 12 states projecting levels 10 percent or more below 2007 collections (figure 1). Seven states project revenues in 2012 to be lower than those collected in 2011, illustrating the variable recovery across the states.

Figure 1

Percent Change in State Tax Revenue: 2007–2012 (projected)

Personal Income, Corporate, and Property Taxes



Source: HMA analysis of data from National Association of State Budget Officers (NASBO), Spring Fiscal Survey of States, 2007–2010 reports, and Fall 2011 Report for 2012 Notes: 2012 figures are enacted. For Illinois, this map uses projected revenue from NASBO's 2006 report because 2007 data was not available.

Revenue recovery appears to be stronger in the northern and upper midwestern states. Illinois projects the highest revenue gains since 2007 (45.3 percent) due to 2011 legislation that significantly increased personal income and corporate tax rates.[8] With the exception of Texas, Oregon, and Arkansas, southern and western states are not faring as well as the upper Midwest. Although Louisiana, Oklahoma, and Arizona expect revenues to increase in 2012, projections remain more than 20 percent below 2007 collection levels.

[8] The personal income tax rate increased from 3 percent to 5 percent and the corporate tax rate from 4.8 percent to 7 percent. Both rates were retroactive to January 2011 and carry through until 2015, when they will drop to 3.25 percent and 5.25 percent, respectively.

Recent economic news suggests that economic recovery for some states will lag far behind that of the rest of the country as states revise their projections. In October 2011, Michigan's House Fiscal Agency reported expected revenues $285 million above the May forecast, while the Senate Fiscal Agency estimated $483 million in additional revenue above the May forecast.[9] In contrast, the state of Washington released preliminary data for 2009–2011 revenue $25 million below its previous forecast, and projected revenue for the 2011–2013 biennium as falling $1.4 billion below the previous forecast.[10] Michigan and Washington serve as just two examples of budget projection revisions and the budget challenges ahead for many states.

In spite of somewhat improved revenue conditions, the NASBO/NGA report[11] notes that most states still expect to struggle to balance their budgets. The report cites Medicaid in particular as a growing concern, as the program continues to consume a larger share of state budgets due to three primary drivers:

- Rapid growth in Medicaid enrollment due to the weak economy and expected growth from the ACA health care reform expansion in 2014;
- Loss of federal stimulus funds provided under the American Recovery and Reinvestment Act (ARRA) of 2009; and
- Per capita health care costs increasing faster than the general economy.

Between October 2008 and June 2011, federal ARRA stimulus funds and the extension of enhanced ARRA Federal Medical Assistance Percentage (FMAP) provided much-needed relief to states' Medicaid and non-Medicaid programs, as well as many other state programs. During the initial phase of the stimulus, the federal government provided $87 billion in enhanced funding to state Medicaid programs. Congress extended the funding for an additional two quarters, but the enhanced FMAP began to phase down beginning in January 2011, and ended altogether on June 30, 2011. With the loss of the extra federal support, states must fill in the funding gap with either increased state funding or decreased spending.

Figure 2 shows the annual percentage change in state general fund Medicaid spending from 2000 to 2012, compared to total Medicaid funding. State funding for Medicaid jumped by nearly 24 percent in FY 2012 budgets. This may be a conservative estimate, as many states indicated that Medicaid budgets adopted by legislatures will be insufficient to meet the rise in state expenditures.[12]

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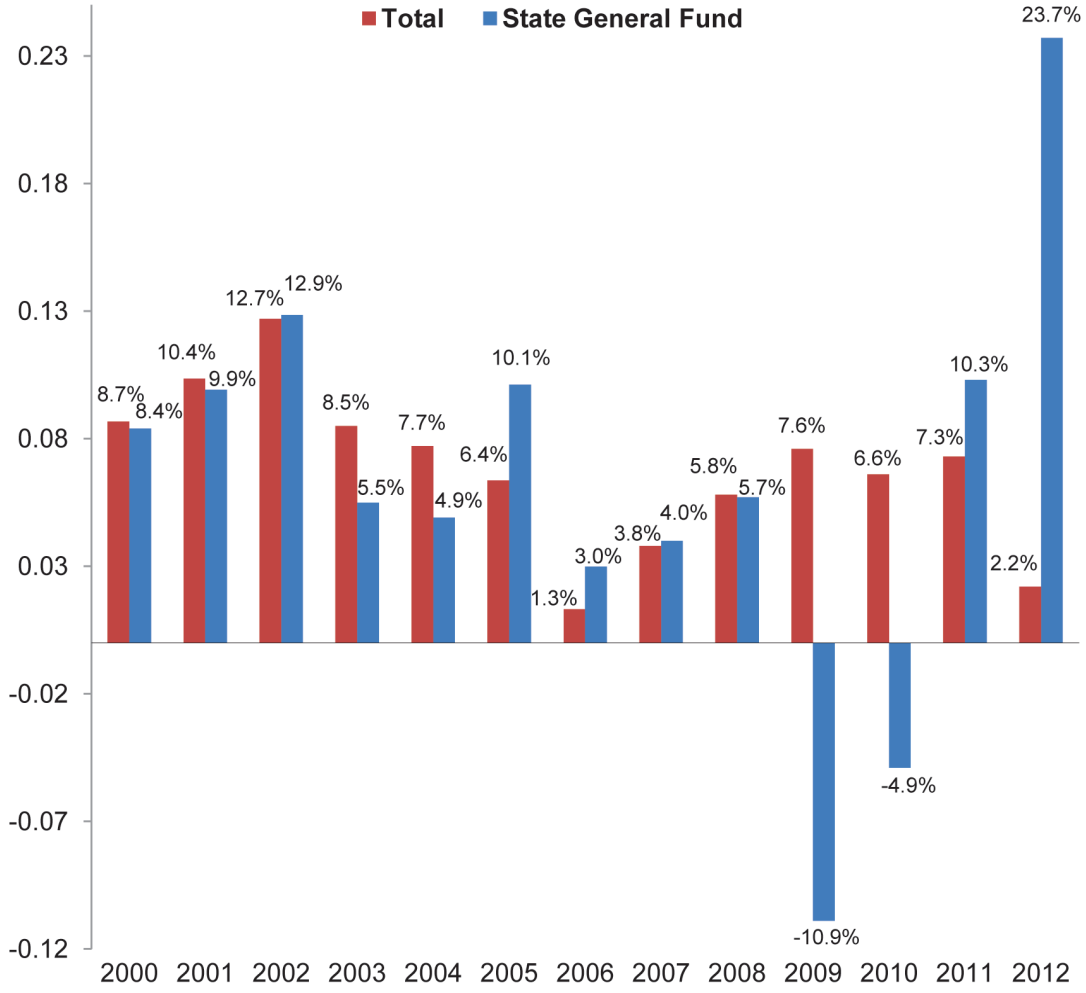
9 As reported by Tim Martin of the Associated Press, October 17, 2011.

10 The State of Washington Economic and Revenue Forecast Council, Press Release, September 15, 2011; http://www.erfc.wa.gov/forecast/documents/pres0911.pdf.

11 *The Fiscal Survey of States, Fall 2011* (Washington, DC: National Association of State Budget Officers, 2011).

12 Smith et al., *Moving Ahead*.

Figure 2
Annual Growth in Total and State Medicaid Spending, 2000–2012



Source: "Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends;" Vernon K. Smith, Kathleen Gifford, Eileen Ellis, et.al.; Kaiser Commission on Medicaid and the Uninsured; October 2011. NOTE: State Fiscal Years.

State Leadership and Agency Changes

With 26 new governors in office in 2011, there was a record number of new state officials: 40 new SADA directors (78 percent turnover) and 11 new Medicaid directors (20 percent turnover).

Another challenge for state programs is the significant turnover in both program staff and leadership. The 2010 elections of 37 governors resulted in state aging and disability agency leadership changes in a record number of states. Of the 37 gubernatorial elections, 26 resulted in a new governor taking leadership, and 14 state offices changed parties. Between February and November 2011, 10 states and the District of Columbia changed Medicaid leadership, which represents 20 percent of state programs.

Even more dramatic was the change in state aging and disability agencies, with 40 new state aging and disability agency (SADA) directors assuming positions in 2011, a

78 percent turnover. In addition, more than half of the SADAs have restructured or will be restructuring their operations. Key reasons cited for reorganization include administrative simplification and personnel reductions.[13] Since the beginning of the economic downturn in fiscal year (FY) 2007, 82 percent of SADAs have reported notable personnel reductions.[14]

Many states resorted to downsizing their entire workforce to address budget constraints:[15]

- In FY 2011, 33 states reduced their overall full-time equivalent (FTE) positions.
- In FY 2012, the number of FTE positions declined by 1.2 percent as 31 states reduced their number.
- In FY 2011, 15 states employed layoffs while 18 states instituted furlough programs to help solve their budget gaps.
- In FY 2012, 16 states employed layoffs and 4 states used furloughs.

According to the Bureau of Labor Statistics, state governments shed 71,000 jobs between November 2010 and November 2011.[16] Turnover and loss of employees present challenges for staff remaining in programs that are already in a state of flux, and the loss of institutional memory as more experienced workers leave is not easily replaced.

Medicaid

Total Medicaid expenditures have grown at a faster rate, mostly because of increased enrollment of families with children. However, Medicaid is the largest source of funding for LTSS, and paid $127.1 billion for LTSS in FY 2009.[17] LTSS spending accounted for 34.5 percent of total Medicaid expenditures in FY 2009.

Medicaid Managed LTSS Movement

A dramatic number of states either have or plan to implement Medicaid Managed LTSS, with 12 states having existing programs and another 11 with plans for implementation in 2012 and 2013. About half of them (11) have or definitely plan to implement statewide.

A striking finding of the survey is the number of states that have or plan to implement Medicaid Managed LTSS (MMLTSS) programs (other than Program for All-Inclusive

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[13] National Association of States United for Aging and Disabilities, *State of the States Survey 2011 – State Aging and Disability Agencies in Times of Change*. (Washington, DC: National Association of States United for Aging and Disabilities, January 2012).

[14] Ibid.

[15] National Governors Association and the National Association of State Budget Officers, *The Fiscal Survey of the States, Fall 2011* – An Update of State Fiscal Conditions (Washington, DC: National Governors Association and the National Association of State Budget Officers, 2011).

[16] Bureau of Labor Statistics, Table B-1, Employees on non-farm payroll by industry sector and selected industry detail. Accessed at http://www.bls.gov/news.release/empsit.t17.htm. Data are seasonally adjusted.

[17] Steve Eiken et al., *Medicaid Expenditures for Long-Term Services and Supports: 2011 Update* (Cambridge, MA: Thomson Reuters, October 31, 2011).

Care of the Elderly [PACE]).[18] This, perhaps, is in response to budget constraints and the fact that older adults and adults with disabilities need services that consume a large portion of Medicaid resources. Some states also see the complexity of needs and health conditions among these populations as factors calling for an integrated system of delivery to which managed care may respond. Most states have provided Medicaid LTSS primarily through a traditional fee-for-service model. In 2004, only 70,000 (2.3 percent) of the 3.1 million Medicaid older and physically disabled enrollees receiving LTSS were in a risk-based managed care arrangement.[19] This is no longer the case. In 2008, 4 percent of the Medicaid population over age 65 and 14 percent of people with disabilities were enrolled in Medicaid managed care.[20]

Twelve states report that they have a Medicaid Managed LTSS program in operation (Arizona, Florida, Hawaii, Idaho, Massachusetts, Minnesota, New Mexico, New York, Tennessee, Texas, Washington, and Wisconsin).[21] Eleven states report plans to implement programs in either 2012 (California, Delaware, Indiana, Nevada, New Jersey, and Rhode Island) or 2013 (Illinois, Kansas, Maine, Michigan, and Ohio) (figure 3).[22]

Figure 4 shows that many states plan to operate statewide MMLTSS programs. Of the six[23] states (Florida, Massachusetts, New York, Texas, Washington, and Wisconsin) currently operating programs in a limited area or pilots, Florida, Massachusetts, and New York indicated plans to expand statewide and Texas plans to expand to a larger area. It is notable that most states with definite plans to implement MMLTSS expect to do so statewide (Delaware, Kansas, Michigan, New Jersey, and Rhode Island) rather than on a limited or pilot basis. Illinois indicated plans to eventually expand statewide.

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[18] 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. PACE programs were not included in this analysis.

[19] Paul Saucier, Brian Burwell, and Kerstin Gerst, *The Past, Present and Future of Managed Long-Term Care* (Washington, DC: U.S. Department of Health and Human Services, April 2005).

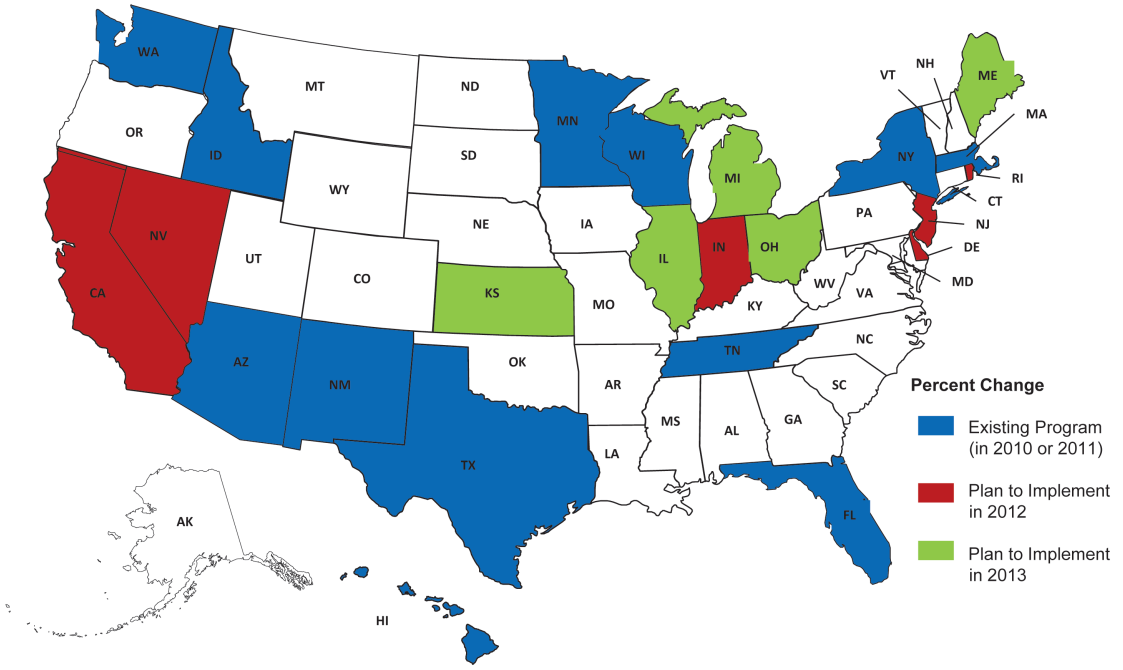
[20] Medicaid and CHIP Payment and Access Commission, *Report to Congress; The Evolution of Managed Care In Medicaid* (Washington, DC: MACPAC, June 2011).

[21] Wisconsin did not respond to this survey but indicated existing managed long-term care programs in a recent survey done for Kaiser Commission on Medicaid and the Uninsured: Kathleen Gifford, Vernon K. Smith, Dyke Snipes, and Julia Paradise, *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 2011). Idaho's managed long-term care is a noncomprehensive prepaid health plan.

[22] New Hampshire released a request for proposal (RFP) in October 2011, after the survey was completed. Although the state did not indicate plans to implement an MMLTSS program on the survey, the RFP includes the nondual aged and disabled as a mandatory population in its managed care program, and dual eligibles as a voluntary population July 1, 2012. The state is also seeking a waiver to include dual eligibles as a mandatory group in managed care.

[23] The number of states operating in a limited area includes Wisconsin's Family Care and Family Care Partnership, which operates in specific geographic areas of the state. Wisconsin information is from Smith et al., *Moving Ahead*, and the state's website at http://www.dhs.wisconsin.gov/LTCare/Generalinfo/Where.htm.

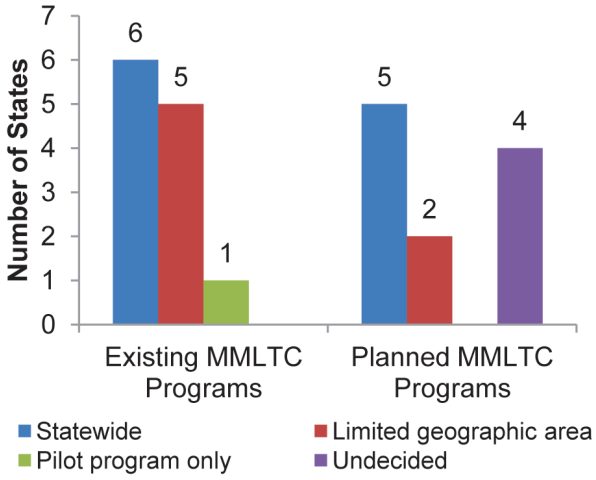
Figure 3
States with or Planning Medicaid Managed Long-Term Services and Supports Programs



Enrollment in MMLTSS

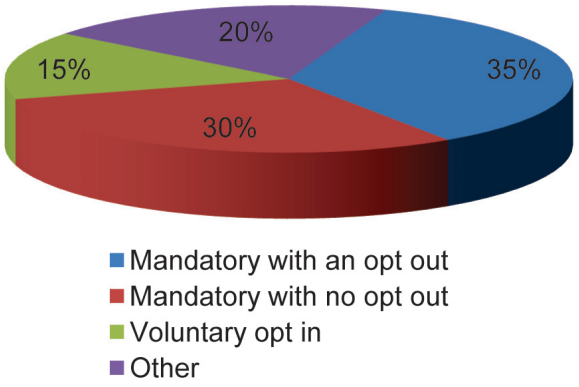
Many states (13) have or will require mandatory enrollment in MMLTSS, but most (9) will have voluntary enrollment or a provision to opt out of mandatory enrollment. Four states have not yet determined whether enrollment will be voluntary or mandatory.

Figure 4
Geographic Area of Medicaid Managed LTSS Programs
n = 23



As shown in figure 5, nine states reported either mandatory enrollment with an opt-out provision (California, Delaware, Michigan, Nevada, Texas, and Washington), a voluntary opt-in arrangement (Idaho and Minnesota), or both an opt-in and opt-out provision (Massachusetts). Six states reported mandatory enrollment with no opt-out (Arizona, Hawaii, Illinois, New Jersey, New Mexico, and Tennessee). Of the four states reporting "Other," Florida will require mandatory enrollment except for certain exempt populations, but did not specify whether opt-in or opt- out provisions will be available in its MMLTSS program. The remaining three states have not decided on the enrollment arrangement (Maine, New York, and Rhode Island).

Figure 5
Enrollment Requirements for Medicaid Managed Long-Term Services and Supports
n = 20



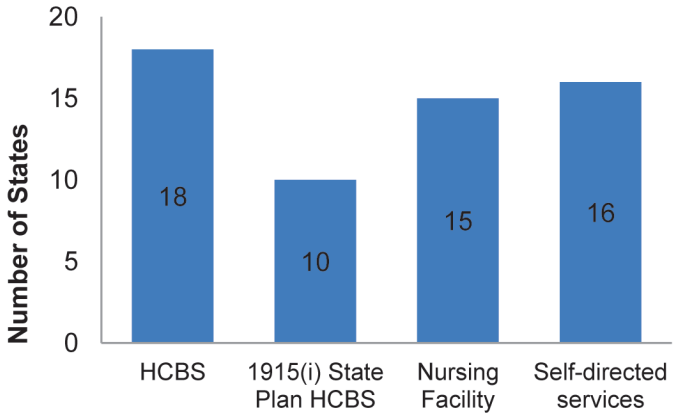
Note: One state is represented in data for both Mandatory with an opt out, and Voluntary opt in.

States that have or plan to implement MMLTSS usually include HCBS within managed care delivery.

Figure 6 shows that of the 23 states responding to the MMLTSS question, 18 indicated that HCBS services are or will be included in their program (see table I in the appendix for a list of the states). Four states excluded HCBS (Illinois, Kansas, Michigan, and Nevada), and Ohio indicated that services were still under consideration. Ten of the 18 states noting HCBS also indicated that 1915(i) State Plan HCBS would be included in the MMLTSS program (see discussion in the ACA section of this report). Fifteen states are or will include nursing facilities,[24] and 16 states are or will include self-directed services to allow participants or their representatives to have decision-making authority over services and manage their services, often with some assistance. Table I in the appendix provides state detail for MMLTSS.

Another area of interest to states in their MMLTSS programs is the integration of services for individuals who are dually eligible for Medicaid and Medicare (figure 7). Seven states (Arizona, Florida, Massachusetts, Minnesota, New Mexico, New York, and Texas) reported that they currently include integrated services within their MMLTSS, and six states have definite plans to do so (Hawaii, Idaho, Indiana, Michigan, Rhode Island, and Wyoming). Eight states indicated that integrated services for dual eligibles

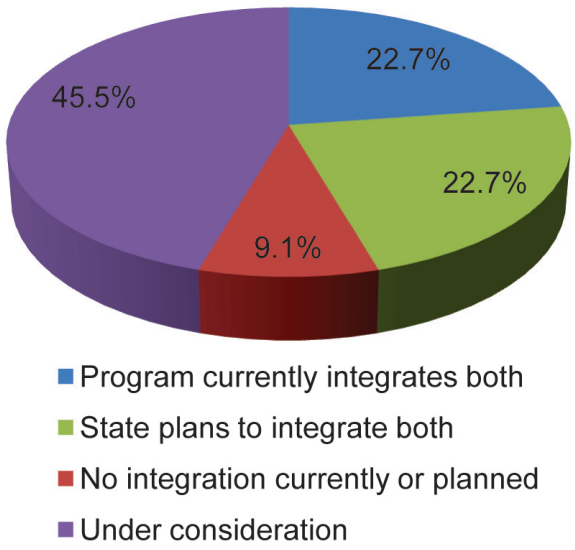
Figure 6
Services Included or Planned for Inclusion in MMLTSS
n = 23



[24] This survey did not specifically request information about the capitation structure of MMLTSS to determine whether services are or will be included under capitation rates or carved out for fee-for-service reimbursement. States with existing MMLTSS that include nursing facility services within their capitation rate are Arizona, Hawaii, Massachusetts, Minnesota, New Mexico, Tennessee, and Wisconsin. New York has partial capitation of these services. Source: Gifford et al., *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured, September, 2011.

within their MMLTSS are under consideration (California, Illinois, Kansas, Maine, Nevada, New Jersey, Ohio, and Tennessee). Delaware and Washington responded that they have no plans to include these services in their MMLTSS program. Table I summarizes state MMLTSS actions.

Figure 7
Integration for People Enrolled in Medicare and Medicaid in MMLTSS
n = 23



Dual Eligible Focus

Many states are focusing on better integrating Medicare and Medicaid care for dual eligibles, with at least 28 states integrating or planning to integrate services for dual eligibles.

States have a keen interest in integrating the care for the 9 million people who are dually eligible for Medicaid and Medicare services. These individuals typically are poorer and sicker than other Medicare beneficiaries, use more health care services, and thus account for a disproportionate share of both Medicare and Medicaid spending.[25] On October 11, 2011, the Centers for Medicare & Medicaid Services (CMS) announced that 37 states plus the District of Columbia had submitted letters of intent to participate in financial alignment demonstration programs to test payment and delivery of service models for their dual-eligible populations. The survey was fielded prior to the CMS deadline for submitting letters of intent for dual integration projects, so the data may underrepresent state interest in pursuing integration strategies.

Thirteen states either integrate services for dual eligibles in their MMLTSS program to some degree (Arizona, Florida, Massachusetts, Minnesota, New Mexico, New York, and Texas) or have definite plans to do so (Hawaii, Idaho, Indiana, Michigan, Rhode Island, and Wyoming). Another eight states indicated that integrated programs are under consideration.

As many as 25 states report enrollment of dual eligibles into their Medicaid managed care programs, either on a voluntary or mandatory basis.[26] In addition, the new Medicare-Medicaid Coordination Office within CMS awarded 15 states contracts for state demonstrations to integrate care for dual eligibles.[27] In the proposals, states indicated

[25] Kaiser Family Foundation, *Caring for People Covered by Both Medicare and Medicaid: A Primer on Dual Eligibles* (webcast) (Washington, DC: Kaiser Family Foundation, June 3, 2011).

[26] Gifford et al., *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*. Kaiser Commission on Medicaid and the Uninsured, September, 2011.

[27] Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office, http://www.cms.gov/medicare-medicaid-coordination/04_StateDemonstrationstoIntegrateCarefor DualEligibleIndividuals.asp#TopOfPage.

that they would use a variety of service delivery models, including both risk-based and nonrisk-based. For example, Tennessee and Wisconsin propose using risk-based private managed care organizations, while five states proposed using other models of care options such as accountable care organizations, integrated care networks, and primary care case management.[28]

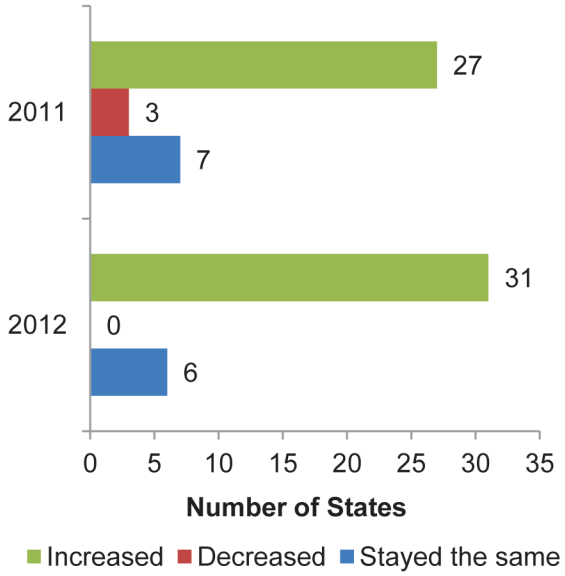
Table II in the appendix summarizes recent state actions around integration of services for dual eligibles.

Prioritizing Home and Community-Based Services

States continued their commitment to strengthen and expand HCBS, with 27 states increasing Medicaid HCBS caseloads in 2011 and 31 states projecting increases in 2012. Likewise, 29 states increased Medicaid expenditures for HCBS from 2010 to 2011.

As shown in figure 8, in 2011, of the 37 states that responded to questions regarding waivers for older adults and adults with physical disabilities, 27 report an increase in caseloads from 2010 to 2011 (73 percent) and 31 report expected increases in 2012 (84 percent). Of the three states that experienced decreases in their caseload in 2011, Iowa and New Mexico expect increases in 2012.

Figure 8
Changes in HCBS Caseload from Previous Year

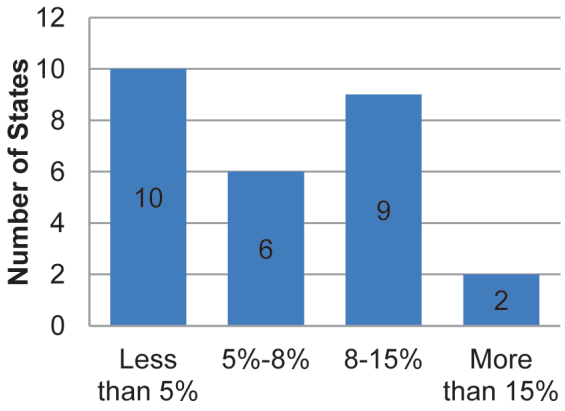


Reflecting the expansions of HCBS caseloads, most states experienced increases in HCBS waiver expenditures (29 of the 37 states). Figure 9 shows responses from states that reported the percentage range of increases in expenditures.

States are also actively changing HCBS benefits. Four states (Alabama, Arkansas, Maryland, and New Mexico) expanded benefits in 2011, and 10 states plan to do so in 2012 (Alabama, California, Delaware, Kansas, Maryland, Missouri, New Hampshire, New Mexico, North Dakota, and Ohio). In contrast, three states (North Dakota, Oregon, and Washington) restricted benefits in 2011, and three (New Hampshire, New Jersey, and Pennsylvania) plan to do so in 2012. Tables III and IV in the appendix provide a state-by-state listing of the HCBS waiver expansions and restrictions.

[28] Kaiser Commission on Medicaid and the Uninsured, *Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS.* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, August 2011).

Figure 9
Home and Community-Based Services Waiver Expenditures



Note: Two states reported an increase in HCBS expenditures from 2010–2011 but did not report the percentage increase.

HCBS benefit expansions were primarily new services added or increased flexibility for existing services. HCBS benefit restrictions primarily capped or limited the amount of services that can be received.

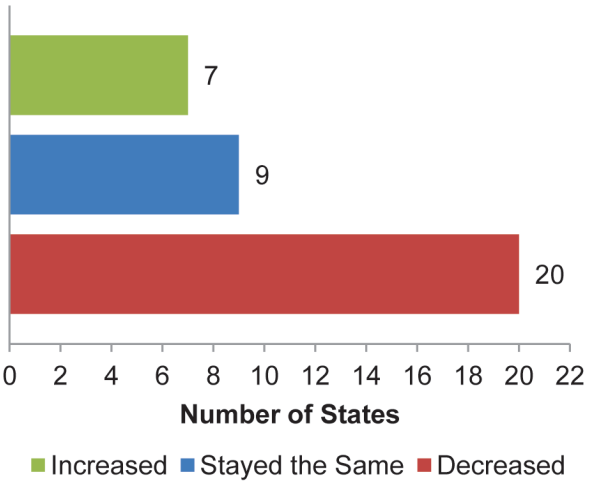
Decreasing or Static Medicaid Nursing Home Census

While Medicaid HCBS census increased in many states, Medicaid nursing home census decreased or stayed the same from FY 2010 to FY 2011.

The National Nursing Home Survey findings indicate that the rate of nursing home care use by people age 65 and older declined by more than one-third (35 percent) between 1984 and 2004.[29] Although the number of older adults in the United States continues to grow, the absolute number of certified nursing home residents has slowly but steadily declined since 2000.[30]

In the survey, state officials were asked to report whether the census of Medicaid nursing home residents increased, decreased, or stayed the same in FY 2011 compared to FY 2010. Twenty of 36 states responding (56 percent) reported declines in FY 2011, while nine states (25 percent) reported that the census stayed the same. Only seven states (Alabama, Arkansas, Indiana, Mississippi, Rhode Island, Texas, and West Virginia) reported growth in the average daily census (figure 10).

Figure 10
Nursing Facility Census Change, FY 2010–FY 2011
n = 36



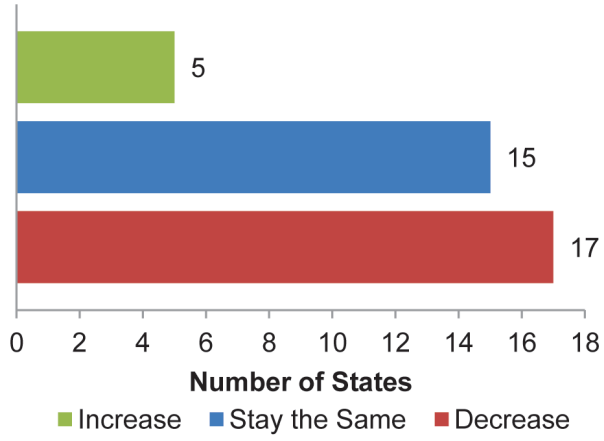
In addition, states continued to balance Medicaid nursing home caseloads in comparison to HCBS caseloads. Of 33 states that reported both nursing home and HCBS

[29] Donald L. Redfoot and Ari Houser, *More Older People with Disabilities Living in the Community: Trends from the National Long-Term Care Survey, 1984–2004*. AARP Public Policy Institute Report No. 2010-08 (Washington, DC: AARP, September 2010).

[30] American Health Care Association Reimbursement and Research Department, *Trends in Nursing Facility Characteristics* (Washington, DC: American Health Care Association, June 2010) (using CMS Nursing Facility OSCA standard health survey data).

caseloads, 15 increased HCBS caseloads while decreasing nursing home caseloads. Six states (Arkansas, Indiana, Mississippi, Rhode Island, Texas, and West Virginia) increased both nursing home and HCBS census. None of the reporting states decreased HCBS census and increased nursing home census. These trends are expected to continue in FY 2012 (figure 11). Table V in the appendix provides state detail on HCBS and nursing home caseloads.

Figure 11
Nursing Facility Census Change FY 2011–FY 2012
n = 37



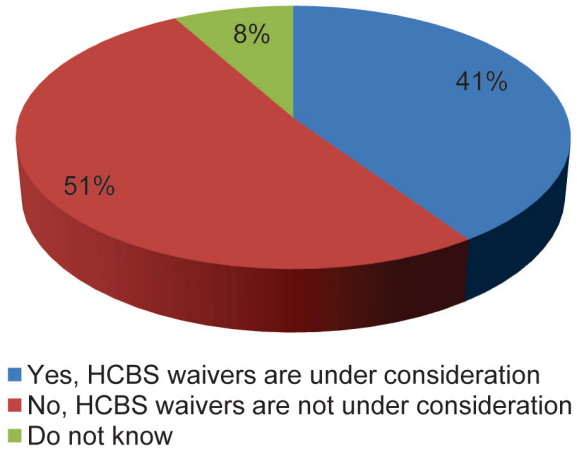
Combining HCBS Waivers

In response to a federal proposed rule as well as states' efforts to improve efficiencies, 15 states are considering combining HCBS waivers.

Most states have multiple Medicaid waivers that provide HCBS targeting specific populations such as older people, adults with physical disabilities, people with HIV/AIDS, people with traumatic brain injury, and people with intellectual disabilities. Waivers allow states to cover different types of services—for example, personal care—that are not paid for under the traditional Medicaid program. With these waivers, states have more flexibility, for example, to set higher financial eligibility limits, to set service and enrollment caps, and to cover limited geographic areas. As a result, there are more than 300 HCBS waiver programs in the United States.

On April 15, 2011, the federal government issued a proposed rule—42 CFR Part 441—in the *Federal Register* that outlined a proposal for allowing states to combine their multiple Medicaid HCBS waivers. Figure 12 shows that 37 states responded to a question regarding combining waivers. Of the 37 states, 19 responded that they were not considering combining HCBS waivers at this time. Fifteen states reported that they are considering combining their HCBS waivers, nine of which specified that waivers for older adults, adults with physical disabilities, and people with developmental disabilities (i.e., the largest waiver populations) are under consideration for consolidation to simplify administrative and programmatic design and to improve efficiencies (Arkansas, Georgia, Indiana, Kansas, Maine, Nevada, Ohio, Pennsylvania, and Rhode Island).

Figure 12
States Combining Home and Community-Based Services Waivers
n = 37



Medicaid State Plans

Few states made LTSS eligibility changes to Medicaid state plans, but a handful of states are cutting or plan to cut personal care services.

Two states reported expanding eligibility for populations of older adults and adults with physical disabilities. Alaska increased its income eligibility standard to 300 percent of Supplemental Security Income (SSI) in 2011, and Connecticut plans to restructure its HCBS through the 1915(i) state plan HCBS option, which will allow individuals on waiting lists for state-funded services to enroll in Medicaid. (The 1915(i) state plan option is described later in this report under the ACA section.)

New Mexico restricted personal care services in 2011, and four states (Arizona, Hawaii, Michigan, and New Mexico) plan to restrict personal care services in 2012. Connecticut placed restrictions on home health services in 2011. Table VI in the appendix describes state actions taken on state plan LTSS benefits.

State Aging and Disability Agencies' Non-Medicaid Budgets

The Older Americans Act programs are the common framework for all SADAs. Most aging and disability agencies also operate non-Medicaid, state-only funded LTSS programs. In SFY 2011, all but seven states (Arkansas, California, Mississippi, Montana, New Hampshire, New Mexico, and Rhode Island) were operating some form of a non-Medicaid, state-only LTSS program targeted to older adults and/or people with physical disabilities.[31] Approximately 70 percent of SADA budgets include some Medicaid funding. Medicaid funding is used for direct services, program administration, or both. Figure 13 provides an overview of common funding sources comprising SADA budgets.

Other important funding sources include U.S. Department of Labor funds for the Senior Community Service Employment Program (SCSEP), U.S. Department of Agriculture funds for programs such as Senior Farmers Market, and Social Services Block Grant (SSBG) funds overseen by the U.S. Administration for Children and Families.

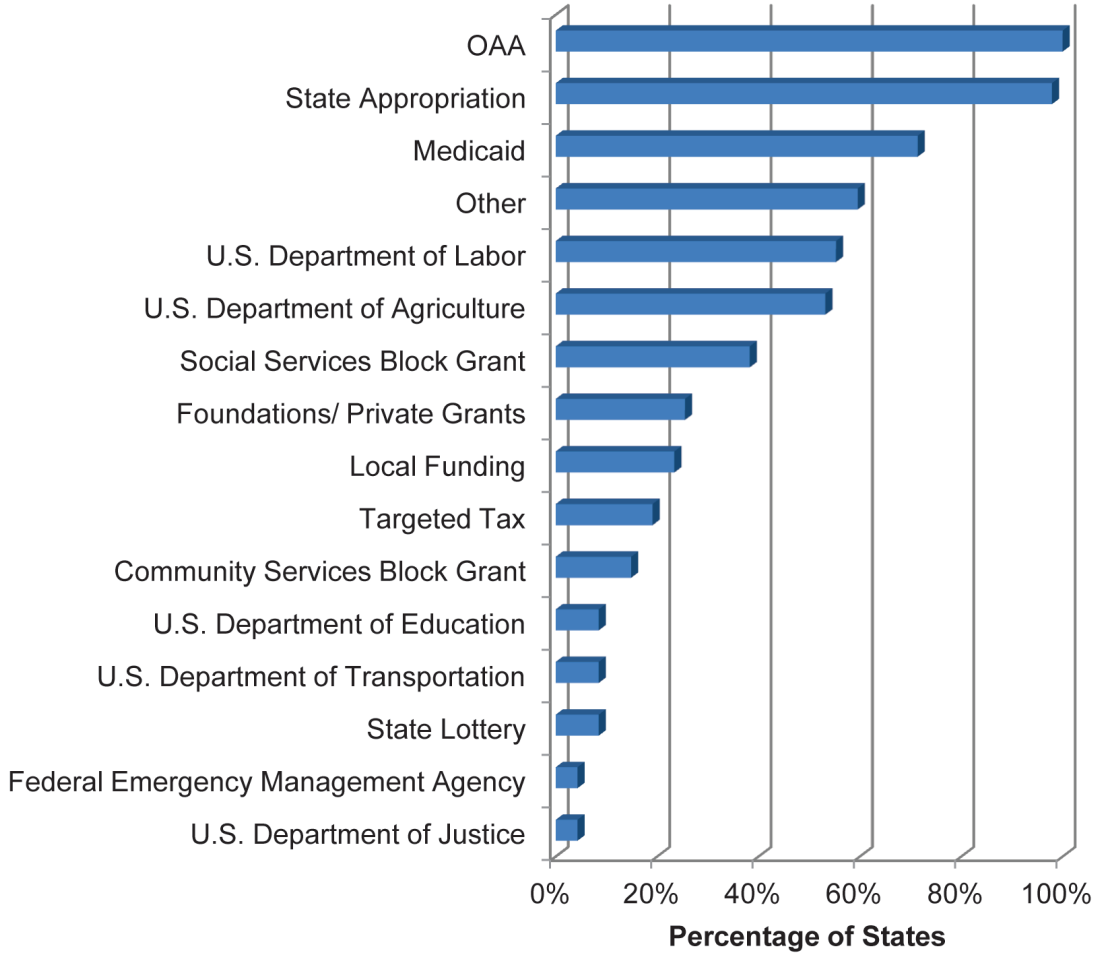
While no national data on the impact of non-Medicaid LTSS programs are available, research indicates that more than 85 percent of those receiving Older Americans Act (OAA)-funded homemaker services, case management, transportation, and home-delivered meals services said that this assistance helped them remain at home.[32] In addition, people receiving OAA services are at higher risk of nursing home placement than others in their age group nationally.[33] However, OAA funds are limited by federal

[31] NASUAD, *State of the States 2011*.

[32] Norma Altshuler and Jody Schimmel, *Aging in Place: Do Older Americans Act Title III Services Reach Those Most Likely to Enter Nursing Homes?* (Washington, DC: Mathematica Policy Research, Inc., July 2010).

[33] Ibid.

Figure 13
Core State Agency Budget Components by Percentage of States



Source: NASUAD, State of the States 2011 – Times of Change.

appropriations and have not kept pace with demand.[34] Many states are exploring strategies to infuse additional revenue into the OAA Aging Network architecture.[35]

[34] General Accountability Office, *Older Americans Act: More Should Be Done to Measure the Extent of Unmet Need for Services*. GAO-11-237 (Washington, DC: General Accountability Office, February 2011).

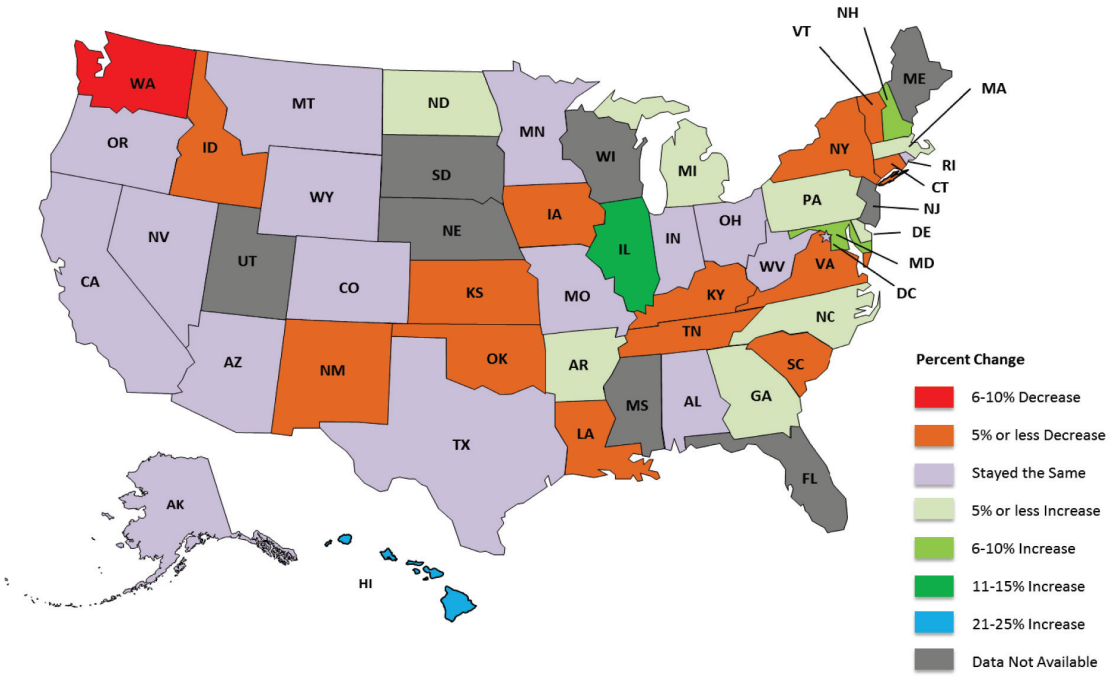
[35] The Older Americans Act statutorily frames a long-term services and supports infrastructure collectively referred to as the Aging Network. However, the Aging Network also serves younger people with disabilities in certain programs. The Aging Network is comprised of the U.S. Administration on Aging, 56 state and territorial SADAs, 629 Area Agencies on Aging, 20,000 local providers, and hundreds of thousands of Aging Network coordinated volunteers. The Aging Network also is a critical resource for vast numbers of family caregivers.

State Aging and Disability Agencies' Overall Budgets

State aging and disability agencies' non-Medicaid budgets fared somewhat better in FY 2011 than in FY 2010.

In FY 2011, 12 states increased non-Medicaid SADA funding, while 17 states made no change. Hawaii increased funding by between 21 and 25 percent, and Illinois increased funding by 11 to 15 percent. Maryland and New Hampshire increased funding by 6 to 10 percent. In FY 2011, only 14 states decreased non-Medicaid program funding. In comparison, in FY 2010, 31 states indicated they would reduce funding for non-Medicaid programs. Some correlation between increased state revenue and increased funding was found. Figure 14 provides an overview.

Figure 14
SFY 2011 Non-Medicaid State Aging and Disability Agency Budget Actions



The trend to preserve non-Medicaid LTSS programs continues from SFY 2011 into planned SFY 2012 budgets. Eight states plan to increase budgets, while an additional 16 plan to maintain expenditures at the same level as in SFY 2011. Eleven states plan to make decreases, while 10 were undecided. Figure 15 provides an overview of SFY 2012 planned changes by state and percentage change. Table VII in the appendix provides state detail around budget actions taken for non-Medicaid services.

Figure 15
SFY 2012 Non-Medicaid State Aging and Disability Agency Budget Actions

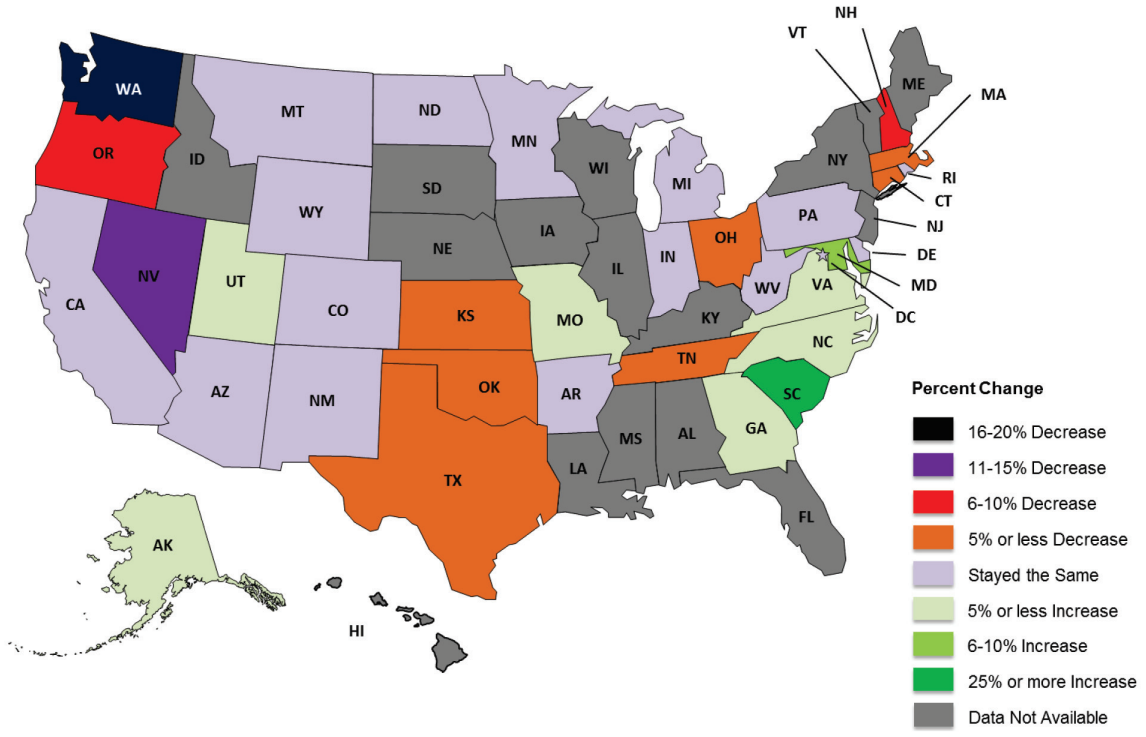
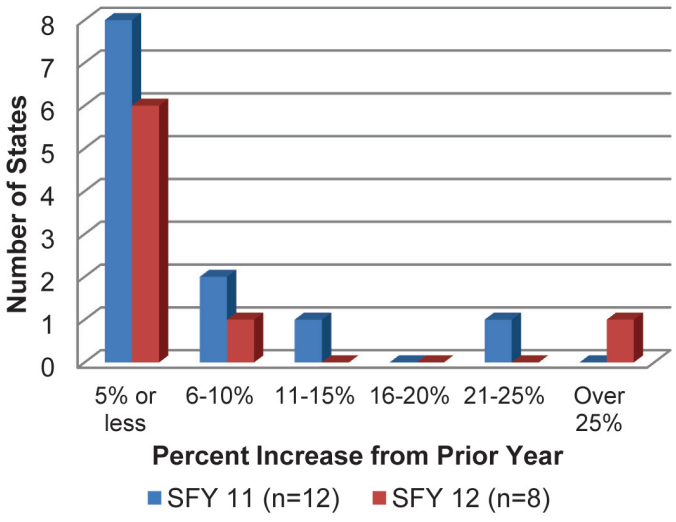


Figure 16 compares SFY 2011 and SFY 2012 SADA budgets. Over the course of SFY 2011 and SFY 2012, 14 states plan to increase non-Medicaid expenditures by 5 percent or less. Two additional states plan increases in the 6 to 10 percent range in SFY 2011, while one state will make a similar increase in SFY 2012. Two states plan to or have increased funding by 21 percent or more (Hawaii in SFY 2011 and South Carolina in SFY 2012).

A small number of states had actual increases in their non-Medicaid state aging and disability budgets in both SFY 2011 and SFY 2012. South Carolina, for example, increased its non-Medicaid aging and disability budget by more than 25 percent for SFY 2012.

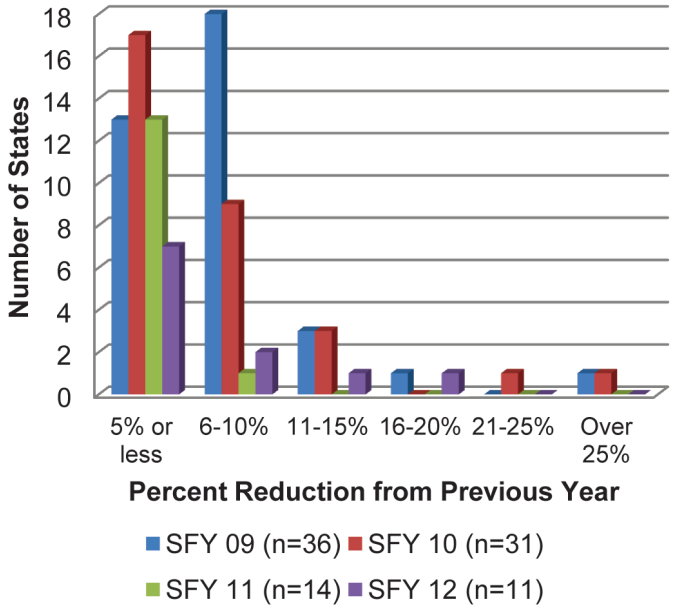
As shown in figure 17, for both SFY 2011 and projected SFY 2012, only Washington made, or plans to make, reductions of more

Figure 16
Increases in Non-Medicaid State Aging and Disability Agency Budgets, SFY 2011–2012



than 15 percent. Only Nevada plans to make reductions between 11 and 15 percent in SFY 2012. Oregon and New Hampshire will make changes between 6 and 10 percent. The vast majority of reductions in SFY 2011 and SFY 2012 will be 5 percent or less, and far fewer states indicate such reductions than in recent years.

Figure 17
Reductions in Non-Medicaid State Aging and Disability Agency Budgets, SFY 2009–2012



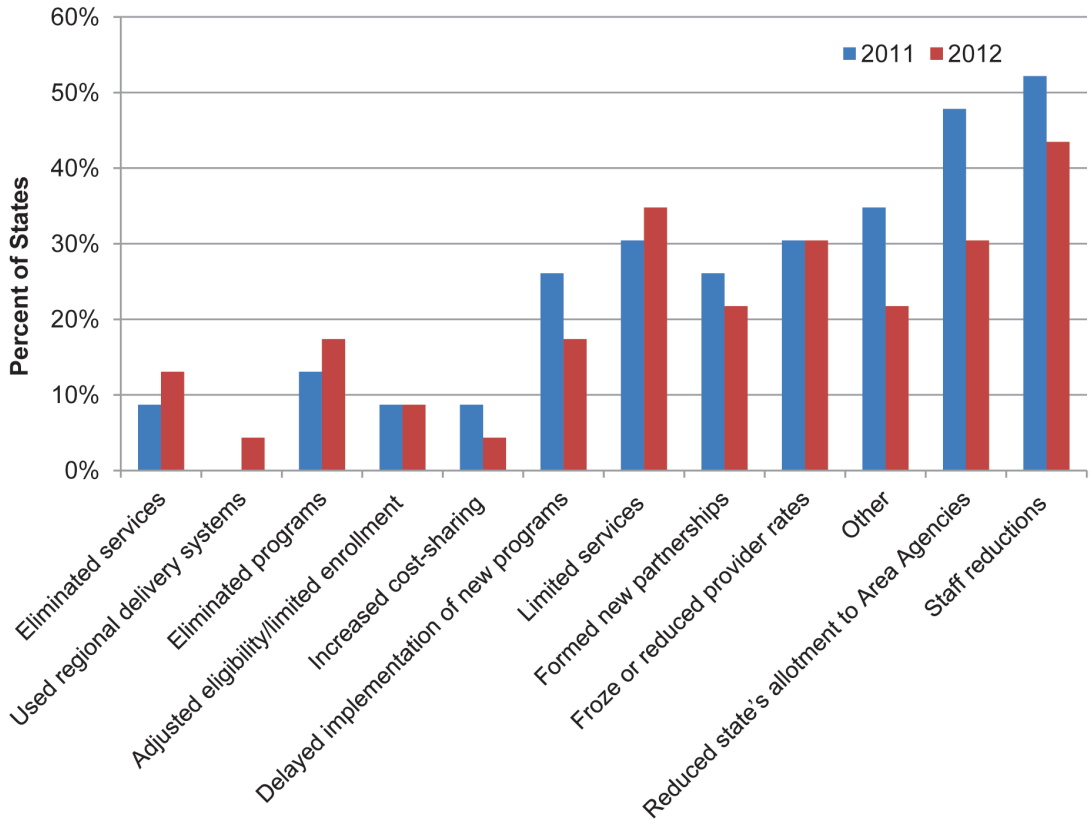
While fewer states made non-Medicaid budget cuts, those states where the economic situation has not started to improve or stabilize are still making reductions, albeit less deeply than in the past. Most interviewed officials noted that reductions might have been larger but, as in 2010, states once again turned to administrative cost-saving measures to preserve existing funding and mitigate service reductions.

Figure 18 shows that many states have or will be making staff reductions to meet savings targets. One state director noted, "We'd rather take the hit ourselves than reduce services again." States also are reducing allocations to Area Agencies on Aging (AAAs) and freezing or reducing provider rates. Several states noted that these strategies have worked for the past four years to preserve services or reduce the impact of budget cuts, but beginning in 2013 services would again become a target because "our staffing levels have been cut to the bone and providers have told us they cannot sustain another hit."

Of the states that have or will be reducing spending, several are exempting certain populations and services. Examples include funding for people at risk of institutionalization and adult protective services. When questioned, states that responded to "other" savings strategies indicated that they were contemplating reductions in the number of AAAs or other budget cuts to the AAAs. States that were considering using regional delivery systems as a method of saving money indicated that they were exploring meal routes and locations of senior centers.

Of note, several states also are investigating innovative strategies to save money while maintaining services. For instance, a number of the states are forging new partnerships to preserve services. Examples include participation in state efforts to better coordinate services for dual eligibles and partnerships with nontraditional sister state agencies. Regarding the latter, one SADA has been asked to assist the Department of Corrections with planning for and delivering services to incarcerated older adults. Another state agency has been asked to deliver aging and disability culture sensitivity training to Department of Motor Vehicles staff. Still others are developing business strategies to make clearer their departments' value to sister state agencies and private

Figure 18
Current and Planned Savings Strategies, SFY 2011–2012



sector partners such as health plans. These examples illustrate creative solutions that extend beyond the single state agency responsible for services.

To receive federal OAA funds, states must provide a nonfederal match ranging from 10 to 25 percent, depending on the program. The ability of most states to meet the OAA match requirement appears to be minimally affected by the economic downturn. In SFY 2011, four states reported difficulty matching OAA federal funds (California, Ohio, Rhode Island, and South Carolina). For SFY 2012, five states (California, New Hampshire, Rhode Island, South Carolina, and Washington) anticipate challenges with meeting their OAA matching requirements.

Some states are able to provide supplemental funding to AAAs. However, a handful of states in both SFY 2011 and SFY 2012 plan to reduce this funding for AAAs and/or local providers. In SFY 2011, nine states (Louisiana, Massachusetts, New Mexico, Oklahoma, South Carolina, Tennessee, Vermont, Virginia, and Washington) reduced state-only funding, and in SFY 2012, five states (Idaho, Illinois, South Carolina, Tennessee, and Washington) plan to make reductions.

Non-Medicaid, State-Only LTSS Programs

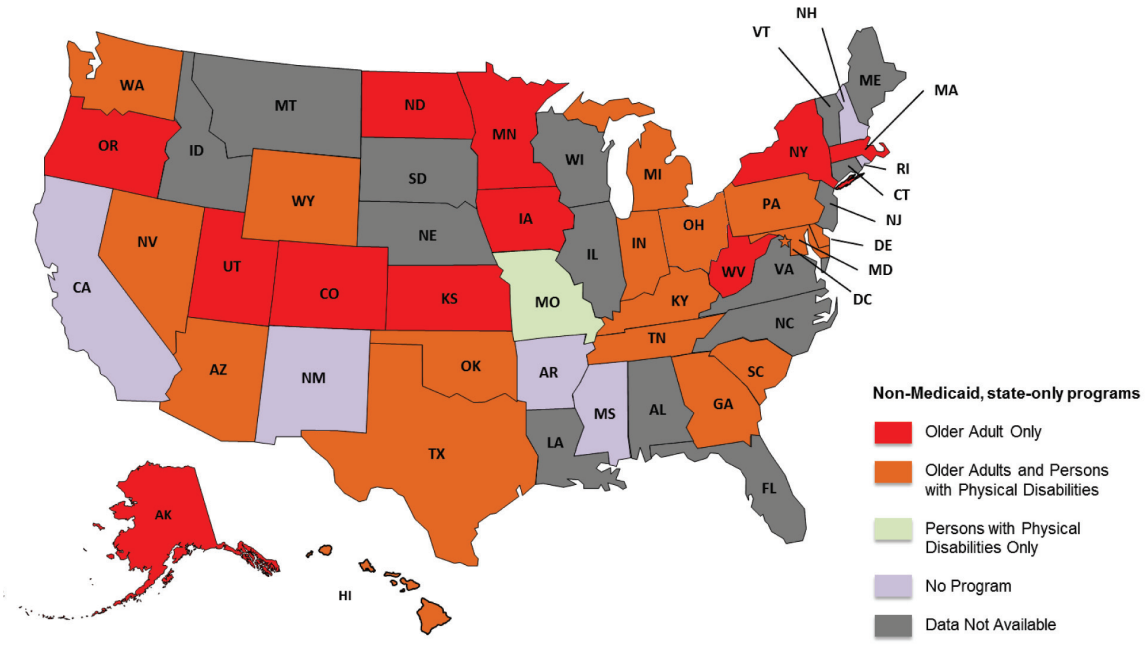
Despite the tough fiscal times, most states preserved non-Medicaid, state-only funded LTSS programs.

Non-Medicaid, state-only LTSS programs are small compared with Medicaid and total SADA budgets. All but seven states (Arkansas, California, Mississippi, Montana, New Hampshire, New Mexico, and Rhode Island) have such programs (figure 19). In interviews, many state officials highlighted the value of these programs:

- State-only portions of such programs allow states considerably more flexibility regarding what may be offered and to whom. Several states target such programs to people who are just above Medicaid eligibility or outside of OAA target populations but who also are critical populations at risk of institutionalization. Some need only minimal or intermittent assistance to remain at home.
- Changes in state-only programs may be made much more quickly, both to meet the needs of older adults and persons with disabilities or address service system issues that leverage federal funds. Specifically, state officials highlighted the administrative burden associated with submitting proposed changes to federal agencies and long delays in securing approval to make what may be time-sensitive changes to programs that involve federal funds.
- State-only programs enable states to serve more people who are not Medicaid eligible or using OAA programs—those with incomes slightly above Medicaid limits or outside of OAA target populations. State-funded programs may divert

Figure 19

Non-Medicaid, State-Only Funded Home and Community-Based Services Programs



Notes: The Alabama, Connecticut, Florida, Idaho, Illinois, Louisiana, Maine, Montana, Nebraska, New Jersey, North Carolina, South Dakota, Vermont, Virginia, and Wisconsin state aging and disability agencies did not provide data on their non-Medicaid, state-only programs.

such individuals from Medicaid or OAA programs. One state official indicated that "our Legislature really likes our state-only program because we've been able to demonstrate that it is slowing our Medicaid enrollment and because we are able to collect fees on a sliding fee scale from participants which help fund the services."

For these reasons, despite the difficult budgetary environment, only California and New Hampshire have eliminated such programs. In addition, Rhode Island leveraged its former non-Medicaid, state-only program funds to draw down federal matching funds for its new Medicaid waiver program and expanded eligibility under the waiver to ensure continued access to participants in the former non-Medicaid, state-only program. The status of Iowa's non-Medicaid, state-only program is in question for the upcoming fiscal year.[36]

Most reporting states indicated only small decreases, flat funding, or small increases in non-Medicaid, state-only funding. States with projected increased funding include Hawaii, Indiana, and Oklahoma. Colorado, Delaware, the District of Columbia, Georgia, Maryland, Michigan, and Wyoming all provided flat funding in the past fiscal year, as well as in the upcoming fiscal year.

Advocates' and state legislators' support of LTSS was the most frequently noted reason for preservation or increases in non-Medicaid, state-only programs. However, while states are investing in such programs, most interviewees expressed concern about the capacity of these programs to keep pace with increased demand and costs. Specifically, states that have flat-funded these programs likely will be unable to serve as many people and/or offer the same levels of services if program funding is unable to keep pace with increasing costs of delivering services. Similar concerns were expressed about Medicaid, despite federal matching.

Increased Service Demands

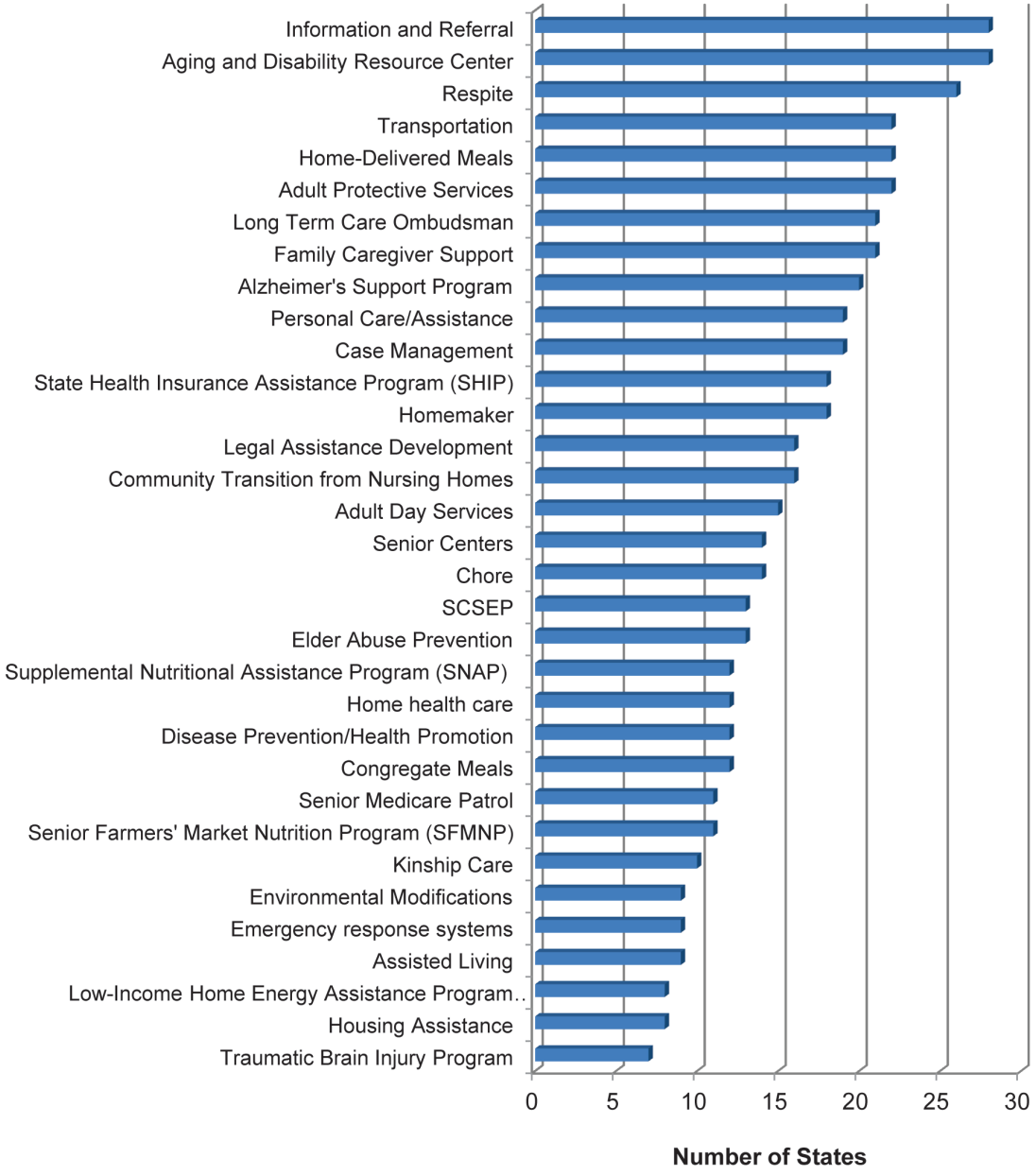
Requests for publicly funded services increased because of the recession, but fewer states reported increased demand in 2011 than in 2010.

The recession and its aftermath have led to mounting demand for public assistance as more people exhaust private resources and request assistance. In SFY 2011, more than half the states reported increased demands for information and referrals, ADRC services, and respite care (figure 20). On average, fewer states reported increased demand in 2011 than in 2010.

While the 2011 survey includes five fewer state responses than in the 2010 survey, the lower response rate does not entirely account for the magnitude of decreases. A relational analysis between increased program spending and decreased demand is beyond the scope of this report; however, two possibilities for decreased demand present themselves. First, due to year-over-year reductions, people may have stopped requesting services that no longer are available or available in sufficient supply. For example, one state director noted that in 2009 the state experienced a significant increase in demand for adult protective services. However, in 2011 she noted a decrease and indicated that "people have stopped calling because they know we no longer have the capacity to respond." Second, increased spending in some non-Medicaid programs may have contributed somewhat to decreased demand.

[36] Interviews with the Iowa SADA staff.

Figure 20
Programs with Increased Service Demands, SFY 2011

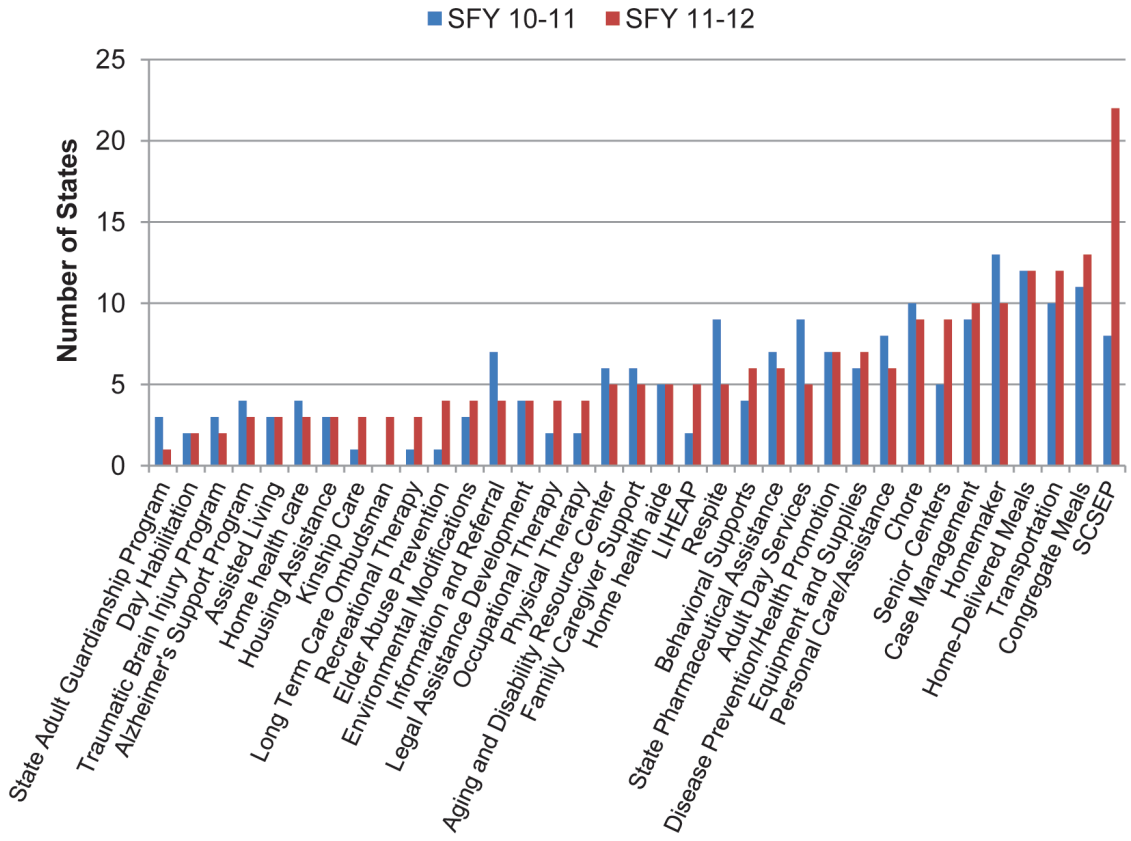


Decreased Service Expenditures for Non-Medicaid Programs

Although demand for non-Medicaid LTSS has increased since the beginning of the recession, state funding for these programs has not kept pace and in several areas has decreased.

The number of states implementing or planning to implement reductions in SFY 2011 or SFY 2012 decreased slightly from the 2010 survey (figure 21). For example, in last year's report, 16 states indicated that they planned to reduce home-delivered meals in SFY 2011. In this year's report, 12 states actually reduced home-delivered meals in

Figure 21
Decreased Service Expenditures for Non-Medicaid Programs, SFY 2010–11 and SFY 2011–12



SFY 2011. Similarly, in last year's report, 14 states indicated plans to decrease congregate meals, while in this year's report 11 actually made such reductions. As a final example, in 2011, nine states planned personal care reductions, and eight implemented such changes. Close to half the states plan to reduce their SCSEP in SFY 2011–12. Federal appropriations for the program likely will be significantly reduced in the coming federal fiscal year. In SFY 2011–12, several states also project decreases in homemaker, senior centers, and respite expenditures.

Again, many states have noted that further reductions were avoided by significant reductions in administrative spending and one-time appropriations. Whether or not future reductions may be avoided or past reductions addressed with new funding will depend on state fiscal health and advocacy efforts to preserve such programs.

Uncertainty Surrounding the Affordable Care Act

Many states report uncertainty about whether they will pursue HCBS provisions in the Affordable Care Act because of pending litigation in the U.S. Supreme Court as well as a lack of final federal guidance on implementation. The exceptions to this finding are the Money Follows the Person program (which was in existence prior to the ACA and for which states had experience) and the dual eligibles integration initiative.

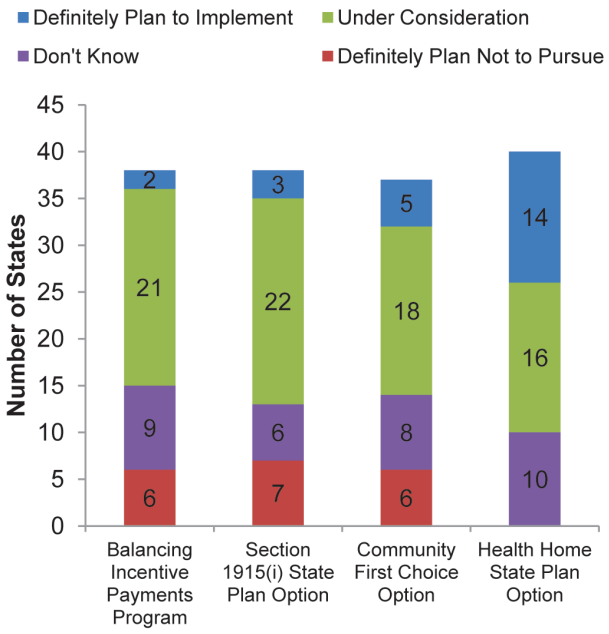
As in our 2011 report, many states reported uncertainty and, as a result, either indicated "Under Consideration" or "Don't Know" for several reasons:

- First, 28 states continue ACA-related litigation; the case will be heard by the U.S. Supreme Court in 2012. At the same time, 45 states are considering some form of state legislation "to limit, alter, or oppose selected state or federal actions."[37] Such actions on the part of governors, attorneys general, and state legislatures may affect state ACA activity.
- Additionally, CMS has released information on optional ACA provisions. However, much of the CMS guidance either is not yet final or was only recently released.

Last year, states were asked whether they were "Very Likely," "Somewhat Likely," "I Don't Know," or "Not Likely" to participate in some of the LTSS program opportunities within the ACA. In this year's survey, states were asked to respond with "Definitely Plan to Implement," "Definitely Plan Not to Pursue," "Under Consideration," or "Don't Know." This year's response required a slightly clearer course of action.

Table IX in the appendix provides state-by-state responses to questions about states' intent to pursue ACA initiatives, and figure 22 shows states' interest in these options. Below, each ACA provision directly relevant to LTSS populations is discussed in detail.

Figure 22
States' Indication of Intent to Pursue Selected Affordable Care Act Options



State Balancing Incentive Program

The State Balancing Incentive Program is a temporary, noncompetitive grant program designed to encourage states to balance their Medicaid spending toward HCBS. To be eligible, the state must have spent less than 50 percent of its total Medicaid LTSS dollars on noninstitutional services in FY 2009. Qualifying

[37] Richard Cauchi, "State Legislation and Actions Challenging Certain Health Reforms, 2011" (Washington, DC: National Conference of State Legislatures, 2011). Accessed October 22, 2011, at http://www.ncsl.org/?tabid=18906.

states must agree to make structural changes and meet a target spending percentage by the end of the balancing incentive period, October 1, 2015. If the state devoted less than 25 percent of its Medicaid LTSS spending to HCBS in FY 2009, it is eligible for a 5 percentage point FMAP increase for noninstitutionally based LTSS during the balancing incentive period. These states must raise their HCBS spending level to at least 25 percent by the end of the grant period. States that spent less than 50 percent, but more than 25 percent, will be eligible to receive a 2 percentage point FMAP increase for noninstitutionally based LTSS during the balancing incentive period. These states must raise their HCBS spending level to at least 50 percent by October 1, 2015.

To qualify for the program, a state must submit a grant application to CMS describing its plans for expanding Medicaid HCBS and changing its delivery system. Within six months of the application submission date, states must submit a work plan to develop a "no wrong door," single entry point system; conflict-free case management services; and a core standardized assessment instrument. Regarding the latter, CMS is not mandating an assessment instrument but rather data elements that must be included in existing or future tools. Participating states also must collect data on service utilization, quality, and beneficiary outcomes for HCBS, and are not allowed to apply more restrictive eligibility standards, methodologies, or procedures than those in effect on December 31, 2010, for all services for which the states will receive an enhanced FMAP.

In October 2011, CMS released a Balancing Incentive Program State Medicaid Directors Letter (SMDL), an application, a suggested state eligibility chart, and Balancing Incentive Program Implementation Manual. However, CMS's information was released after data collection for this survey. Of responding states, the majority either indicated that a Balancing Incentive Program is "Under Consideration" (21 states) or "Don't Know" (nine states). However, two states, Georgia and New Jersey, definitely plan to apply; New Hampshire has already submitted an application to CMS.

Section 1915(i) State Plan Option

Section 6086 of the Deficit Reduction Act of 2005 originally established the Section 1915(i) State Plan Option. Section 1915(i) is similar to Section 1915(c) HCBS waivers in the flexibility it offers in service definition and benefit package design. However, the Section 1915(i) state plan option differs in several important ways: (1) there is no requirement that individuals meet an institutional level of care in order to qualify; (2) states may not cap enrollment; and (3) the plan must operate statewide.[38] States also may have multiple Section 1915(i) State Plan Options targeting different populations and offering different services. While Section 1915(i) is a State Plan Option and not a waiver, states still must renew the state plan option every five years if their program targets a population, and alert CMS if enrollment trends higher than projected. In August 2010, CMS released a Section 1915(i) SMDL containing guidance incorporating ACA changes to the Section 1915(i) State Plan Option. However, no Section 1915(i) rules have been released that reflect changes made in the ACA.

Of responding states, 22 indicated that Section 1915(i) is under consideration, while three (California, Indiana, and Texas) indicated that they definitely plan to implement.

[38] The latter two differences are true for all Medicaid state plan benefits except for targeted case management (TCM). States may target TCM to specific geographic regions.

California and Texas have submitted Medicaid State Plan Amendments to CMS, and Indiana is in the concept development stage. At the time of the survey, seven states (Arizona, Hawaii, Michigan, Mississippi, Missouri, Tennessee, and Vermont) indicated that they definitely will not pursue Section 1915(i).

Community First Choice Option

The Community First Choice Option (CFCO) gives states the option to add a new participant-directed state plan HCBS attendant services and supports benefit. For services and supports delivered under CFCO, states will receive an enhanced FMAP of 6 percentage points for all enrollees for the lifetime of the program. CFCO has two eligibility groups: (1) individuals eligible for Medicaid under the state plan with incomes up to 150 percent of poverty who do not need to have an institutional level of care; and (2) individuals with incomes above 150 percent of poverty and up to 300 percent of SSI, provided they meet the state's institutional eligibility requirements.

During the first full fiscal year in which the state plan amendment is implemented, the state must maintain or exceed the level of state Medicaid HCBS expenditures provided to older Americans and individuals with disabilities in the previous fiscal year. In February 2011, CMS released a CFCO Notice of Proposed Rule Making; no final rule has been released.

Despite the enhanced FMAP, state officials are concerned about the costs associated with this program because, as a state plan benefit, all qualifying individuals are entitled to receive CFCO services. State officials also have expressed concern about state capacity to meet CFCO quality monitoring requirements. Similar to the Balancing Incentive Program, the majority of states are unclear about their course of action, with 18 states indicating "Under Consideration," while an additional eight responded "Don't Know." Five states (Alaska, Arizona, California, New York, and Rhode Island) indicated that they definitely plan to implement CFCO. All five are in the concept development phase.

Medical/Health Home Incentives

Medical/health homes are providers or a health team that coordinates care across settings for people with chronic conditions and/or mental health conditions. The ACA includes several options for states to provide medical/health homes; to date, three options have been offered. The first, a planning grant to states for the purposes of developing a health home state plan amendment, began in January 2011. The second option allows a state to enact the state plan amendment and provide coordinated care to Medicaid-eligible individuals with chronic conditions through a health home. Participating states would receive a 90 percent FMAP with respect to payments for health home services for the first two years the state plan amendment is in effect. The third option provides grants to states to establish community health teams for the purpose of supporting the development of patient-centered medical homes. A detailed Health Home SMDL was released in November 2010.

Of responding states, 14 definitely plan to implement, 16 are considering implementation, and 10 don't know. No states indicated that they definitely plan not to pursue the health home state plan optional benefit. States' efforts on the health home state plan option are more mature than other ACA options.

Money Follows the Person Rebalancing Demonstration and Other Enhanced Federal Match Opportunities

The Money Follows the Person Rebalancing Demonstration Program provides transition funding for Medicaid beneficiaries leaving nursing homes for community settings, and it also funds initiatives that improve opportunities for people to choose HCBS instead of institutional services. This demonstration program began in FY 2007 but was slated to expire at the end of FY 2011. The ACA extended and enhanced it, and provided an additional $2.25 billion in funding from FY 2012 to FY 2016, for total funding of $4 billion since FY 2007.[39] Forty-three states plus the District of Columbia are implementing Money Follows the Person programs.[40]

In the 2011 survey, the Money Follows the Person participation question was broadened to include other sources of enhanced FMAP, including enhanced Medicaid information systems matching. Of the responding states, 32 are using enhanced matching funds to build sustainable systems to balance LTSS systems. Of that figure, 23 are using funding to divert people from nursing homes, 20 are using funding to build interagency infrastructure, and 16 are enhancing systems to identify and secure affordable and accessible housing.[41] Only two, Connecticut and Texas, are using enhanced FMAP to close Medicaid nursing home beds.

ACA Initiatives with Unclear State Involvement

Accountable Care Organizations

An accountable care organization (ACO) is a type of payment and service delivery model intended to link provider reimbursements to quality metrics and reductions in the total cost of care for an assigned patient population. ACOs are composed of coordinated health care providers, which then deliver health care. The ACO may use a range of different payment models (i.e., capitation or fee-for-service with varying shared savings arrangements). The ACO is accountable to the patients and the third-party payer for the quality, appropriateness, and efficiency of health care provided. According to CMS, an ACO is "an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it." Section 3022 of the ACA created the Medicare Shared Savings program, allowing ACOs to contract with Medicare by January 2012. The ACA Medicare Shared Savings program promotes "accountability for a patient population and coordinates items and services under Part A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery."

Since ACO is an ACA Medicare effort and primarily aimed at the private marketplace, state involvement has been unclear. However, 10 states indicated that they are involved

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[39] Lynda Flowers and Wendy Fox-Grage, *Health Reform Law Creates New Opportunities for States to Save Medicaid Dollars* (Washington, DC: AARP Public Policy Institute, July 2011).

[40] U.S. Centers for Medicare & Medicaid Services. Accessed at https://www.cms.gov/CommunityServices/20_MFP.asp.

[41] States could select multiple ways to leverage enhanced FMAP.

in ACO development. Activities noted include (1) the state is serving as the lead entity in ACO development; (2) the state is working with the private marketplace to develop ACOs; and/or (3) the state is working with regional or local entities to develop ACOs. In several of the active states, AAAs and HCBS providers are included in their efforts.

Partnership for Patients

The Partnership for Patients effort is a broad federal initiative aimed at improving the quality, safety, and affordability of health care. Federal guidance suggests coordination among local entities such as home health providers, AAAs, and HCBS providers and community stakeholders, but not with state efforts. Of responding states, seven indicated that they are not involved in a Partnership for Patients effort while 26 indicated they were unsure of whether they would engage in such an effort; seven noted that they were engaged in some effort. Of the seven, four are acting as a convener or facilitator for HCBS provider involvement.

Table VIII in the appendix provides state-by-state detail for the above ACA options.

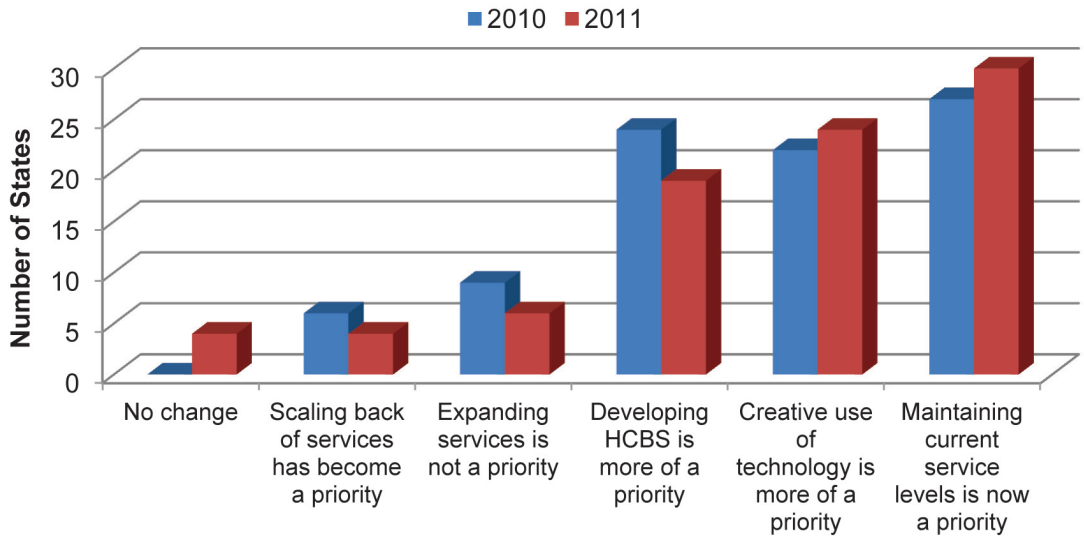
Outlook and Promising Practices

Maintaining current service levels continues to be the top state LTSS priority during these difficult economic times.

While a trend toward maintaining current service levels was found in 2010 and 2011, fewer states noted that HCBS development was a priority. It is possible that states interpreted this question to mean developing new programs rather than expanding existing programs.

Use of technology remains an important promising practice, with more than 20 states reporting such activities in both 2010 and 2011. States are using technology both to expand HCBS programs and to improve efficiency and effectiveness. During interviews, many states noted that technology efforts are under way, while others noted the need to enhance technology as part of achieving greater efficiencies and delivering more effective LTSS. Examples include Arkansas' integrated data systems and universal assessment tool, and Massachusetts' ongoing efforts to coordinate data and program performance information across funding streams and populations. Connecticut, as part of broader state initiative, is developing consolidated program reporting as part of an agency-by-agency dashboard reporting system for public use. Figure 23 and table IX in the appendix provide state detail around SADA priorities for long-term services and supports.

Figure 23
State Long-Term Services and Supports Priorities



Conclusion

Many states are undergoing or are about to undergo a dizzying array of LTSS transformations. The lagging economy and the increased demand for publicly funded LTSS have put pressure on state policymakers to redefine the way LTSS are financed and delivered in order to maximize access and system capacity.

Many of the state officials who are charged with implementing these significant reforms—which often include moving to managed LTSS, integrating care for dual eligibles, and figuring out the various HCBS options in the ACA—are new to their jobs. In addition, the majority of state agencies are conducting day-to-day work while also implementing critical changes with less staff due to continued staff reductions. The majority of states made administrative reductions before making changes to benefits and services.

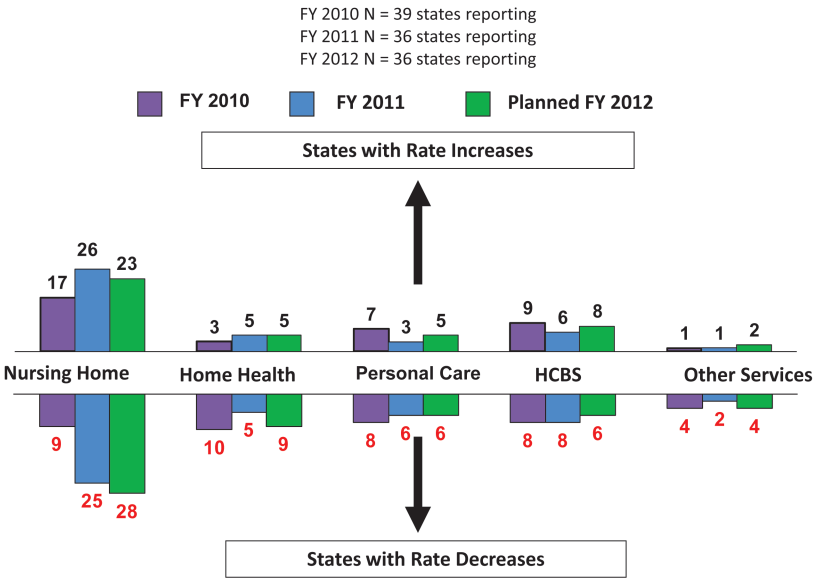
Many of the reforms hold great promise for cost containment as well as improved delivery of care for those who need LTSS. Yet, as many state aging and disability agency directors who were interviewed noted, many of the service delivery systems changes still are unfolding. They expressed concern over ongoing uncertainty about federal activity, including congressional budget actions and yet-to-be-released ACA guidance. The next few years will be critical as the transformations discussed in this report go from policy and demonstrations to full implementation and affect the lives of some of our most vulnerable citizens.

Appendix

Provider Reimbursement

Much like the findings in our 2011 report, Medicaid LTSS provider rate increases and decreases were mixed. With the exception of nursing home rates, states appear to be making somewhat fewer changes to provider reimbursement rates, whether increases or decreases, but this could be an anomaly due to fewer states responding to this set of questions in this year's survey.

Figure A1
Provider Reimbursement



Note: 39 states responded to the FY 2010 NF reimbursement questions in the survey with 36 states responding to questions for FY 2011 and FY 2012. Nursing Home reimbursement data for the remaining 12 and 15 states, respectively, was obtained from : "Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends;" Vernon K. Smith, Kathleen Gifford, Eileen Ellis, et.al.; Kaiser Commission on Medicaid and the Uninsured; October 2011.

Thirty-six states responded to the question regarding nursing home rates for at least one of the years. We obtained data for the remaining states and fiscal year from the Kaiser Commission's annual budget survey of states.[1] Institutional providers such as nursing facilities typically receive cost-of-living (COLA) or inflationary adjustments as an element of reimbursement, so are more likely to change reimbursement in a given year. Some states have a legal requirement to increase nursing home reimbursement rates. States that did not provide the COLA increase or the full COLA increase were treated as states with rate decreases. State detail around rate changes for LTSS providers can be found in table 11.

[1] V. Smith et.al. October 2011.

Table I
Medicaid Managed Long-Term Care Services and Supports

	Existing program 2010, 2011	Plan to Implement		Have or Plan Statewide Program	Services Included or Planned to Be Included						Other	Dual Integration
		2012	2013		Acute Care	HCBS	1915(i) State Plan HCBS**	Nursing Facility	Self-Directed Services	Family Caregiver Services		
	12	6	5	11	16	18	10	15	16	8	5	13
Alabama												
Alaska												
Arizona	√			√	√	√		√	√	√		√
Arkansas												
California		√				√	√	√	√		Behavioral Health	C
Colorado												
Connecticut												
Delaware		√			√	√		√	√			N
District of Columbia												
Florida	√			√		√		√	√			√
Georgia												
Hawaii	√			√	√	√		√	√	√		√
Idaho	√			√	√	√		√				√
Illinois			√	√	√						Mental Health Substance Abuse	C
Indiana		√			√	√	√	√	√	√		√
Iowa												
Kansas			√								All Other LTSS Services	C

Table I (continued)
Medicaid Managed Long-Term Care Services and Supports

	Existing program 2010, 2011	Plan to Implement		Have or Plan Statewide Program	Services Included or Planned to Be Included						Other	Dual Integration
		2012	2013		Acute Care	HCBS	1915(i) State Plan HCBS**	Nursing Facility	Self-Directed Services	Family Caregiver Services		
Kentucky												
Louisiana												
Maine			√			√	√	√	√	√		C
Maryland												
Massachusetts	√			√	√	√	√	√	√	√	Behavioral Health and other supports (benefits under development)	√
Michigan			√		√							√
Minnesota	√			√	√	√	√	√	√	√		√
Mississippi												
Missouri												
Montana												
Nevada		√										C
New Hampshire*												
New Jersey		√				√	√		√			C
New Mexico	√			√	√	√		√	√	√		√
New York	√			√		√	√	√			Benefits under development	√
North Carolina												
North Dakota												
Ohio			√			√			√			C

Table I (continued)
Medicaid Managed Long-Term Care Services and Supports

	Existing program 2010, 2011	Plan to Implement		Have or Plan Statewide Program	Services Included or Planned to Be Included						Other	Dual Integration
		2012	2013		Acute Care	HCBS	1915(i) State Plan HCBS**	Nursing Facility	Self-Directed Services	Family Caregiver Services		
Oklahoma												
Oregon												
Pennsylvania												
Rhode Island		√			√	√		√	√			√
South Carolina												
Tennessee	√			√	√	√		√	√	√		C
Texas	√				√	√	√		√			√
Utah												
Vermont												
Virginia												
Washington	√				√	√	√		√			N
West Virginia												
Wisconsin**	√			√	√	√	√	√	√			
Wyoming					√							√

√ = the state does or plans to include in its program. C = Under consideration; N = Does not currently or plan to include in the program.

* New Hampshire released an RFP in October 2011, after the survey was completed. Although the state did not indicate plans to implement an MMLTSS program on the survey, the RFP includes the nondual eligible aged and disabled as a mandatory population in its managed care program, and dual eligibles as a voluntary population as of July 1, 2012. The state is also seeking a waiver to include dual eligibles as a mandatory group in managed care.

** Wisconsin did not respond to the survey. Data for Wisconsin are from outside sources, including the state's website at http://dhfs.wisconsin.gov/wipartnership/ and http://dhfs.wisconsin.gov/LTCare/. Wisconsin has two MMLTC programs—the Partnership program, which includes physically disabled frail older people, and Family Care, which includes adults and older people (65+) with physical disabilities. Only the Partnership includes acute care services. The state plans to expand the Family Care program statewide.

*** Only five states had implemented 1915(i) State Plan HCBS services in 2010 (Colorado, Iowa, Nevada, Washington, and Wisconsin). Washington discontinued its services in 2011, and California has submitted a 1915(i) State Plan Amendment. The states that indicate 1915(i) HCBS services will be included in their MMLTC programs have also indicated that they are considering or will pursue a 1915(i) Plan Amendment under the new provisions in the ACA.

Table II

State Activity around Medicaid/Medicare Dual Eligible Service Integration

	Letters of Intent for Dual Integration Pilots	Integration Demonstration Grants	Currently Enroll Duals into Non-PACE Managed Care	Currently Integrate Dual Services into MMLTSS	Plan to Integrate Dual Services into MMLTSS
	38	15	25	7	6
Alabama					
Alaska	√				
Arizona	√		√	√	
Arkansas					
California	√	√	√		
Colorado	√	√	√		
Connecticut	√	√			
Delaware	√				
District of Columbia	√		√		
Florida	√		√	√	
Georgia			√		
Hawaii	√		√		√
Idaho	√		√		√
Illinois	√				
Indiana	√				√
Iowa	√		√		
Kansas	√				
Kentucky	√		√		
Louisiana					
Maine	√				
Maryland	√				
Massachusetts	√	√	√	√	
Michigan	√	√	√		√
Minnesota	√	√	√	√	
Mississippi					
Missouri	√				
Montana	√				
Nebraska					
Nevada	√				
New Hampshire					
New Jersey			√		
New Mexico	√		√	√	
New York	√	√	√	√	

Table II (continued)
State Activity around Medicaid/Medicare Dual Eligible Service Integration

	Letters of Intent for Dual Integration Pilots	Integration Demonstration Grants	Currently Enroll Duals into Non-PACE Managed Care	Currently Integrate Dual Services into MMLTSS	Plan to Integrate Dual Services into MMLTSS
North Carolina	√	√	√		
North Dakota					
Ohio	√				
Oklahoma	√	√			
Oregon	√	√	√		
Pennsylvania	√		√		
Rhode Island	√				√
South Carolina	√	√	√		
South Dakota					
Tennessee	√	√	√		
Texas	√		√	√	
Utah			√		
Vermont	√	√			
Virginia	√				
Washington	√	√	√		
West Virginia					
Wisconsin	√	√	√		
Wyoming					√

Table III
Home and Community-Based Services: Benefit Expansions

State	FY 2011	FY 2012
Alabama	▪ Expanded medical criteria ▪ Added Alabama Community Transition waiver	▪ Expand level of care criteria
Arkansas	▪ Added 600 hours of long-term facility respite as an allowed service in adult family homes	
California		▪ Change in In-Home Operations waiver. Add adult day health care (ADHC) participants who meet nursing facility B level of care (NF-B LOC) criteria. Note: ADHC state plan benefit elimination effective 12/1/11.
Delaware		▪ Terminating 1915(c) and replacing with managed long-term care
Kansas		▪ Adding telehealth services
Maryland	▪ Added or expanded transition benefit	▪ Adding case management as a service
Missouri		▪ Adding a new adult day care waiver
New Hampshire		▪ Adding nonmedical transportation
New Mexico	▪ Added specialized medical equipment and supplies to Medically Fragile waiver ▪ Added community services and transition services to Coordination of Long-Term Services waiver in managed care	▪ Adding Money Follows the Person services
North Dakota		▪ Adding more flexibility in extended personal care services ▪ Adding more flexibility in transportation for the Technology Dependent waiver
Ohio		▪ Eligibility provisions for the Assisted Living waiver were modified to allow individuals in the community who are not in a waiver program to access services. Previously, the waiver was limited to individuals on other HCBS waivers or those currently living in a licensed residential care facility.

Table IV
Home and Community-Based Service Waivers: Benefit Restrictions

State	FY 2011	FY 2012
New Hampshire		▪ Place limits on specialized medical equipment ▪ Eliminate assistive technology services (program services were never used)
New Jersey		▪ Cap environmental accessibility adaptations (EAAs). EAA modification services will be limited to $5,000 per participant per waiver year. Additional modification costs exceeding those limits may be requested if a participant's health and safety require special consideration; however, services are subject to a $10,000 lifetime cost cap for each participant assessed to require such adaptation(s).
North Dakota	▪ Instituting more prescriptive case management activities	
Oregon	▪ Instituting a 5% reduction in authorized in-home hours	
Pennsylvania		▪ New restrictions and limits on community integration services
Washington	▪ Reducing personal care services hours	

Table V
State Medicaid HCBS Waiver and Nursing Facility Activity

	HCBS Waiver Census Change		HCBS Expenditure Change		Nursing Facility Census Change	
	2010 to 2011	2011 to 2012 (projected)	2010 to 2011	2011 to 2012	2010 to 2011	2011 to 2012
Alabama			+5%–8%	+5%–8%	↑	0
Alaska	↑	↑	+8%–15%	+ More than 15%	↓	0
Arizona	0	↑			↓	↓
Arkansas	↑	↑	+Less than 5%	+Less than 5%	↑	↑
California	↑	↑	+	+	↓	0
Colorado						
Connecticut	↑	↑	+5%–8%	+Less than 5%	↓	↓
Delaware	0	0				
District of Columbia					0	0
Florida	↑	↑	+Less than 5%	+Less than 5%	0	0
Georgia	↑	↑	+Less than 5%	+Less than 5%	0	0
Hawaii					↓	↓
Idaho	↑	↑	+8%–15%	+5%–8%	0	0
Illinois	↑	↑	-(Less than 5%)	+Less than 5%	↓	↓
Indiana	↑	↑	+Less than 5%	+Less than 5%	↑	↓
Iowa	↓	↑	-(Less than 5%)	+5%–8%	↓	↓
Kansas	0	↑	+Less than 5%		↓	↑
Kentucky						
Louisiana						
Maine	↑	↑	+Less than 5%	+Less than 5%	↓	0
Maryland	↑	↑	+	+		
Massachusetts	↑	↑	+5%–8%	+8%–15%	↓	↓
Michigan	↑	↑	+8%–15%	+5%–8%	0	0
Minnesota	↑	↑	+Less than 5%	+Less than 5%	↓	↓
Mississippi	↑	↑	+8%–15%	+8%–15%	↑	↑
Missouri	↑	↑	+5%–8%	+5%–8%	↓	0
Montana						
Nebraska						
Nevada	0	0			0	↓
New Hampshire	↑	↑	- (5%–8%)		↓	0

Table V (continued)
State Medicaid HCBS Waiver and Nursing Facility Activity

	HCBS Waiver Census Change		HCBS Expenditure Change		Nursing Facility Census Change	
	2010 to 2011	2011 to 2012 (projected)	2010 to 2011	2011 to 2012	2010 to 2011	2011 to 2012
New Jersey	↑	↑	+ More than 15%	+Less than 5%	↓	↓
New Mexico	↓	↑	+5%–8%	+	↓	↓
New York						
North Carolina						
North Dakota	0	0	+8%–15%	+5%–8%	0	0
Ohio	↑	↑	+8%–15%	+Less than 5%		↓
Oklahoma	↓	0	+Less than 5%	+Less than 5%	0	0
Oregon	↑	↑	+Less than 5%		↓	↓
Pennsylvania	↑	↑	+ More than 15%		↓	0
Rhode Island	↑	↑	+8%–15%		↑	↓
South Carolina						
South Dakota						
Tennessee	↑	↑	+8%–15%	+8%–15%	↓	↓
Texas	↑	0	+Less than 5%		↑	0
Utah	0	↑	0			
Vermont	↑	↑	-(Less than 5%)	+Less than 5%	↓	↓
Virginia						
Washington	↑	↑	+5%–8%	+	↓	↓
West Virginia	↑	↑	+8%–15%	+5%–8%	↑	↑
Wisconsin						
Wyoming	0	0			0	↑

↑ = census increase ↓= census decrease 0 = census did not change + = expenditure increase -() = expenditure decrease

Table VI
State Actions Taken on State Plan LTSS Benefits

Benefit	State Action Taken on State Plan Benefits
Personal Care Services	(↓) 2011: New Mexico imposed personal care service assessment restrictions and reduced the number of hours for temporary state plan personal care option (PCO) services.
	(↓) 2012: Arizona plans to reduce the total number of allowable respite care hours.
	(↓) 2012: Hawaii plans to decrease the benefit limit from a maximum of 20 hours per week to 10 hours per week. (Noninstitutional LTSS are provided under an 1115 demonstration waiver.)
	(↓) 2012: Michigan will eliminate eligibility for individuals who require only instrumental activities for daily living. Each individual will be reevaluated at renewal of eligibility.
	(↓) 2012: New Mexico will combine ten PCO services into six, prohibit retroactive service approvals, and require new health and physical with each level of care determination.
Adult Day Health	(↔) 2012: Missouri will eliminate adult day health from the state plan and offer the services under a new waiver.
	(↔) 2012: California will eliminate adult day health from the state plan and transition the services to community-based adult services (CBAS) offered under an 1115 waiver. There will be no enrollment cap for the services. Adult day health recipients found not eligible for CBAS will be provided enhanced case management to transition to other community-based support services.
HCBS State Plan Option	(↑) 2012: Connecticut plans to add 1915i services.
	(↔) 2012: New Jersey plans to roll out a managed care model for state plan services.
Home Health	(↓) 2011: Connecticut limited the number of health home assistant hours available without prior authorization.
Other	(↑) 2011: Maryland expanded unspecified transitional benefits.
	(↑) 2012: Maryland will add case management as a service.
	(↑) 2012: Alabama is expanding access to PACE.

(↑) Benefit Increase (↓) Benefit Decrease (↔) No Benefit Impact

Table VII
Budget Summary

State	SFY 2011 State Agency Non-Medicaid Budget	SFY 2011 Change	Percent Increase/Decrease	Exempted Populations, Services, or Programs	SFY 2012 Change	Percent Increase/Decrease	Exempted Populations, Services, or Programs
Alabama	Between $25 and $50 million	0			DK		
Alaska	Between $25 and $50 million	0			+	5% or less	No
Arizona	Between $50 and $100 million	0			0		
Arkansas	Between $25 and $50 million	+	5% or less	No	0		
California	Between $5 and $15 million	0			0		
Colorado	Between $5 and $15 million	0			0		
Connecticut	Between $25 and $50 million	-	5% or less	No	-	5% or less	No
Delaware	Between $25 and $50 million	+	5% or less	No	0		
District of Columbia	Between $15 and $25 million	0			0		
Florida							
Georgia	Between $25 and $50 million	+	5% or less	Yes	+	5% or less	Yes
Hawaii	Between $5 and $15 million	+	21%–25%	No	DK		
Idaho	Between $5 and $15 million	-	5% or less		DK		
Illinois	More than $100 million	+	11%–15%		DK		
Indiana	Between $50 and $100 million	0			0		
Iowa	Between $5 and $15 million	-	5% or less	No	DK		
Kansas	Between $25 and $50 million	-	5% or less	No	-	5% or less	No
Kentucky	Between $50 and $100 million	-	5% or less	No	DK		
Louisiana	Between $25 and $50 million	-	5% or less	No	DK		
Maine	Between $15 and $25 million	DK			DK		
Maryland	Between $25 and $50 million	+	6%–10%	No	+	6%–10%	No
Massachusetts	More than $100 million	+	5% or less	No	-	5% or less	No
Michigan	Between $50 and $100 million	+	5% or less	No	0		
Minnesota	Between $25 and $50 million	0			0		
Mississippi							
Missouri	Between $50 and $100 million	0			+	5% or less	No

Table VII (continued)
Budget Summary

State	SFY 2011 State Agency Non-Medicaid Budget	SFY 2011 Change	Percent Increase/Decrease	Exempted Populations, Services, or Programs	SFY 2012 Change	Percent Increase/Decrease	Exempted Populations, Services, or Programs
Montana	Less than $1 million	0			0		
Nebraska							
Nevada	Between $50 and $100 million	0			-	11%–15%	No
New Hampshire	Between $15 and $25 million	+	6%–10%	Yes	-	6%–10%	Yes
New Jersey							
New Mexico	Between $15 and $25 million	-	5% or less	No	0		
New York	More than $100 million	-	5% or less	No	DK		
North Carolina	More than $100 million	+	5% or less	No	+	5% or less	No
North Dakota	Between $15 and $25 million	+	5% or less		0		
Ohio	Between $50 and $100 million	0			-	5% or less	Yes
Oklahoma	More than $100 million	-	5% or less	Yes	-	5% or less	Yes
Oregon	Between $15 and $25 million	0			-	6%–10%	No
Pennsylvania	More than $100 million	+	5% or less	No	0		
Rhode Island	Between $15 and $25 million	0			0		
South Carolina	Between $25 and $50 million	-	5% or less	No	+	over 25%	No
South Dakota							
Tennessee	Between $25 and $50 million	-	5% or less	Yes	-	5% or less	Yes
Texas	More than $100 million	0			-	5% or less	No
Utah	Between $15 and $25 million				+	5% or less	No
Vermont	Between $25 and $50 million	-	5% or less		DK		
Virginia	Between $50 and $100 million	-	5% or less	No	+	5% or less	No
Washington	Between $25 and $50 million	-	6%–10%	No	-	16%–20%	No
West Virginia	Between $25 and $50 million	0			0		
Wisconsin							
Wyoming	Between $50 and $100 million	0			0		

Table VIII
Long-Term Services and Supports—Affordable Care Act Initiatives

State	Community First Choice Option	Amended Section 1915(i)	Balancing Incentive Payment Program	Money Follows the Person	Health Homes	Improved Care Coordination for Dual Eligible Individuals	Accountable Care Organizations	Partnership for Patients
Alabama	Under Consideration	Under Consideration	Under Consideration	No	Definitely Plan to Implement	No	No, not under consideration	Do not know
Alaska	Definitely Plan to Implement	Under Consideration	Definitely Do Not Plan to Pursue	No	Under Consideration	Yes	No, not under consideration	No
Arizona	Definitely Plan to Implement	Definitely Do Not Plan to Pursue	Definitely Do Not Plan to Pursue	Yes	Definitely Plan to Implement	Yes	Do not know	Do not know
Arkansas	Under Consideration	Under Consideration	Under Consideration	Yes	Definitely Plan to Implement	No	No, not under consideration	No
California	Definitely Plan to Implement	Definitely Plan to Implement	Do not know	Yes		Yes	Do not know	Do not know
Colorado								
Connecticut	Under Consideration	Under Consideration	Under Consideration	Yes	Definitely Plan to Implement	Yes	Yes, for both older adults and people with physical disabilities	Do not know
Delaware	Under Consideration	Do not know	Under Consideration	Yes	Do not know	Yes	Do not know	Yes
District of Columbia						No		Do not know
Florida			Do not know	Do not know	Do not know	Yes	No, not under consideration	Do not know
Georgia	Under Consideration	Under Consideration	Definitely Plan to Apply	Yes	Under Consideration	No		Do not know
Hawaii	Don't Know	Definitely Do Not Plan to Pursue	Under Consideration	Yes	Definitely Plan to Implement	Yes	No, not under consideration	Yes

Table VIII (continued)

Long-Term Services and Supports—Affordable Care Act Initiatives

State	Community First Choice Option	Amended Section 1915(i)	Balancing Incentive Payment Program	Money Follows the Person	Health Homes	Improved Care Coordination for Dual Eligible Individuals	Accountable Care Organizations	Partnership for Patients
Idaho	Definitely Plan Not to Pursue	Under Consideration	Under Consideration	Yes	Under Consideration	Yes	No, not under consideration	Do not know
Illinois	Under Consideration	Under Consideration	Under Consideration	Yes	Definitely Plan to Implement	Yes	Yes, for both older adults and people with physical disabilities	Yes
Indiana	Definitely Plan Not to Pursue	Under Consideration	Do not know	Yes	Under Consideration	Yes	Do not know	Do not know
Iowa	Under Consideration	Under Consideration	Under Consideration	Yes	Definitely Plan to Implement	No	Yes, for both older adults and people with physical disabilities	No
Kansas	Do not know	Do not know	Do not know	Do not know	Do not know	No	Do not know	Do not know
Kentucky								
Louisiana								
Maine	Under Consideration	Under Consideration	Under Consideration	Yes	Do not know	Yes	Do not know	Do not know
Maryland	Under Consideration	Under Consideration	Under Consideration	Yes	Under Consideration	No	Do not know	Yes
Massachusetts	Under Consideration	Under Consideration	Under Consideration	Yes	Under Consideration	Yes	Yes, for both older adults and people with physical disabilities	Do not know

Table VIII (continued)

Long-Term Services and Supports—Affordable Care Act Initiatives

State	Community First Choice Option	Amended Section 1915(i)	Balancing Incentive Payment Program	Money Follows the Person	Health Homes	Improved Care Coordination for Dual Eligible Individuals	Accountable Care Organizations	Partnership for Patients
Michigan	Do not know	Definitely Do Not Plan to Pursue	Under Consideration	Yes	Under Consideration	Yes	Yes, for both older adults and people with physical disabilities	Do not know
Minnesota	Under Consideration	Under Consideration	Definitely Do Not Plan to Pursue	Yes	Definitely Plan to Implement	Yes	Yes, for both older adults and people with physical disabilities	Do not know
Mississippi	Under Consideration	Definitely Do Not Plan to Pursue	Under Consideration	Yes	Under Consideration	No	No, not under consideration	Do not know
Missouri	Definitely Plan Not to Pursue	Definitely Do Not Plan to Pursue	Under Consideration	Yes	Under Consideration	No	No, not under consideration	Do not know
Montana								
Nebraska								
Nevada	Do not know	Under Consideration	Under Consideration	Under Consideration	Under Consideration	Yes	Do not know	No
New Hampshire	Under Consideration	Under Consideration	Under Consideration	Yes	Under Consideration	Yes	Do not know	Do not know
New Jersey	Do not know	Under Consideration	Definitely Plan to Apply	Yes	Definitely Plan to Implement	Yes	Yes, for both older adults and people with physical disabilities	Yes
New Mexico				Yes	Do not know	Yes	Do not know	Do not know

Table VIII (continued)

Long-Term Services and Supports—Affordable Care Act Initiatives

State	Community First Choice Option	Amended Section 1915(i)	Balancing Incentive Payment Program	Money Follows the Person	Health Homes	Improved Care Coordination for Dual Eligible Individuals	Accountable Care Organizations	Partnership for Patients
New York	Definitely Plan to Implement	Do not know	Do not know	Do not know	Definitely Plan to Implement		Do not know	Do not know
North Carolina								
North Dakota	Do not know	Under Consideration	Do not know	Yes	Under Consideration	No	Do not know	Do not know
Ohio	Definitely Plan Not to Pursue	Do not know	Under Consideration	Yes	Under Consideration	Yes	Yes, for both older adults and people with physical disabilities	No
Oklahoma	Under Consideration	Under Consideration	Under Consideration	Do not know	Under Consideration	Yes	Do not know	Do not know
Oregon	Under Consideration	Under Consideration	Do not know	Yes	Do not know	Yes	Yes, for both older adults and people with physical disabilities	Do not know
Pennsylvania	Under Consideration	Under Consideration	Under Consideration	Yes	Under Consideration	Yes	Do not know	Do not know
Rhode Island	Definitely Plan to Implement	Do not know	Under Consideration	Yes	Definitely Plan to Implement	Yes	No, not under consideration	Yes
South Carolina								
South Dakota								
Tennessee	Definitely Plan Not to Pursue	Definitely Do Not Plan to Pursue	Under Consideration	Yes	Do not know	Yes	No, not under consideration	Do not know
Texas	Do not know	Definitely Plan to Implement	Do not know	Yes	Do not know	Yes	Do not know	Do not know

Table VIII (continued)

Long-Term Services and Supports—Affordable Care Act Initiatives

State	Community First Choice Option	Amended Section 1915(i)	Balancing Incentive Payment Program	Money Follows the Person	Health Homes	Improved Care Coordination for Dual Eligible Individuals	Accountable Care Organizations	Partnership for Patients
Utah								
Vermont	Definitely Plan Not to Pursue	Definitely Do Not Plan to Pursue	Definitely Do Not Plan to Pursue	Yes	Definitely Plan to Implement	Yes	No, not under consideration	No
Virginia	Do not know	Do not know	Do not know	Yes	Do not know		Do not know	Do not know
Washington	Under Consideration	Under Consideration	Definitely Do Not Plan to Pursue	Yes	Definitely Plan to Implement	Yes	Do not know	Yes
West Virginia								
Wisconsin								
Wyoming	Under Consideration	Under Consideration	Definitely Do Not Plan to Pursue	No	Under Consideration	No	No, not under consideration	No

* Response is taken from "Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage, and Policy Trends. Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012; Vernon K. Smith, Kathleen Gifford and Eileen Ellis; Health Management Associates; and Robin Rudowitz and Laura Snyder; Kaiser Commission on Medicaid and the Uninsured; October 2011. These states indicated they intend to pursue options in 2012.

Table IX
State Agency on Aging and Disabilities Priorities, 2010–2011

State	No Change	Expanding Services is Not a Priority	Developing HCBS is More of a Priority	Developing HCBS is Less of a Priority	Scaling Back of Services Has Become a Priority	Maintaining Current Service Levels is Now a Priority	Creative Use of Techology is More of a Priority	Other
Alabama								
Alaska			√				√	
Arizona						√	√	
Arkansas						√	√	
California						√		
Colorado						√		
Connecticut		√	√			√	√	
Delaware			√			√		
District of Columbia						√		
Florida								
Georgia			√			√	√	
Hawaii			√				√	√
Idaho			√				√	√
Illinois			√			√	√	
Indiana	√							
Iowa						√	√	√
Kansas					√			
Kentucky						√	√	
Louisiana						√	√	
Maine			√			√	√	

Table IX (continued)
State Agency on Aging and Disabilities Priorities, 2010–2011

State	No Change	Expanding Services is Not a Priority	Developing HCBS is More of a Priority	Developing HCBS is Less of a Priority	Scaling Back of Services Has Become a Priority	Maintaining Current Service Levels is Now a Priority	Creative Use of Techology is More of a Priority	Other
Maryland			√			√		
Massachusetts			√				√	
Minnesota			√				√	
Mississippi								
Missouri		√				√	√	
Montana						√		
Nebraska								
Nevada								√
New Hampshire			√			√	√	
New Jersey								
New Mexico		√				√		
New York	√							
North Carolina		√				√		
North Dakota	√							
Ohio			√			√	√	
Oklahoma			√			√	√	√
Oregon						√		
Pennsylvania						√		√
Rhode Island		√				√		
South Carolina			√		√		√	
South Dakota								
Tennessee		√				√		

Table IX (continued)
State Agency on Aging and Disabilities Priorities, 2010–2011

State	No Change	Expanding Services is Not a Priority	Developing HCBS is More of a Priority	Developing HCBS is Less of a Priority	Scaling Back of Services Has Become a Priority	Maintaining Current Service Levels is Now a Priority	Creative Use of Techology is More of a Priority	Other
Texas	√							
Utah			√			√		
Vermont			√				√	
Virginia					√	√		√
Washington					√		√	
West Virginia			√			√	√	
Wisconsin								
Wyoming								√

Table X
Provider Reimbursement Rate Changes, SFY 2011 and Planned for SFY 2012

State	Nursing Home		Home Health		Personal Care Services		HCBS Waiver Services		Other	
	SFY 10–11	SFY 11–12	SFY 10–11	SFY 11–12	SFY 10–11	SFY 11–12	SFY 10–11	SFY 11–12	SFY 10–11	SFY 11–12
	↑ = 26 ↓ = 25 0 = 0	↑ = 23 ↓ = 28 0 = 0	↑ = 5 ↓ = 5 0 = 24	↑ = 5 ↓ = 9 0 = 19	↑= 3 ↓ = 6 0 = 22	↑ = 5 ↓ = 6 0 = 19	↑ = 6 ↓ = 8 0 = 22	↑ = 8 ↓ = 6 0 = 22	↑ = 1 ↓ = 2 0 = 12	↑ = 2 ↓ = 4 0 = 9
Alabama	1%–3%	1%–3%	No change	No change	No change	No change	No change	No change		
Alaska	1%–3%	1%–3%	No change	No change	1%–3%	1%–3%	1%–3%	1%–3%		
Arizona	Decrease	(4%–6%)	(4%–6%)	(4%–6%)	(4%–6%)	(4%–6%)	(4%–6%)	(4%–6%)	(4%–6%)	(4%–6%)
Arkansas*	1%–3%	1%–3%					1%–3%	1%–3%		
California*	Decrease	Increase	Decrease	Decrease	No change	Decrease	Decrease	Decrease	Change with neutral effect	
Colorado*	(1%–3%)	(1%–3%)								
Connecticut*	(1%–3%)	1%–3%	Decrease	No change	Decrease	No change	Decrease	No change	4%–6%	
Delaware*	Decrease	Decrease	No change	1%–3%	No change	1%–3%	No change	1%–3%		1%–3%
District of Columbia*	7%–9%	Decrease								
Florida	1%–3%	(4%–6%)	No change	No change	No change	No change	No change	No change		
Georgia	Increase	Decrease	No change	Decrease	No change	No change	No change	No change	No change	Decrease
Hawaii	<1%	Decrease	No change	No change	No change	No change	No change	No change		
Idaho*	Decrease	Decrease	1%–3%	1%–3%	No change	No change	No change	No change	No change	No change
Illinois*	Decrease	Increase**	No change	No change	No change	No change	1%–3%	1%–3%		No change
Indiana	Decrease	(4%–6%)	No change	Decrease	No change	No change	(4%–6%)	No change	No change	No change
Iowa*	Decrease	7%–9%	No change				No change	1%–3%		
Kansas	1%–3%	1%–3%	7%–9%	No change			No change	No change	No change	1%–3%
Kentucky*	1%–3%	1%–3%								
Louisiana*	Increase	Increase								

Table X (continued)

Provider Reimbursement Rate Changes, SFY 2011 and Planned for SFY 2012

State	Nursing Home		Home Health		Personal Care Services		HCBS Waiver Services		Other	
	SFY 10–11	SFY 11–12	SFY 10–11	SFY 11–12	SFY 10–11	SFY 11–12	SFY 10–11	SFY 11–12	SFY 10–11	SFY 11–12
Maine	(<1%)	Decrease	No change	No change	No change	No change	No change	No change	No change	No change
Maryland*	Increase	Increase								
Massachusetts*	Decrease	1%–3%	No change	No change	4%–6%	No change	No change	No change		
Michigan	1%–3%	1%–3%	1%–3%	1%–3%	No change	No change	No change	No change		
Minnesota	1%–3%	Decrease	(1%–3%)	(1%–3%)	(1%–3%)	(1%–3%)	(1%–3%)	(1%–3%)		
Mississippi	<1%	<1%					4%–6%	4%–6%		
Missouri*	Decrease	Decrease	No change	No change	(1%–3%)	1%–3%	(1%–3%)	1%–3%		
Montana*	1%–3%	(1%–3%)								
Nebraska*	<1%	(1%–3%)								
Nevada*	Decrease	(4%–6%)	No change	No change	No change	No change	No change	No change	No change	(4%–6%)
New Hampshire	(4%–6%)	4%–6%	(7%–9%)	No change	(1%–3%)	No change	(1%–3%)	No change	(1%–3%)	No change
New Jersey*	Decrease	(1%–3%)	No change	No change	(4%–6%)	No change	No change	No change	No change	No change
New Mexico*	Decrease	Decrease	No change	No change	No change	No change	No change	No change	No change	No change
New York*	Decrease	Decrease								
North Carolina*	Decrease	Decrease								
North Dakota	1%–3%	1%–3%	1%–3%	1%–3%	1%–3%	1%–3%	1%–3%	1%–3%		
Ohio*	Increase	(4%–6%)	No change	(1%–3%)			No change	(1%–3%)		
Oklahoma	Decrease	Decrease	No change	No change	No change	No change	No change	No change	No change	No change
Oregon	1%–3%	(7%–9%)	No change	No change	No change	No change	No change	No change		
Pennsylvania*	Increase	Decrease		(4%–6%)		(4%–6%)		(4%–6%)		Decrease
Rhode Island	(1%–3%)	(1%–3%)	No change	(<1%)	No change	(<1%)	No change	No change		
South Carolina*	(1%–3%)	Decrease								
South Dakota*	Decrease	Decrease								
Tennessee	1%–3%	(7%–9%)	No change	(7%–9%)	No change	(7%–9%)	No change	No change		

Table X (continued)

Provider Reimbursement Rate Changes, SFY 2011 and Planned for SFY 2012

State	Nursing Home		Home Health		Personal Care Services		HCBS Waiver Services		Other	
	SFY 10–11	SFY 11–12	SFY 10–11	SFY 11–12	SFY 10–11	SFY 11–12	SFY 10–11	SFY 11–12	SFY 10–11	SFY 11–12
Texas*	(1%–3%)	Decrease	No change		No change		(1%–3%)	(1%–3%)		
Utah*	Increase	Increase								
Vermont*	Increase	Increase	No change	No change	No change	No change	No change	No change		
Virginia*	Decrease	Decrease								
Washington*	4%–6%	<1%	No change	No change	No change		No change		No change	
West Virginia	1%–3%	1%–3%	1%–3%	1%–3%	No change	Increase	7%–9%	No change		
Wisconsin*	Increase	Increase								
Wyoming	Decrease	Decrease	No change	No change	No change	No change	No change	No change	No change	No change

* Not all states indicated an answer for nursing facility rate changes. We obtained information about nursing facility rate changes for one or more years from the Kaiser Budget survey.

** Illinois' nursing home increase in 2012 reflects a new provider tax.