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At the Crossroads: Providing Long-Term Services and Supports at a Time of High Demand and Fiscal Constraint

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Research Report

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

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 2012. State aging and disability agencies and Medicaid agencies responded with information on long-term services and supports (LTSS) programs for older individuals and adults with physical disabilities. Forty-nine states plus the District of Columbia responded to the survey. This report is the third annual study of the AARP Public Policy Institute, the National Association of States United for Aging and Disabilities (NASUAD), and Health Management Associates (HMA).

Findings

Lagging Economic Recovery and Staff Reductions

The lagging recovery of state budget revenues as well as staff reductions and turnover all continue to challenge states' provision of LTSS. Although most states (34) project 2013 tax revenues above 2007 pre-recession levels, many (16) project collections to remain below 2007 levels. Even 6 years after the recession, revenues in much of the country—especially states in the South and West—have not recovered to pre-recession levels. Significant staff reductions in state agencies pose another challenge directly related to the lagging economy.

Home and Community-Based Services Continue to Expand

Nevertheless, most states continue to expand Medicaid home and community-based services (HCBS) waiver recipients and expenditures. Over 2012 and 2013, 80 percent of the responding states indicated that HCBS waiver census has or will increase. While nearly three-fourths of responding states reported that Medicaid nursing facility residents continue to decrease or remain unchanged, slightly more than one-fourth of states reported "slight" increases in Medicaid nursing home populations in 2012.

Reduced or Flat Funding but High Demand for Non-Medicaid Aging and Disability Services

Whereas Medicaid funding for HCBS has increased, in large part because of the ability to leverage federal Medicaid matching funds and perhaps new funding for HCBS initiatives under the Affordable Care Act (ACA), less than a quarter of the states are increasing non-Medicaid aging and disability services funding, with 30 percent actually reducing expenditures. Despite the reduced or flat funding, states reported high demand for aging and disability services. Disturbingly, caseloads for adult protective services—from victims of abuse, neglect, and exploitation—have increased within each of the 3 years from 2010 to 2012, without increases in expenditures in many states. Although most states experienced flat funding, there were two exceptions: both Aging and Disability Resource Centers and home-delivered meals had increases in expenditures from state fiscal year (SFY) 2011 to SFY 2012 in 21 states each, and many states expected increases in SFY 2013.

The Transformation of LTSS

Rather than making deep cuts to services and programs, state policy makers are opting to fundamentally restructure services and financing to achieve efficiencies, reduce duplication, and function with reduced staffing levels. Of particular significance are state

efforts to better coordinate care for people who are dually eligible for Medicare and Medicaid services, the so-called "duals." Two-thirds of the states (34) either have or will launch new initiatives over the next 2 years. The vast majority of states are turning to risk-based managed care models to deliver integrated services to duals. As states reform the ways in which they pay for and deliver publicly funded LTSS, they are also restructuring the state agencies that administer aging and disability services.

HCBS Options within the ACA

The ACA included several LTSS options and health care programs with implications for LTSS populations. Optional Medicaid provisions within the ACA provide financial incentives for states to support greater access to HCBS. State participation in HCBS options within the ACA is increasing.

Conclusion

State fiscal conditions continue to improve into SFY 2013, but recovery is inconsistent across states as low revenue collection continues to plague states in the South and West. Rising demand for aging and disability services, coupled with reduced or flat funding, means that states are striving to do more with less. As a result, they continue to make administrative reductions to control costs in lieu of reducing benefits or services for people with LTSS needs.

Reforms are under way that will transform how LTSS are financed and delivered. Many states are moving toward a risk-based managed care model that emphasizes better integration of care for people who are dually eligible for Medicare and Medicaid services. States are also restructuring agencies that administer aging and disability services and working toward providing a comprehensive vision, establishing consistent policy making and administrative simplification. Increasingly, states are beginning to implement the LTSS options within the ACA, most of which provide additional revenue for implementing states.

INTRODUCTION

This report describes transformations and reforms related to long-term services and supports (LTSS) in the states and identifies new and emerging LTSS trends. It finds that LTSS are at a crossroad:

- State finances are strained by the lingering and persistent impact of the Great Recession, which continues to drive public policy decisions.
- Publicly funded LTSS are in high demand.
- States are in the process of transforming their LTSS systems to provide these services to vulnerable populations.

The states were surveyed in the fall of 2012. The survey asked about state LTSS initiatives for older adults and adults with physical disabilities.[1] A description of the research methodology is included in Appendix I.

The research was conducted prior to the inception of congressional budget sequestration,[2] which imposed roughly $1 trillion in across-the-board cuts to federal program budgets, including an approximate 5 percent cut in fiscal year (FY) 2013 nondefense discretionary programs. Although Medicaid is exempt from these cuts, other non-Medicaid aging and disability programs are not. On March 7, 2013, the Administration on Community Living released preliminary estimates of how the sequester will affect state formula grant programs under the Older Americans Act, which are administered by state aging and disability agencies.[3] The impact of these cuts are not factored into our survey findings.

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1 The survey did not address services for people with intellectual or developmental disabilities.

2 The budget cuts were enacted in the Budget Control Act of 2011 and set to begin on January 1, 2013. Initiation of the cuts were then delayed by 2 months to March 2013 with passage of the American Taxpayer Relief Act of 2012.

3 *AoA Releases Estimates of Sequester Impact for State Formula Grant Programs*. Accessed on March 27, 2013, at www.nasuad.org/newsroom/archive/2013/sequester_impact_for_state_formula_grant_programs.html.

FINDINGS

Slow and Uneven Recovery of State Budgets

FINDING: Although most states (34) project 2013 tax revenues above 2007 pre-recession levels, many (16) project collections to remain below 2007 levels.

State revenue is slowly improving in the aftermath of the Great Recession. Overall, aggregate state tax collections at the end of state fiscal year (SFY) 2012 exceeded the pre-recession peak reported in SFY 2008 by 1.3 percent. However, when adjusted for inflation, collections remained 4.9 percent below peak levels.[4,5] According to the National Governors Association and the National Association of State Budget Officers, total state general fund revenue collections in FY 2013 are projected to grow to $692.8 billion, exceeding 2008 collections by about $12.5 billion.[6]

Although aggregate data show improvement, state-level data indicate uneven recovery across the states. Approximately 80 percent of states' general fund revenues are generated by some combination of personal income tax, sales taxes, and corporate income tax collections.[7] Figure 1 illustrates the percentage increase in revenue from these major sources since pre-recession levels (SFY 2007) to projected SFY 2013 for each of the states (data are not adjusted for inflation).

In SFY 2013, 16 states still project revenue from major sources below 2007 levels. Three states have revenue remaining more than 15 percent below 2007 levels: Oklahoma (-15.6 percent), Arizona (-16.2 percent), and Louisiana (-26.0 percent). If adjusted for inflation, the number of states below SFY 2007 revenue levels from major sources of tax collections would increase.

Figure 1 provides a snapshot of the state's current revenue condition relative to pre-recession collections. The recession's impact and timing, however, varied across states, as has the timing of recovery (Figure 2). In SFY 2010, all but a handful of states were experiencing revenue collections from major sources below SFY 2007 levels, many well below. While collections improved slightly in SFY 2011, by SFY 2012, more than half of

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4 L. Dadayan and D. J. Boyd, *Sales Tax Revenues Continue Slow Rebound,* State Revenue Report No. 90 (University of Albany, State University of New York: The Nelson A. Rockefeller Institute of Government, February 2013). Accessed February 2013 at http://www.rockinst.org/pdf/government_finance/state_revenue_report/SSR-90.pdf.

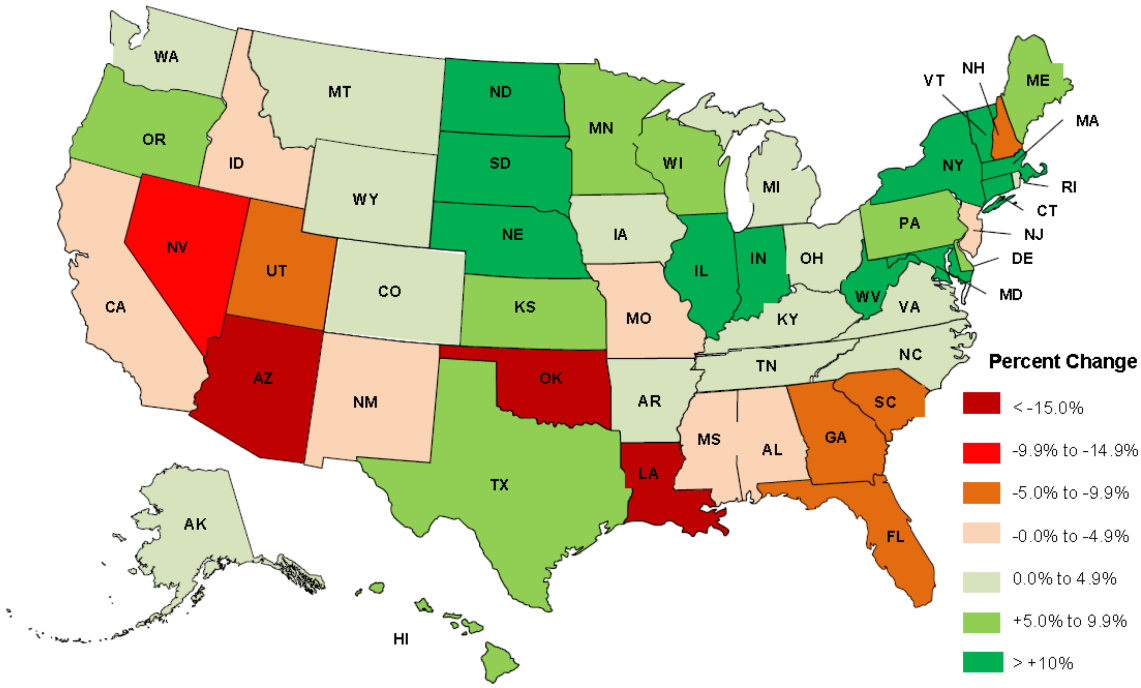
5 It should be noted that much of the revenue increases between April 2012 and April 2013 resulted from income tax growth. While this growth reflects economic recovery in part, some of it was due to wealthy taxpayers shifting income into 2012 in anticipation of federal tax rate increases in 2013. Source: E. McNichol, "States Should React Cautiously to Recent Income Tax Growth; April Surge Provides Opportunity to Invest in Infrastructure, Boost Reserves" (Washington, DC: Center on Budget and Policy Priorities, June 13, 2013).

6 National Governors Association and National Association of State Budget Officers, *Fiscal Survey of the States: Fall 2012*. An update of state fiscal conditions, accessed January 2013 at http://www.nasbo.org/sites/default/files/Fall%202012%20Fiscal%20Survey%20of%20States.pdf.

7 *Ibid*.

Figure 1
Percent Change in State Tax Revenue

2007 (actual) to 2013 (projected)
Personal Income, Corporate, and Sales Tax



Source: HMA analysis of data from National Association of State Budget Officers (NASBO), Fall Fiscal Survey of States, 2007–2010 reports, and Fall 2012 Report for 2013. Notes: Data are not adjusted for inflation. The 2013 figures are enacted. For Illinois, this map uses projected revenue from NASBO's 2006 report because 2007 revenue data were not available.

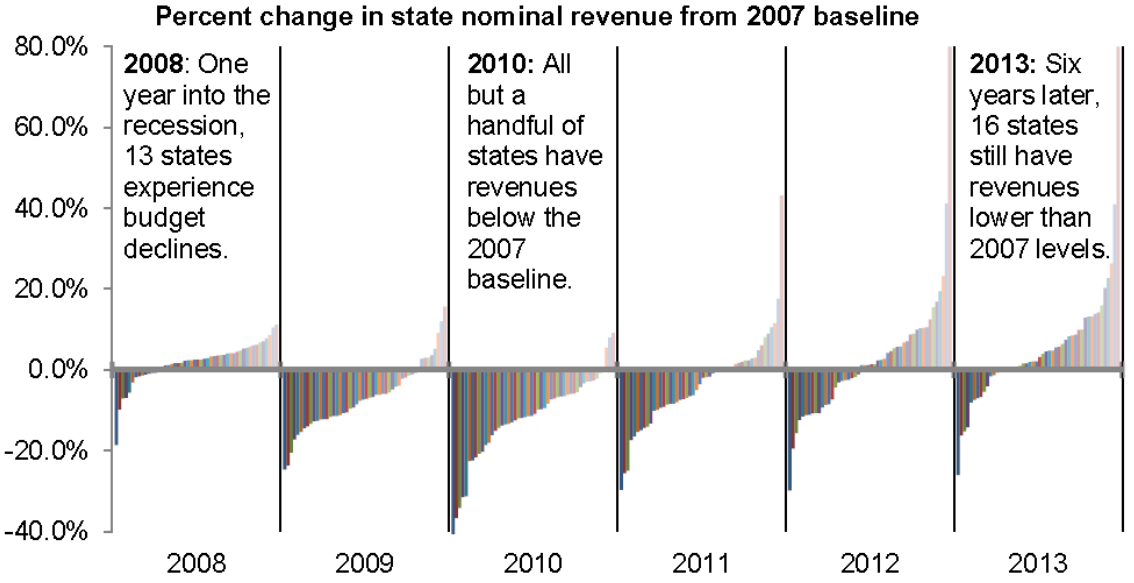
states (28) had revenue above the 2007 baseline. In SFY 2013, 34 states project general fund revenue from the three major sources above SFY 2007 levels.[8]

The recession affected states at different times, and to different degrees. Some states found their revenues decimated to such a degree that they have not yet closed the revenue gap. Other states experienced 1 or 2 years of turmoil but generally weathered the aftermath of the recession with slow and steady improvements in revenue. Intuitively, the impact of the economic decline in any single state would be cumulative over time and would depend not only on the magnitude of revenue decline from pre-recession levels, but also on the length of time the state experienced such a decline.

Figure 3 looks at the cumulative effects of the recession using each state's revenue collection experience over the 6 years during and after the recession. The data measure the average fluctuation of a state's revenue collection from the 2007 pre-recession baseline over the 6-year period.

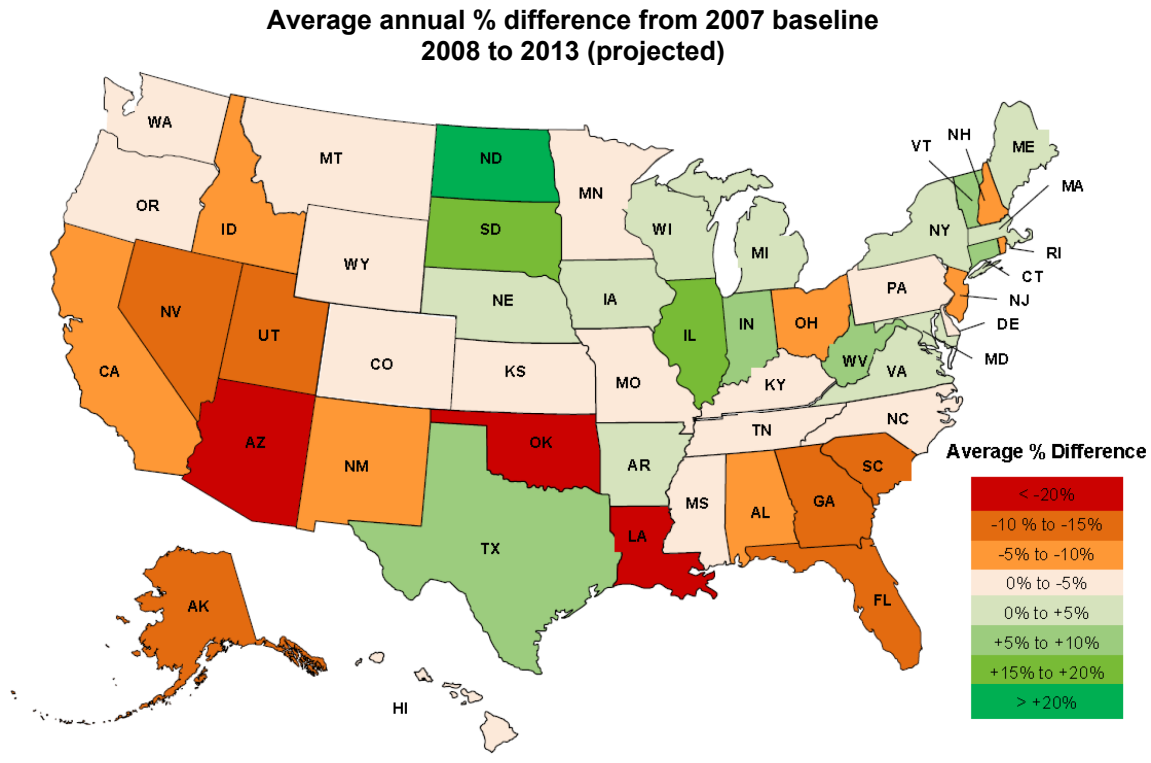
[8] Some states enacted tax increases or tax decreases over the time frame illustrated. For instance, Illinois enacted a significant increase to personal income and corporate tax rates in 2011.

Figure 2
State Revenue Changes for 50 States through and beyond the Recession



Source: Computed from data reported in National Association of State Budget Directors and National Governors' Association *Fiscal Survey of the States, Spring 2012* for 2011, 2012, and 2013 (projected) and from *Fiscal Survey of the States, Fall 2011* for 2010.

Figure 3
Cumulative Revenue Experience



Source: HMA analysis of data from National Association of State Budget Officers (NASBO), Fall Fiscal Survey of States, 2007–2012 reports. NOTE: The data are the average of each state's percentage difference from the 2007 baseline revenue over the 6 years. No states fell within +10% to 15%, or -15% to -20% ranges.

FINDING: Even 6 years after the recession, revenues in much of the country—especially states in the South and West—have not recovered to pre-recession levels.

Using this measure of cumulative revenue experience, a regional pattern emerges. Southern and western states sustained a more negative impact to revenue collections than did midwestern and New England states. Their revenue declined to a greater degree or remained below 2007 levels for a longer period, or both.

There are a few exceptions (such as Texas and Ohio), and the data have limitations. Some states derive significant revenue from sources other than the three sources used in the analysis (personal income, sales, and corporate taxes), so the proxy does not give an accurate picture of some states. For example, Alaska does not have personal income or sales taxes, but derives the vast majority of its revenues from oil-based tax collections. In addition, not all revenue fluctuations are a direct result of economic conditions. Tax legislation (to either increase or decrease rates) over the period affects collections; for example, Illinois enacted a significant increase in personal income tax and corporate tax rates in SFY 2011. North Dakota is the only state whose revenue did not decline below 2007 levels in any of the 6 years during and post-recession. Arizona had the most precipitous decline from FY 2007, with revenues 42.8 percent lower in FY 2010. Arizona, Oklahoma, and Louisiana all averaged more than 20 percent below 2007 revenue levels over the 6-year period.

Unemployment, a lagging indicator of economic decline and recovery, was at its highest rate in October 2009, at 10 percent. Over 3 years, the unemployment rate fell to 7.8 percent in September 2012, its lowest point since January 2009.[9] As the unemployment rate continues to decrease, state revenue from income tax collections should also continue to improve. A recent Congressional Budget Office analysis projects, however, that the national unemployment rate will remain above 7.5 percent through 2014.[10]

Enrollment in the Medicaid program—another lagging indicator—also serves as an important gauge of state economic health. The countercyclical nature of the Medicaid program means the program experiences higher overall enrollment growth during economic downturns, while program growth slows as the economy improves. Indeed, recent reports indicate a steady decrease in the rate of Medicaid enrollment growth over the past 3 years. Figure 4 illustrates that enrollment slowed from a 4.4 percent growth rate in FY 2011 to a projected 2.75 percent in FY 2013, another sign of easing economic pressures.[11]

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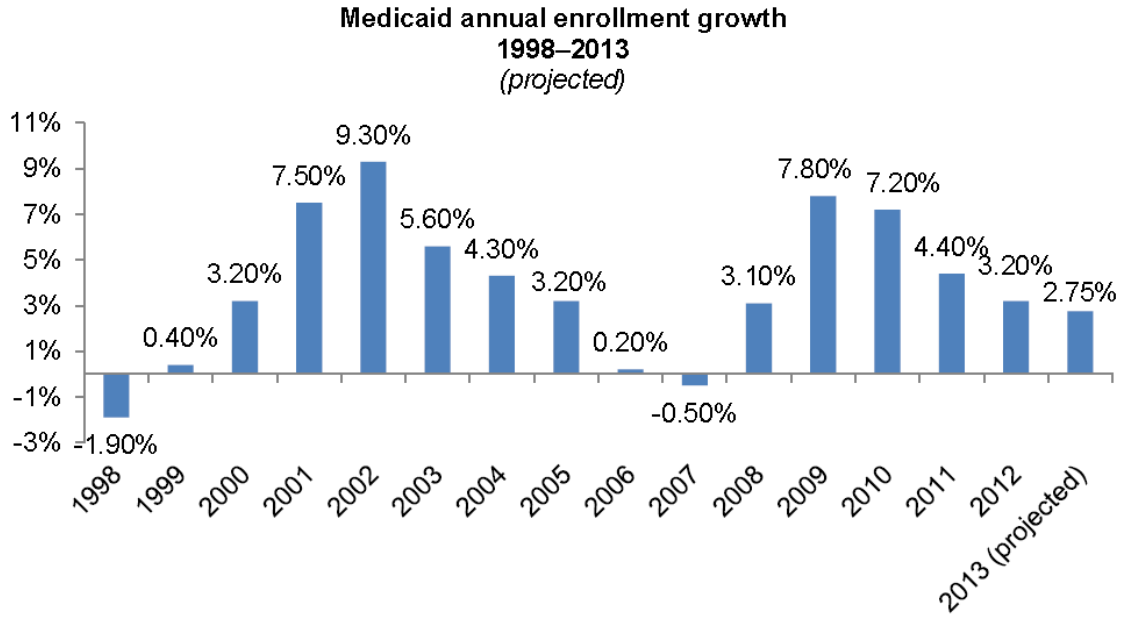
[9] U.S. Bureau of Labor Statistics, Unemployment Rate 2003 to 2013. Accessed February 2013 at http://data.bls.gov/timeseries/LNS14000000.

[10] See the U.S. Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2013 to 2023* (February 2013). Accessed February 2013 at http://www.cbo.gov/publication/43907. The analysis assumes no change to present federal law. Anticipated congressional action on the federal budget, deficit, and existing scheduled tax increases and budget cuts (i.e., the "fiscal cliff") could change these assumptions.

[11] V. K. Smith, K. Gifford and E. Ellis, Health Management Associates; and R. Rudowitz and L. Snyder, Kaiser Commission on Medicaid and the Uninsured; "Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment and Policy Trends. Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013" (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2012).

Figure 4
Medicaid Enrollment Growth Has Slowed Significantly



Source: "Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment and Policy Trends. Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013"; Vernon K. Smith, Kathleen Gifford, Eileen Ellis, et al.; Kaiser Commission on Medicaid and the Uninsured; October 2012. Note: Enrollment percentage changes from June to June of each year.

A decrease in the rate of total Medicaid spending growth corresponded with this trend. Overall spending grew 2.0 percent from FY 2011 to FY 2012, one of the lowest rates on record (Figure 5).[12] However, the states' portion of Medicaid spending increased significantly in FY 2012 (27.5 percent) due to the expiration of the federal Medicaid stimulus funds enacted in the American Recovery and Reinvestment Act (ARRA) of 2009. ARRA enhanced federal Medicaid matching funds expired June 30, 2011, and states were required to make up for this loss of funds beginning in FY 2012.

State Staff Reductions

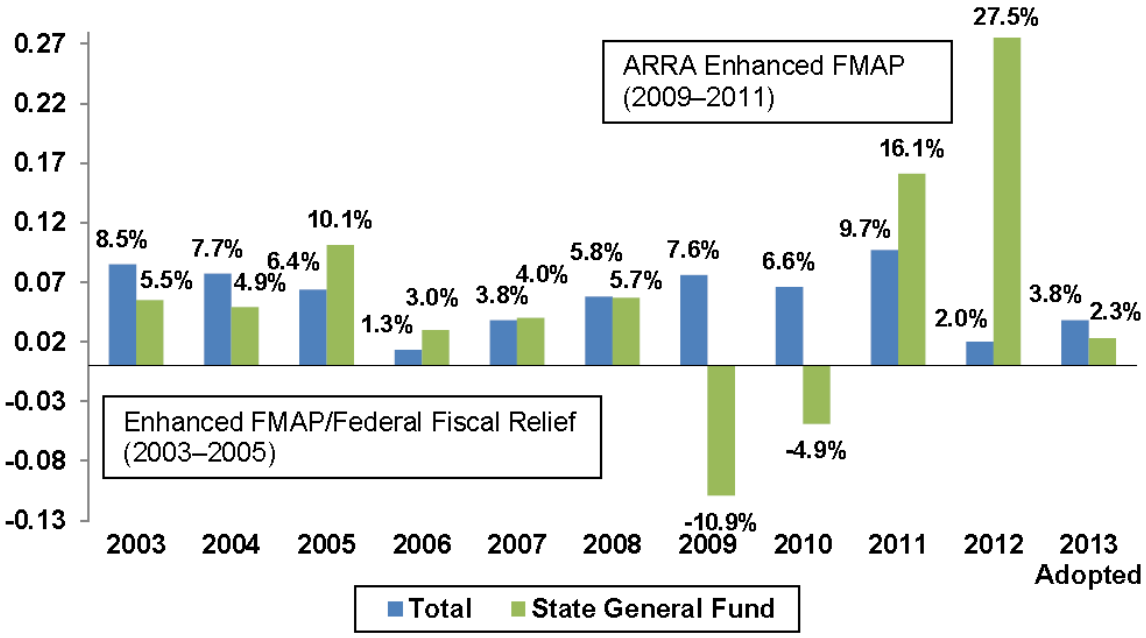
FINDING: States continue to reduce their workforce.

Another challenge that is directly related to the lagging economy is the significant staff reductions at state agencies. According to the National Association of State Budget Officers, 33 states cut the number of full-time equivalent (FTE) positions in FY 2012, and 16 states are expected to decrease their numbers of FTEs in FY 2013. The total number of FTEs fell by 2.4 percent in FY 2012 and is projected to fall another 1.7 percent in FY 2013.[13]

[12] *Ibid*.

[13] National Governors Association and National Association of State Budget Officers, *Fiscal Survey of the States: Fall 2012*. An update of state fiscal conditions accessed February 2013 at http://www.nasbo.org/sites/default/files/Fall%202012%20Fiscal%20Survey%20of%20States.pdf.

Figure 5
Annual Growth in Total and State Medical Spending, 2003–2013



Source: "Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment and Policy Trends. Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013"; Vernon K. Smith, Kathleen Gifford, Eileen Ellis, et al.; Kaiser Commission on Medicaid and the Uninsured; October 2012. Note: Years are state fiscal years.

In a 2012 survey of aging and disability agencies,[14] three-quarters reported experiencing personnel reductions since the beginning of the economic downturn. The agencies also reported using three primary methods to reduce personnel—92 percent implemented hiring freezes, 54 percent carried out reductions in force, and 49 percent instituted furloughs. Of the agencies reducing FTEs, 41 percent reported a loss of 10 percent or fewer FTEs, 34 percent reported a loss of 11 percent to 20 percent of their FTEs, and 25 percent reported a loss of more than 20 percent of their FTEs. Only two states reported staffing increases since 2007.[15]

[14] National Association of States United for Aging and Disabilities, *2012 State of Aging and Disabilities Survey—Another Year of Challenges Tempered by Opportunities* (Washington, DC: NASUAD, 2012). Accessed at http://www.nasuad.org/documentation/nasuad_materials/NASUAD%202012%20States%20Rpt%20final.pdf.

[15] *Ibid*.

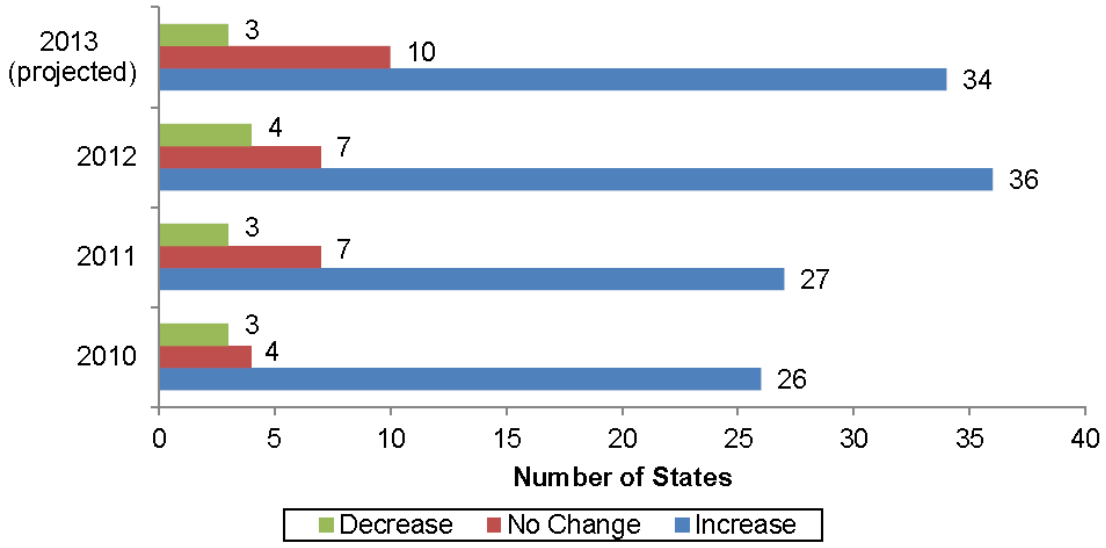
Medicaid

Combined federal and state Medicaid funding for LTSS totaled more than $131 billion in 2011,[16] continuing the trend that Medicaid is the largest payer for LTSS. Medicaid LTSS beneficiaries represent 7 percent of Medicaid recipients but account for 30 percent of total Medicaid expenditures.[17]

FINDING: Medicaid HCBS waiver recipients and expenditures are on the rise.

As in previous surveys,[18] this survey finds states continuing to increase HCBS waiver resources and services for older people and adults with disabilities. Over 2012 and 2013, 80 percent of the 47 states that responded indicated that HCBS waiver recipients have or will increase (Figure 6).

Figure 6
HCBS Waiver Recipient Change from Previous Year 2010–2013



N = 33 for 2010
N = 37 for 2011
N = 47 for 2012 and 2013

[16] C. V. O'Shaughnessy, *The Basics: National Spending for Long-Term Services and Supports (LTSS), 2011* (Washington, DC: National Health Policy Forum, February 1, 2013). See also Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Role in Meeting the Long-Term Care Needs of America's Seniors* (Washington, DC: Kaiser Family Foundation Policy Brief, January 2013). Accessed at http://www.kff.org/medicaid/upload/8403.pdf.

[17] Kaiser Commission on Medicaid and the Uninsured. *Medicaid: A Primer*. (Washington, DC: The Henry J. Kaiser Family Foundation, March 2013).

[18] See J. Walls et al., *Weathering the Storm: The Impact of the Great Recession on Long-Term Services and Supports* (Washington, DC: AARP Public Policy Institute, January 2011); and M. Cheek et al., *On the Verge: The Transformation of Long-Term Services and Supports* (Washington, DC: AARP Public Policy Institute, February 2012).

Nearly all of the 36 states that report a census increase in 2012 also expect the census to increase in 2013 (32 states). Four—California, Connecticut, Georgia, and Montana—project no additional increase in 2013.

Of the seven states reporting no change in the 2012 census from 2011, two states—Alabama and Louisiana—project an increase in 2013, bringing the total number of states with an increase in HCBS waiver recipients to 38 over the 2-year period.

Four states—Maine, Nebraska, Nevada, and Wyoming—project no change in either 2012 or 2013.

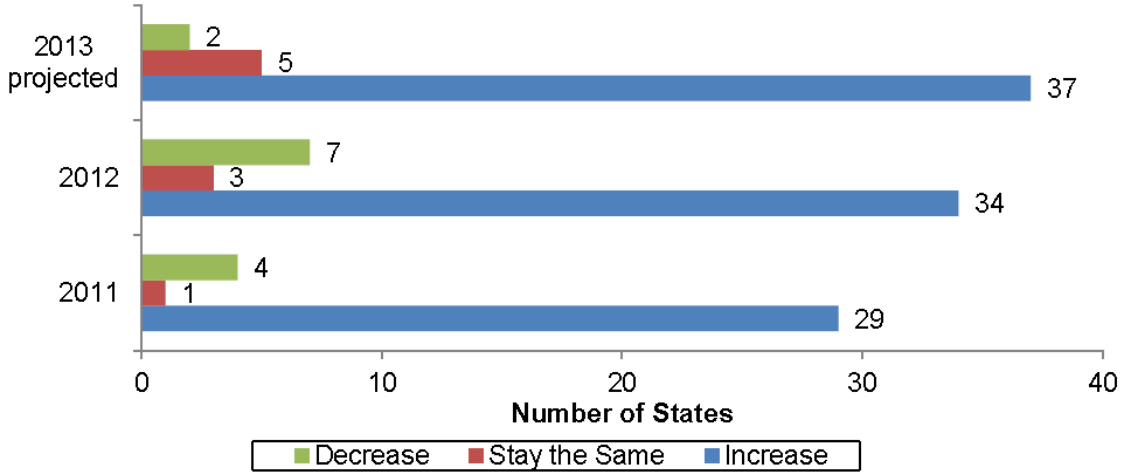
Of the four states with decreased 2012 HCBS waiver recipients, two states—New York and Texas—project a decrease in 2013, and two states—Kansas and Kentucky—project their HCBS census will stay the same in 2013.

HCBS waiver expenditures mirror the census trends. Figure 7 shows state expenditure changes over each year for HCBS waiver services for older people and adults with physical disabilities.

Some states provided additional information about expenditure changes. Eight states that reported increased spending in 2012, and seven in 2013, noted that at least some of the increase is due to enrollment increases. Of the seven states reporting decreased HCBS expenditures in SFY 2012, five project increases in SFY 2013 (the District of Columbia, Indiana, Kansas, Nebraska, and New Mexico). The remaining two states—Missouri and New York—project further decreases in SFY 2013. New York credits the shift to managed LTSS for expenditure decreases. Of the three states that project no changes in HCBS expenditures in 2012, two states—Idaho and Alabama—project increases in 2013.

More than half (18) of the 34 states that increased HCBS waiver expenditures in 2012 increased expenditures by 5 percent or more. In 2013, 21 states expect to increase

Figure 7
HCBS Expenditure Change from Previous Year
2011–2013



N = 34 for 2011
N = 44 for 2012 and 2013

expenditures by 5 percent or more. Five states report significant increases of 15 percent or more: Massachusetts (in both years), Maryland, Mississippi (in both years), Tennessee (in both years), and South Dakota. Most of the states that did not increase HCBS expenditures reported either flat funding or decreases of less than 5 percent (Figure 8).

States have been actively redefining their Medicaid HCBS programs with increased changes to their HCBS waiver programs and state plans. Appendix III provides an analysis of these changes, and Appendix V details the state-level data.

FINDING: The Medicaid nursing facility population continues to decrease or remain unchanged.

Consistent with trends seen in earlier surveys, the average daily Medicaid nursing facility population in most states continues to either decrease or remain unchanged from year to year. A change was seen, however, in the distribution of states reporting flat nursing facility enrollment versus those reporting declines (Figure 9). More states reported that their average daily Medicaid nursing facility population remained unchanged in SFY 2012 (15 states) and SFY 2013 (20 states) compared with SFY 2011 (9 states). SFY 2012 also saw an increase in the number of states reporting a population increase (13 states compared with 7 in SFY 2011).

Several states described the Medicaid nursing facility population change as "slight" or "minimal": Four states reported slight increases in 2012 (California, Delaware, Louisiana, and New York) and two in 2013 (Missouri and South Carolina). South Carolina noted that the state increased Medicaid permits for patient days in counties with the greatest need. Three states reported slight decreases in 2012 (Massachusetts, Virginia, and Wyoming), and two project minimal decreases in 2013 (Massachusetts and Missouri).

Figure 8
Percent Change in HCBS Expenditures

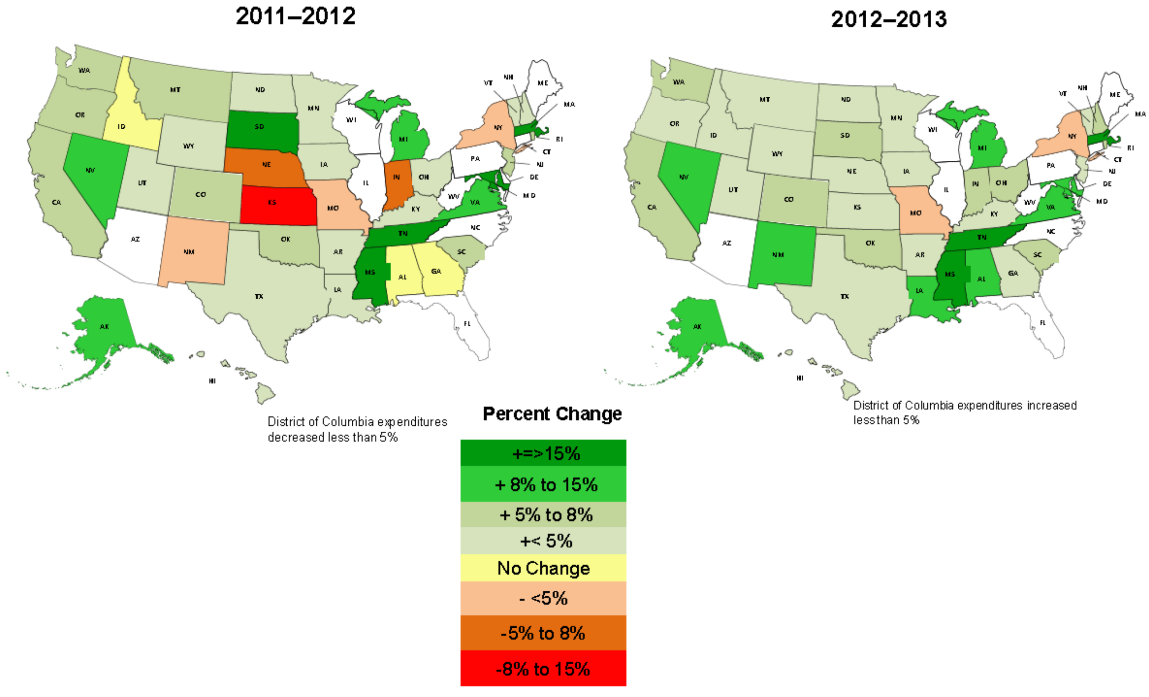
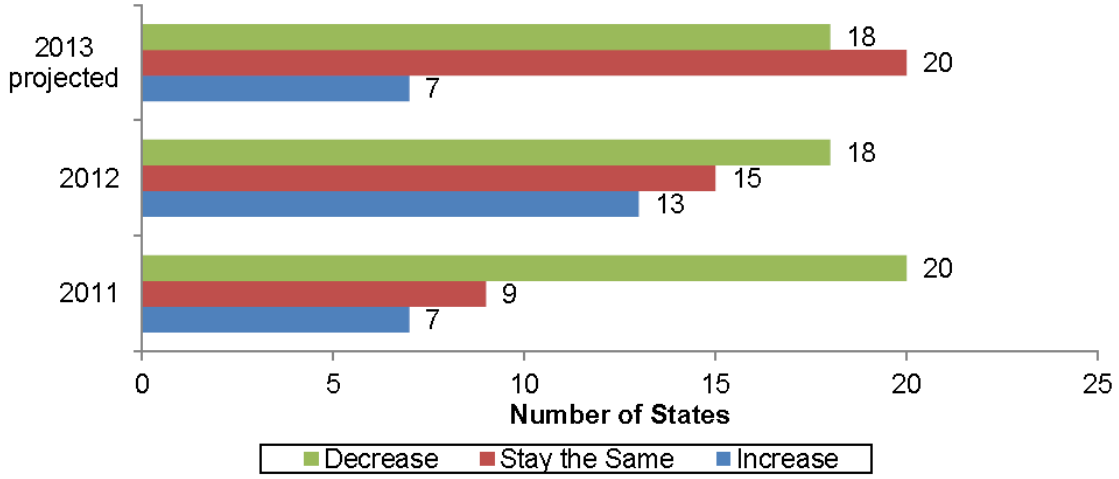


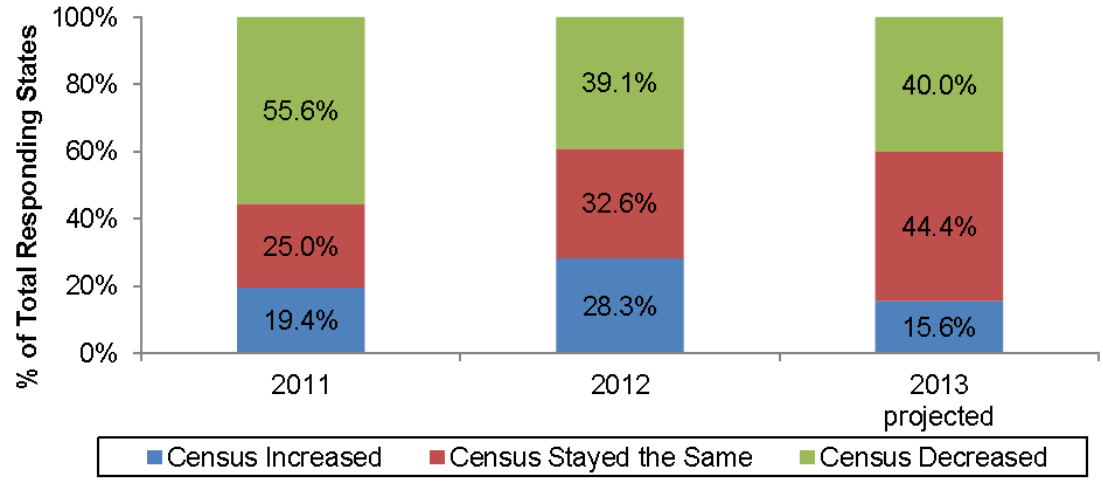
Figure 9
Nursing Facility Census Change from Previous Year
2011–2013



N = 36 for 2011
N = 46 for 2012
N = 45 for 2013

Figure 10 shows the nursing facility data response as a percentage of total states responding. While 72 percent of responding states reported that the average daily Medicaid nursing facility population decreased or remained unchanged in 2012, 28 percent of states reported increases. The data, however, suggest that the decline in Medicaid nursing facility utilization may be not as vigorous, with more than 55 percent of states reporting population decreases in 2011 compared with about 40 percent in SFY 2012 and SFY 2013. With only 2 years of actual data (2013 is a projection), it is not possible to determine if this represents an emerging trend.

Figure 10
Nursing Facility Census Change
2011–2013

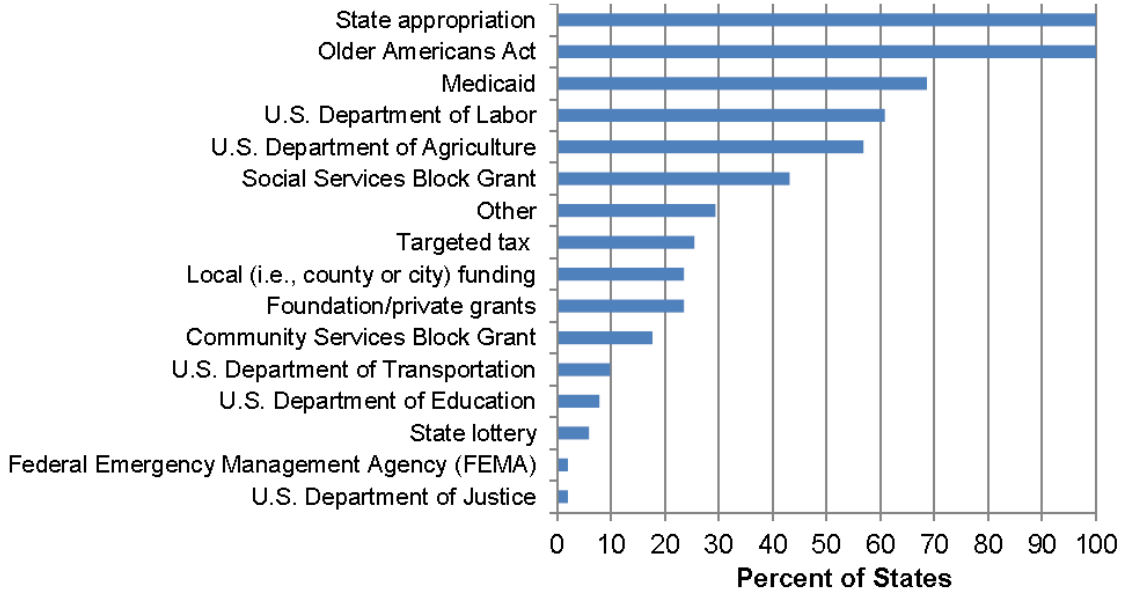


N = 36 for 2011
N = 46 for 2012
N = 45 for 2013

State Aging and Disability Agencies' Budgets

Although Medicaid is the largest source of funding for LTSS, state aging and disability agencies receive funding from a wide variety of sources (Figure 11). Of all the funding sources, only federal Older Americans Act funds and state appropriations are received by every state agency. Almost 70 percent of these state agencies receive Medicaid funding; 61 percent receive funding from the U.S. Department of Labor; 57 percent receive funding from the U.S. Department of Agriculture; and 43 percent receive funding from the U.S. Department of Health and Human Services, Administration for Children and Families (Social Services Block Grant).[19]

Figure 11
Funding Sources for State Aging and Disability Agencies



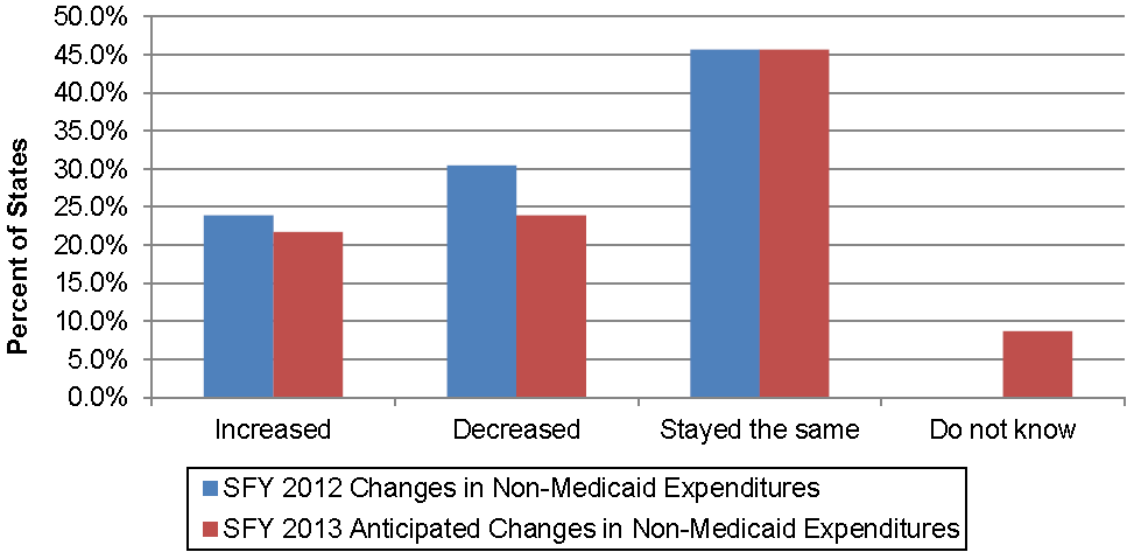
Non-Medicaid LTSS

FINDING: Non-Medicaid LTSS funding and expenditures have either decreased or remained unchanged in most states.

Figure 12 compares actual expenditures by state aging and disability agencies in the non-Medicaid portion of their budgets from SFY 2011 to SYF 2012 and projected expenditures from SFY 2012 to SFY 2013. Comparing SFY 2011 with SFY 2012, expenditures remained the same in 46 percent of these agencies, decreased in 30 percent, and increased in 24 percent. In SFY 2013, most of these agencies expect to see similar expenditure levels.

[19] National Association of States United for Aging and Disabilities, *2012 State of Aging and Disabilities Survey—Another Year of Challenges Tempered by Opportunities* (Washington, DC: NASUAD, 2012). Accessed at http://www.nasuad.org/documentation/nasuad_materials/NASUAD%202012%20States%20Rpt%20final.pdf.

Figure 12
Non-Medicaid Expenditures
(SFY 2012 vs. SFY 2013)



Of the state aging and disability agencies that experienced a change in non-Medicaid expenditures in SFY 2012, the increase or decrease was 5 percent or less in 60 percent of the agencies, 6 percent to 10 percent in 32 percent of the agencies, and 11 percent to 15 percent in 8 percent of the agencies[20] (Figure 13). The state aging and disability agencies that anticipate a change in non-Medicaid expenditures in SFY 2013 expect similar percentages of increases or decreases (Figure 14).

While most states experienced flat funding for most aging and disability services from SFY 2011 to SFY 2013 (see Figure 15 for SFY 2011 to SFY 2012 change in actual service expenditures; Figures 28 and 29 in Appendix II for increases and decreases in service expenditures from SFY 2011 to SFY 2012 and from SFY 2012 to SFY 2013), some services were more frequently targeted for increases or decreases:

- ***Aging and Disability Resource Centers (ADRCs).*** Twenty-one states had increases in expenditures for ADRCs from SFY 2011 to SFY 2012, and 14 states expected increases from SFY 2012 to SFY 2013.
- ***Home-delivered meals.*** Twenty-one states had increases in expenditures for home-delivered meals from SFY 2011 to SFY 2012, and 11 states expected increases from SFY 2012 to SFY 2013.
- ***Senior Community Service Employment Programs (SCSEPs).*** Eighteen states had decreases in expenditures for SCSEPs from SFY 2011 to SFY 2012, and 12 states expected decreases from SFY 2012 to SFY 2013. ARRA provided a temporary infusion of funding for SCSEP. The expiration of that funding accounts for the decreases.

[20] Ohio was one of the states with an 11 percent to 15 percent decrease; it resulted from a $10 million program that moved from the Department of Aging to the Department of Mental Health.

Figure 13
SFY 2011–2012 State by State Changes in Non-Medicaid Expenditures

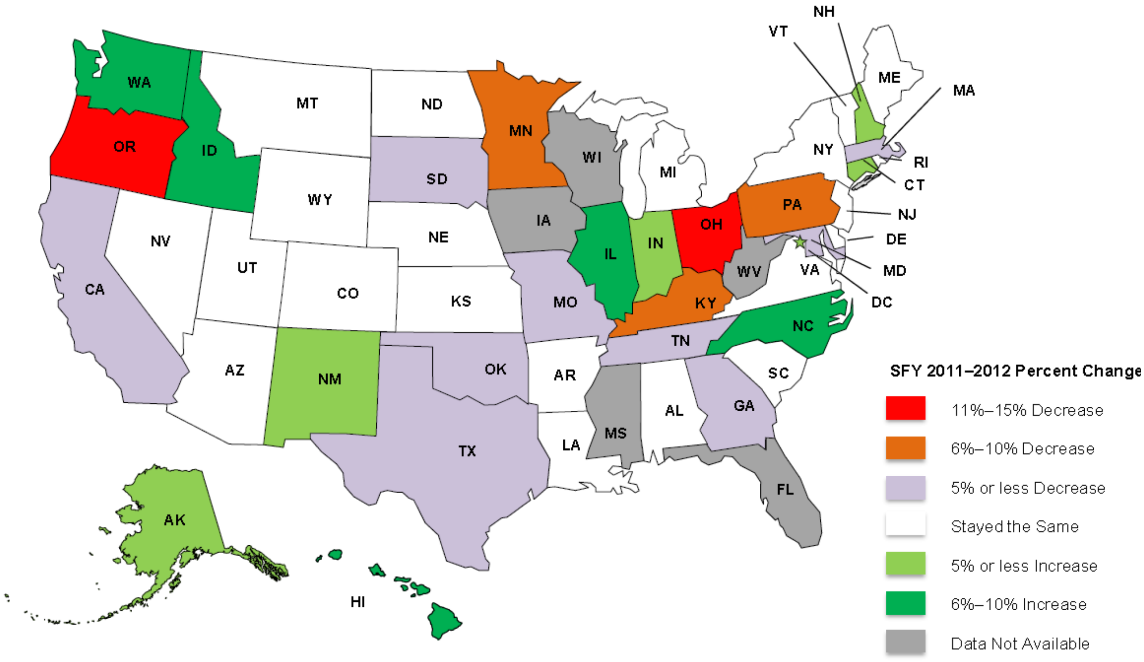


Figure 14
SFY 2013 Anticipated State by State Changes in Non-Medicaid Expenditures

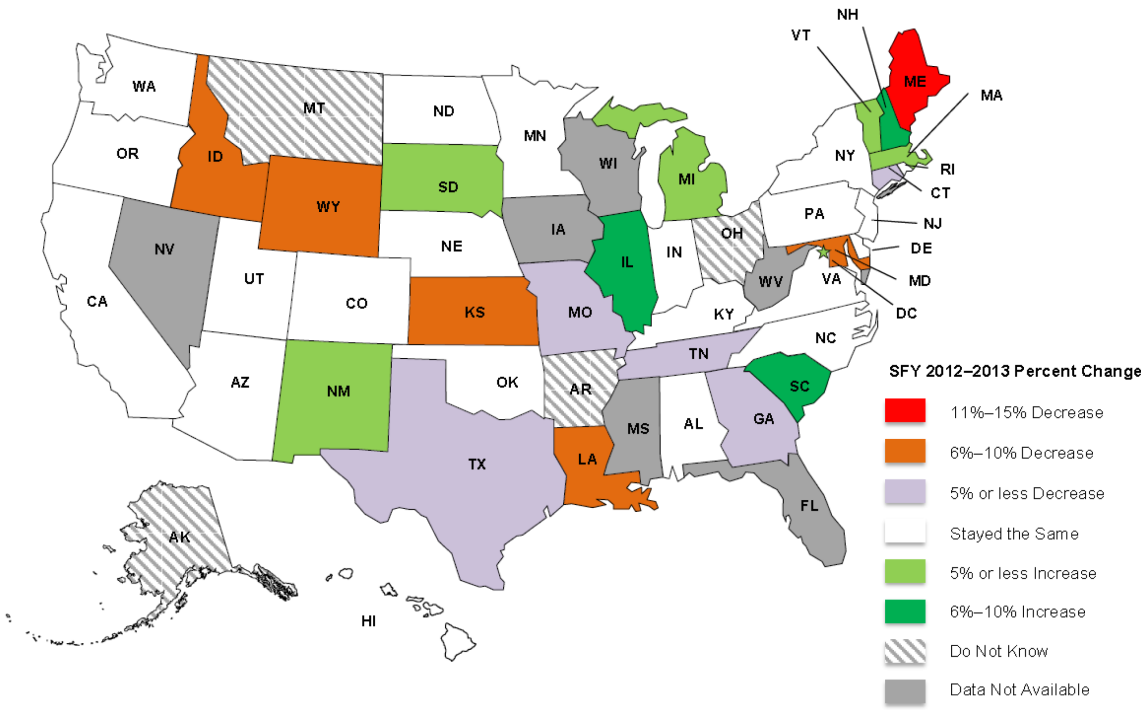
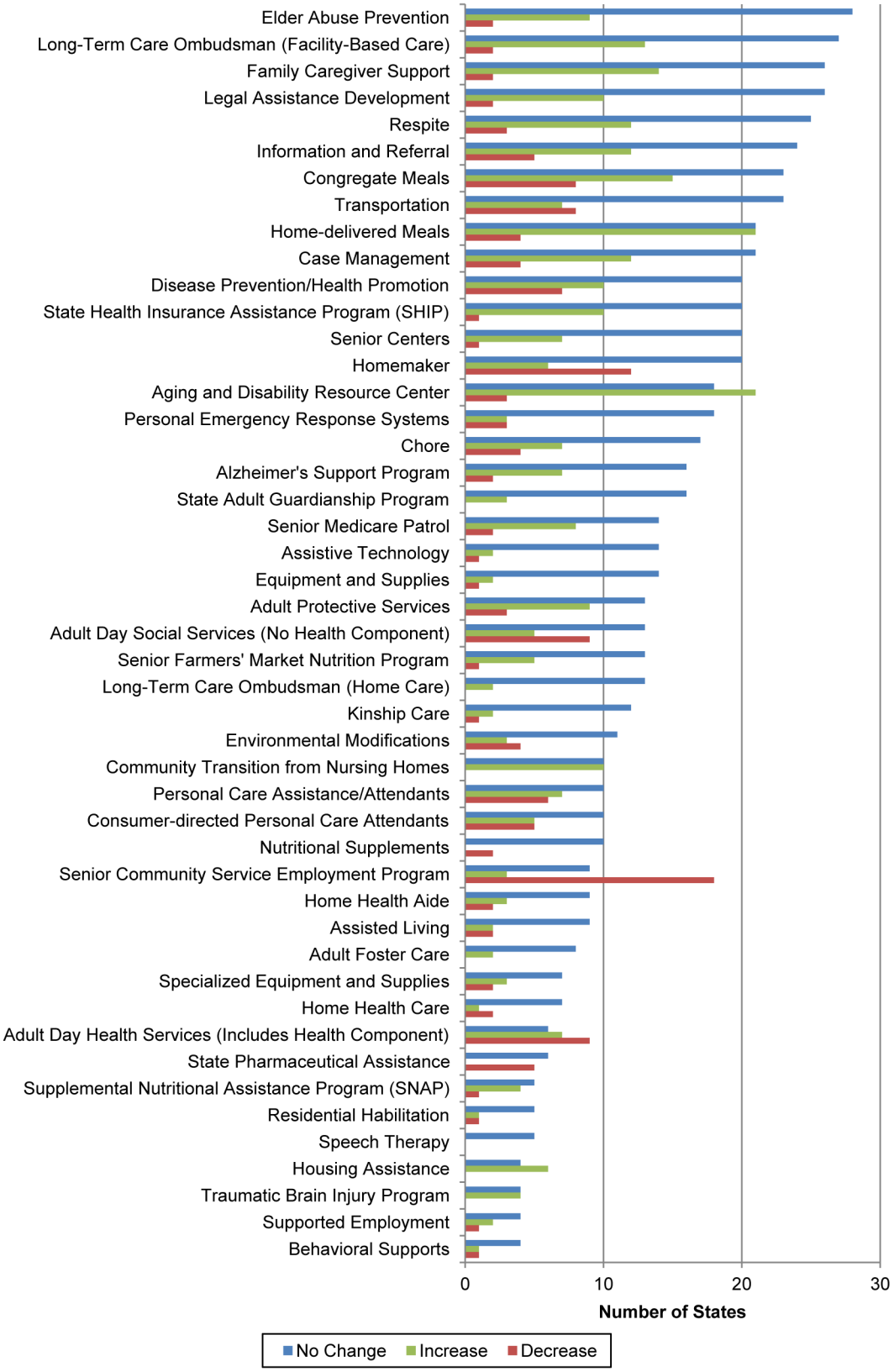


Figure 15
Change in Service Expenditures SFY 2011 to SFY 2012



State aging and disability agencies used a range of strategies to reduce or control non-Medicaid costs during SFY 2012. However, as in the previous surveys, most states chose to reduce administrative expenses rather than eliminate services and programs (Figure 16).

- The most frequently used strategy was streamlining state-level operations.
- The next most frequently identified strategies were forming new partnerships (for example, sharing functions with other entities to leverage resources) and reducing staff (for example, through layoffs, reduced work hours, and hiring freezes).
- Only one state eliminated programs, and one state eliminated services.

Streamlining state-level operations and forming new partnerships were the most frequently identified strategies in both SFY 2012 and SFY 2013, but the number of states using these strategies decreased slightly in 2013. Staff reductions were also less frequently cited in 2013 (9 states) compared with 2012 (17 states). This is largely because state aging and disability agencies also reported that they are unable to further reduce staff.

FINDING: While most state budgets for non-Medicaid programs have remained level or decreased, demand for aging and disability services has grown.

Most states are experiencing significant increases in demand for aging and disability services. Figure 17 shows changes in service demand from SFY 2011 to SFY 2012 and illustrates the following findings:

- More than 30 states reported increased service demand for aging and disability resource centers (35 states) and home-delivered meals (32 states).

Figure 16
Strategies Used or Planned to Control Non-Medicaid Costs
(SFY 2012 and SFY 2013)

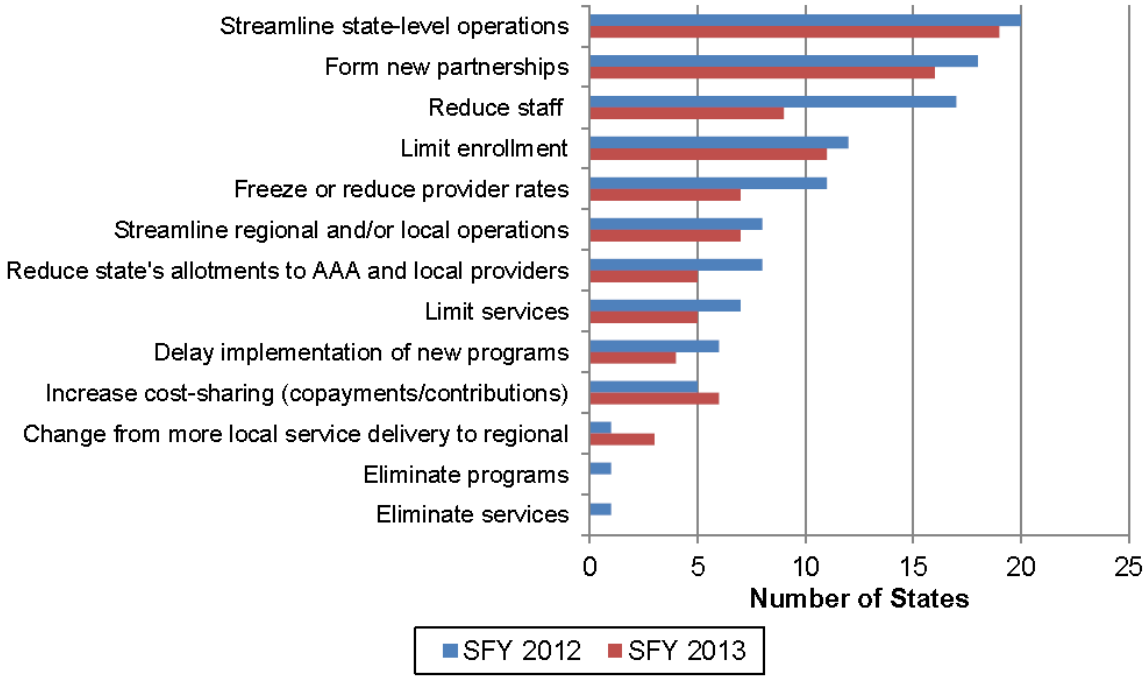
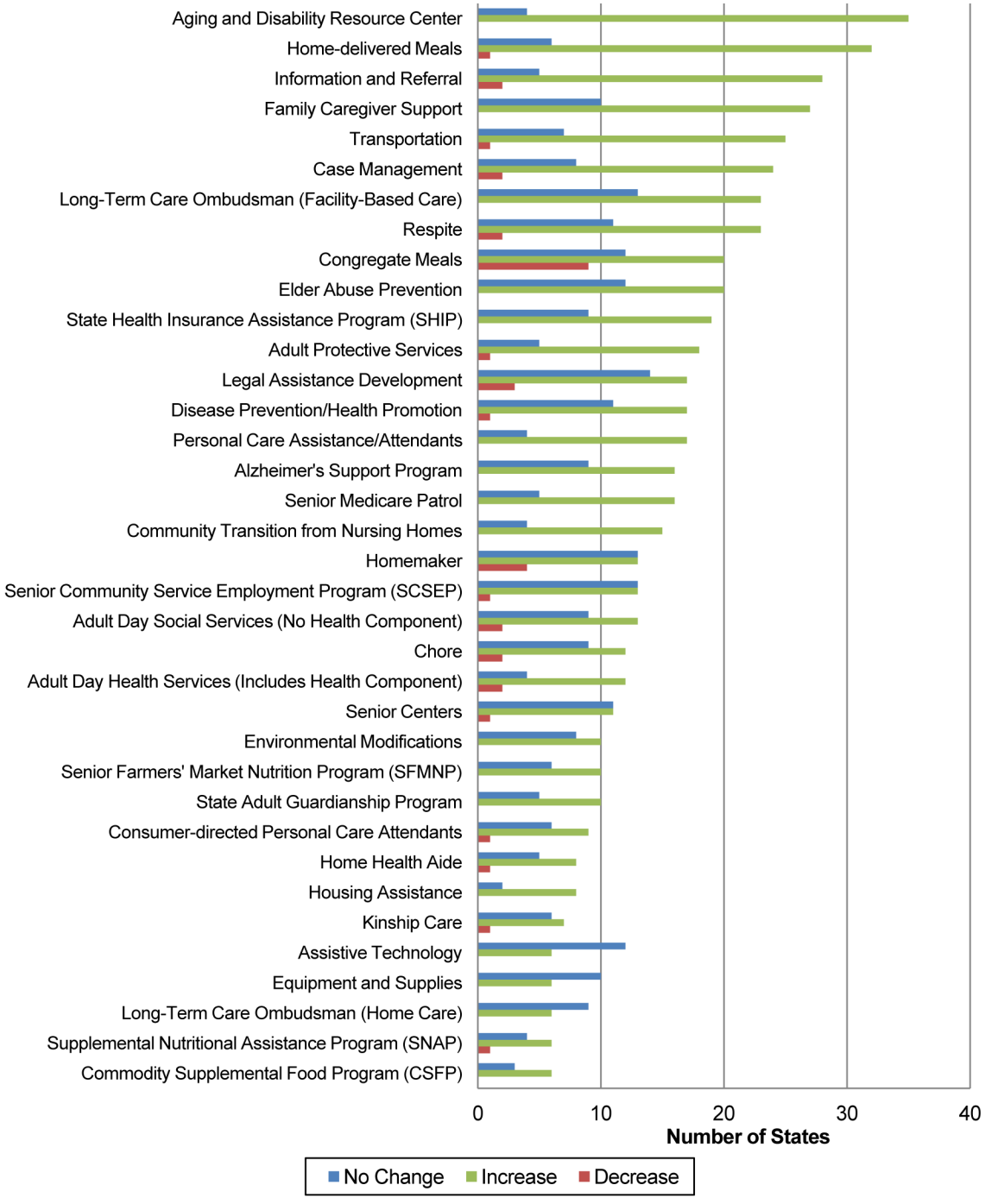


Figure 17
Service Demand Change SFY 2011 to SFY 2012



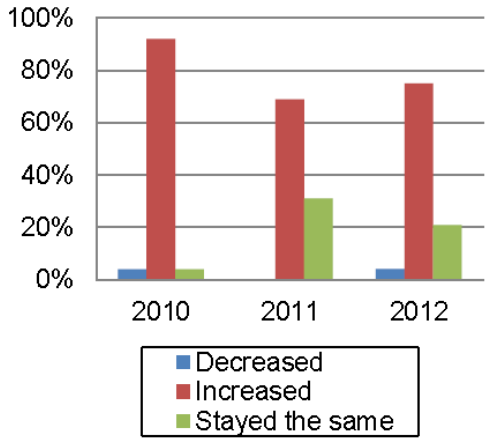
- Twenty or more states reported increased service demand for the following services: information and referral (28 states), family caregiver support (27 states), transportation (25 states), case management (24 states), Long-Term Care Ombudsman Program for facility-based care and respite (23 states each), and congregate meals (20 states).
- Conversely, demand for congregate meals decreased in nine states, and demand for homemaker services decreased in four states. No other services were cited by more than three states as experiencing decreased demand.

FINDING: Increasing adult protective services (APS) caseloads have outpaced expenditures.

All three annual surveys found a significant and alarming trend: APS caseloads have increased. From SFY 2010 to SFY 2012, more than 60 percent of responding states within each of the 3 years have reported increased demand for APS (Figure 18). Despite the increase in caseloads, expenditures for this service have remained unchanged or have been reduced in many states. This is disturbing because APS caseworkers are often the first responders to reports of abuse, neglect, or exploitation for some of the most vulnerable adults.

Currently, no dedicated federal funding stream exists to support the work of APS programs. Although the Elder Justice Act (EJA), which passed in 2010 as part of the ACA, authorizes a direct federal funding stream for state and local APS programs, Congress has yet to appropriate any funding for the EJA. Due to their heavy reliance on state funds, APS programs exhibit particular sensitivity to economic downturns and declines in state revenues.

Figure 18
Change in APS Caseloads: SFY 2010–2012
Percent of Responding States



Transformation of LTSS

Rather than making deep cuts to services and programs, state policy makers are opting to fundamentally restructure services and financing to achieve efficiencies, reduce duplication, and function with reduced staffing levels.

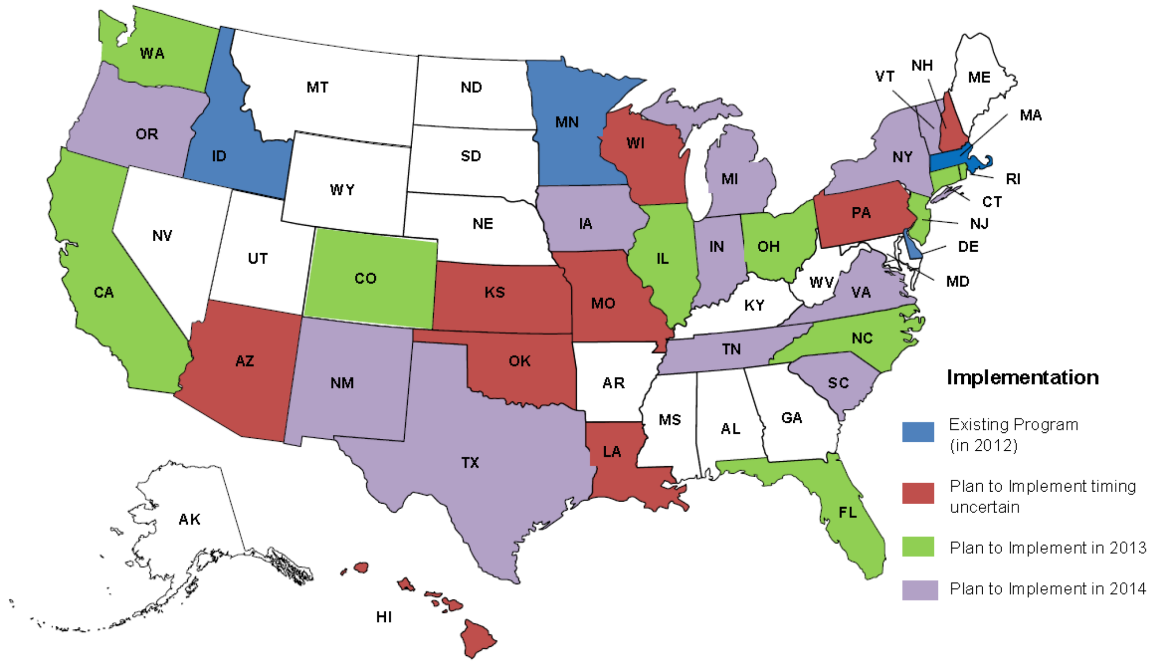
Duals Initiatives

FINDING: One of the significant developments is state efforts to better coordinate care for people who are dually eligible for Medicare and Medicaid services, the so-called "duals."

Two-thirds of the states (34) either have or will launch new initiatives over the next 2 years (Figure 19).

Roughly 10.2 million people are dually eligible for Medicare and Medicaid services; of these, 7.4 million are eligible for both Medicare and full Medicaid benefits. Although they are a diverse group, 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. To contain the growth of costs and improve care, the federal government, in partnership with many states, is exploring models to better serve duals and align the Medicaid and Medicare programs to remove adverse incentives.

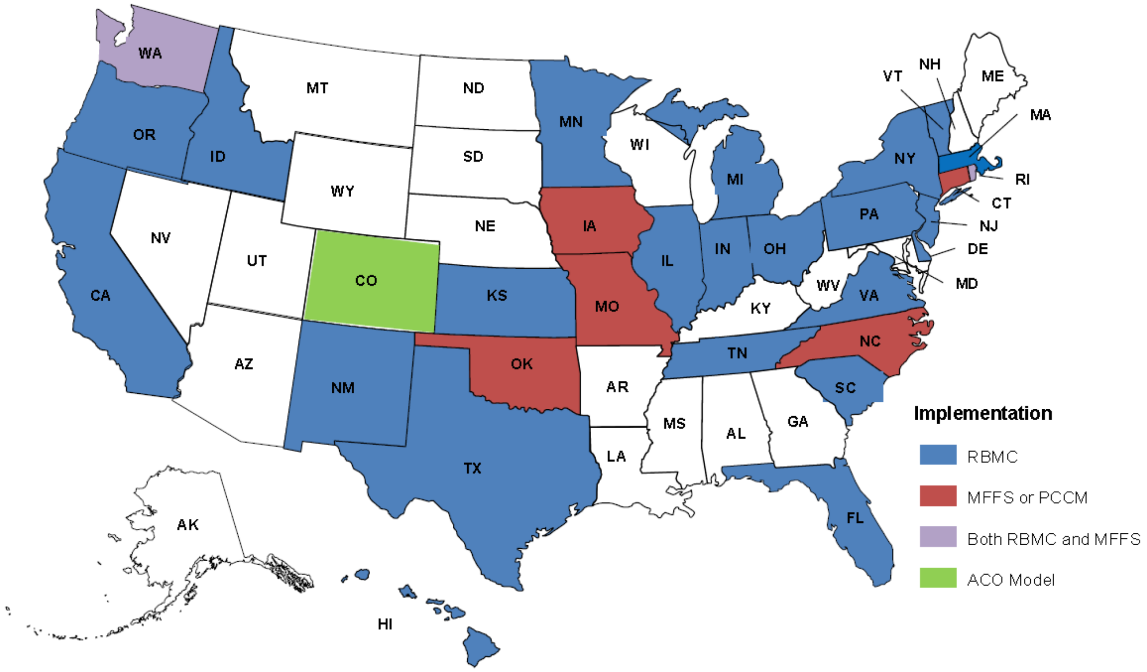
Figure 19
Two-thirds of States Have or Are Planning Duals Integration Initiatives



FINDING: Most states are turning to risk-based managed care models to deliver integrated services to duals.

Of the 33 states describing dual integration initiatives, 25 described a risk-based managed care (RBMC) financial structure, 7 described a managed fee-for-service or primary care case management structure, and 1 described an accountable care organization structure (Figure 20).[21]

Figure 20
State Duals Integration Finance Structure



Two states—Rhode Island and Washington—indicated that they would use both RBMC and managed fee-for-service reimbursement structures within their financial alignment demonstrations. Most of the states proposing RBMC are working with the Medicare-Medicaid Coordination Office (MMCO) to align the financing between the state Medicaid program and Medicare.

Most states with RBMC models intend to include not only HCBS but also some nursing facility care and behavioral health services within a capitated rate,[22] putting managed care organizations at financial risk for the entire spectrum of LTSS services.

[21] Louisiana is unsure about the reimbursement structure, and Arizona did not respond to questions about reimbursement structure. West Virginia, Wisconsin, and Wyoming did not respond to the duals integration survey questions, but Wisconsin has a financial alignment demonstration proposal pending CMS approval.

[22] The survey did not request detail from states about the structure of capitation rates. For instance, the survey did not ask whether the state plans to use a single blended rate using Medicaid and Medicare funding, or whether the program would use multiple rates.

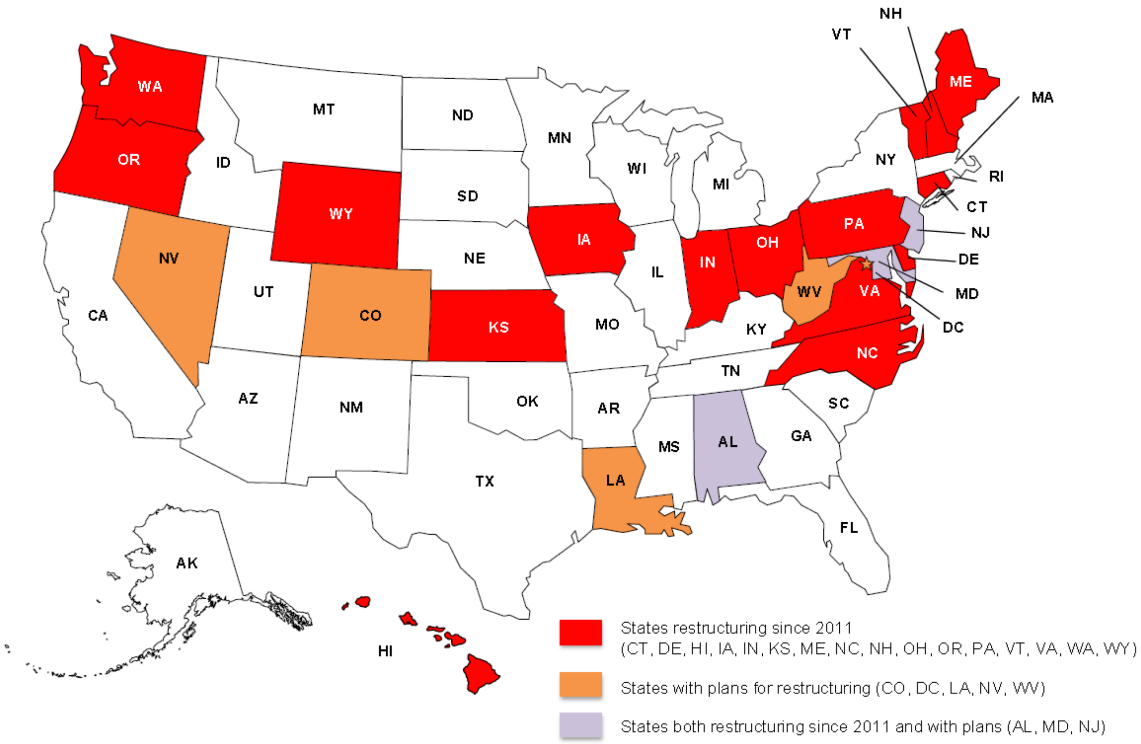
This information was excerpted from *Two-thirds of States Integrating Medicare and Medicaid Services for Dual Eligibles*, our April 2013 paper resulting from this survey.[23] Since the time of that publication, some states have dropped out of the MMCO demonstration or have delayed the implementation date. For current information on these initiatives, please see NASUAD's ongoing State Medicaid Integration Tracker©, which is updated monthly.

State Aging and Disability Agencies' Restructuring

FINDING: As states are reforming the ways in which they pay for and deliver publicly funded LTSS, they are also restructuring the state agencies that administer aging and disability services.

In 2011, more than half the state aging and disability agencies reported that they had restructured since 2009 or had plans to restructure.[24] Similarly, Figure 21 indicates that in 2012, 24 state agencies reported that they had been restructured since 2011 (16 states), had plans for restructuring (5 states), or both had been restructured *and* had plans for further restructuring (3 states).[25] Restructuring is broadly defined and includes state-level

Figure 21
States Restructuring State Aging and Disability Agencies



[23] J. Walls, W. Fox-Grage, K. Ujvari, D. Scully, E. Cho, J. M. Hall, *Two-thirds of States Integrating Medicare and Medicaid Services for Dual Eligibles* (Washington, DC: AARP Public Policy Institute, April 2013).

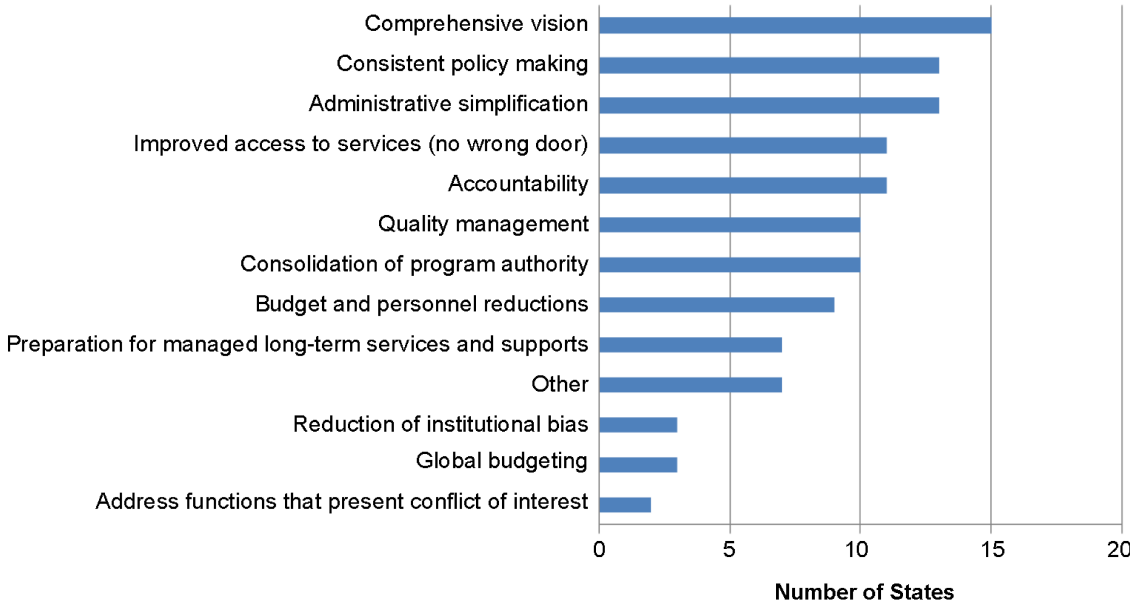
[24] National Association of States United for Aging and Disabilities, *2012 State of Aging and Disabilities Survey—Another Year of Challenges Tempered by Opportunities* (Washington, DC: NASUAD, 2012). Accessed at http://www.nasuad.org/documentation/nasuad_materials/NASUAD%202012%20States%20Rpt%20final.pdf.

[25] *Ibid.*

reorganizations or relocation of Long-Term Care Ombudsman Programs as well as local and regional efforts to consolidate or change Area Agencies on Aging and Medicaid HCBS operations, and designated planning and service areas under the Older Americans Act.

Figure 22 provides an overview of factors driving state agency restructuring as reported by the states in 2012.[26] The top three factors driving agency restructuring include providing a comprehensive vision, consistent policy making, and administrative simplification. States identified challenges related to restructuring, including difficulty serving multiple populations and agency turf battles.

Figure 22
Factors Driving State Aging and Disability Agency Restructuring



In addition to state-level restructuring, local and regional restructuring is occurring.[27] Approximately one-third of states in 2011 and 2012 indicated that regional or local restructuring efforts were under way or planned.

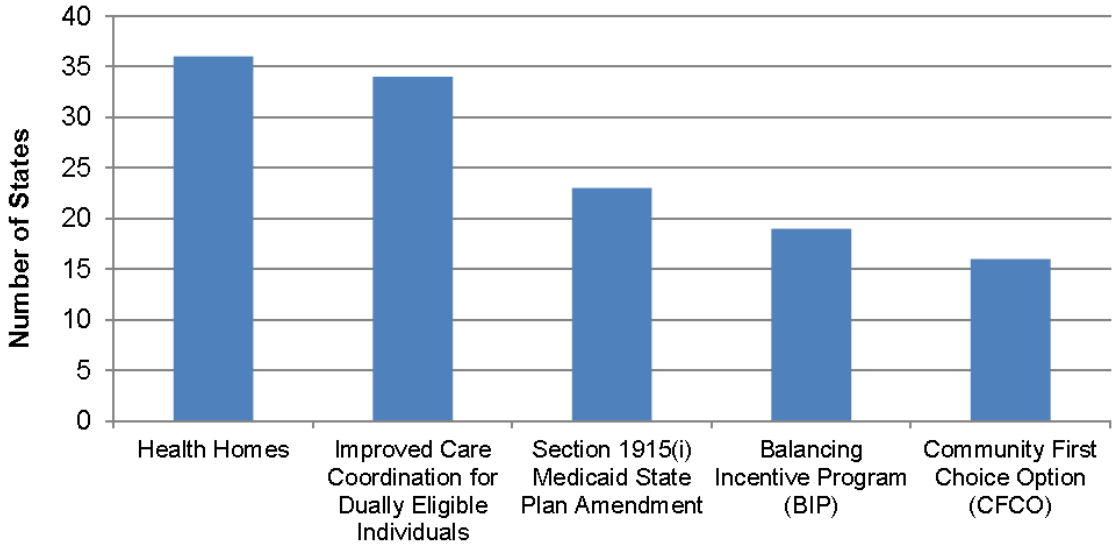
Affordable Care Act

FINDING: State participation in HCBS options within the ACA is increasing.

The ACA included several LTSS options and health care programs with implications for LTSS populations. Optional Medicaid provisions in the ACA that support HCBS include health homes, improved care coordination for dually eligible individuals, the

[26] *Ibid.*
[27] *Ibid.*

Figure 23
Overview of State Interest in ACA Options That Impact LTSS Populations



Community First Choice option under Section 1915(k), amendments to Section 1915(i) HCBS State Plan Option, and the Balancing Incentive Program.[28]

In 2011, fewer than half the states reported that they were engaged in implementing ACA options relating to LTSS. At that time, the majority of responding states indicated that they were not currently pursuing ACA options pending CMS guidance and the outcome of the Supreme Court decision.[29] Figure 23 illustrates state interest in ACA programs for LTSS populations.

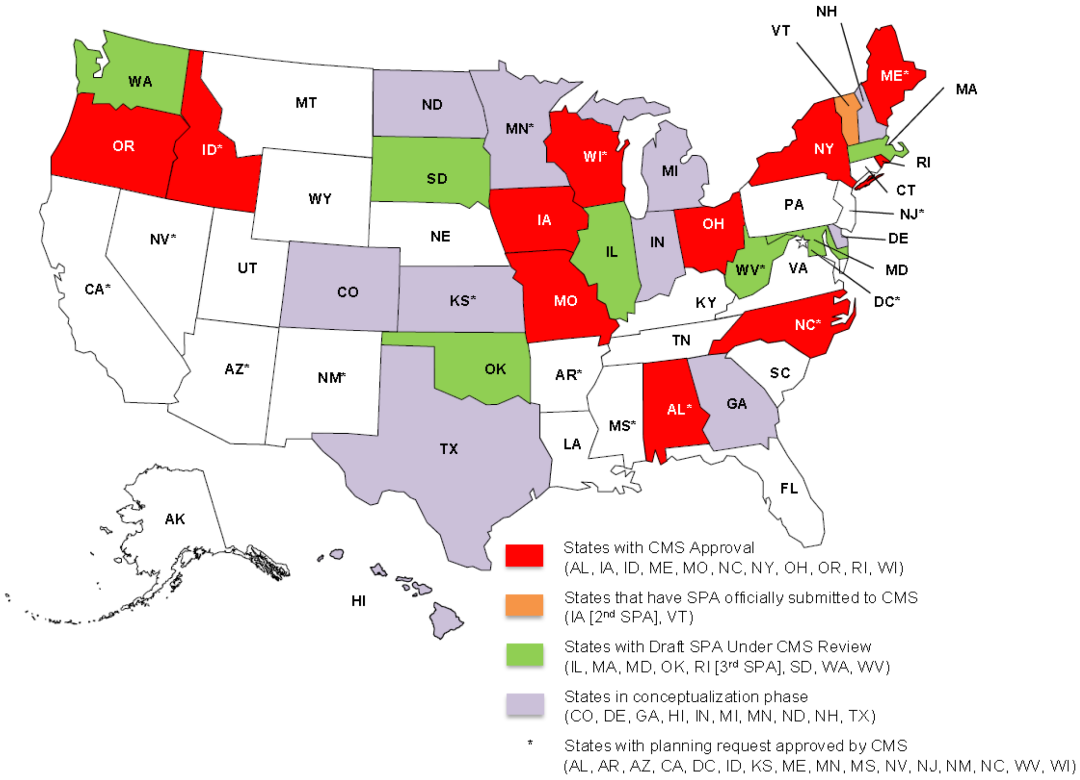
Health homes are providers or a health team that coordinates care across settings for people with chronic conditions or mental health conditions, or both. More than 30 states are either participating or are working toward health homes:[30]

[28] The implementation status of ACA programs described in this report is based on multiple sources: this 2012 LTSS and Economic Trends Survey; NASUAD's 2012 State of Aging and Disabilities Survey; and NASUAD's ongoing State Medicaid Integration Tracker©, updated monthly. When information in this report is different from information in previous publications, it is because of the flurry of ACA planning and implementation activities at the state level. In many instances, states considering options or conceptualizing how to proceed several months ago have now submitted proposals for consideration by CMS. In other cases, some states have decided to forgo further planning or to pursue other options.

[29] On June 28, 2012, the Supreme Court resolved the constitutionality of the ACA in the *National Federation of Independent Businesses et al. v. Sebelius*. At issue was the individual mandate and the Medicaid expansion rather than the LTSS provisions that are described in this section of the paper. However, because of the uncertainty surrounding the ACA's constitutionality, many states were waiting on this historic Supreme Court decision before implementation.

[30] At least five states (Idaho, Kansas, Oklahoma, Michigan, and Washington) have included health homes as part of their care coordination initiatives for people who are dually eligible for Medicaid and Medicare. It is possible that additional states, not listed in the report, also are including health homes in their initiatives.

Figure 24
States Involved in Health Homes for Individuals with Chronic Conditions



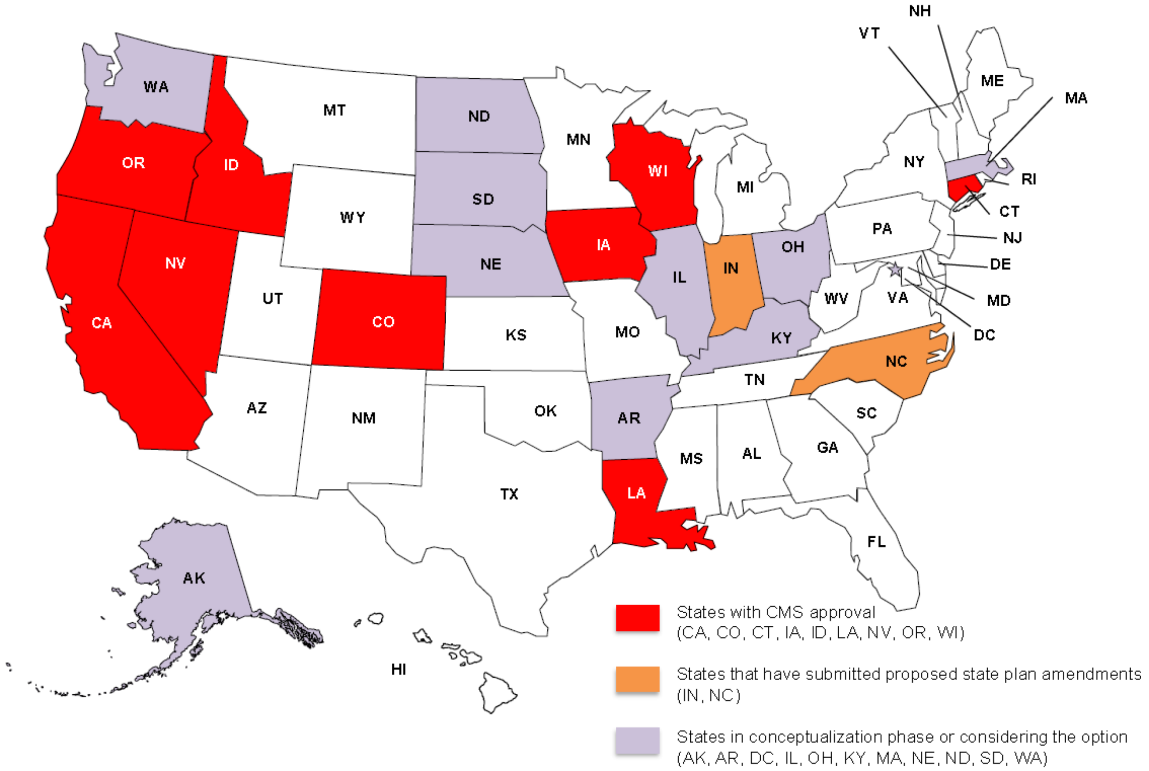
Eleven states (Alabama, Idaho, Iowa, Maine, Missouri, North Carolina, New York, Ohio, Oregon, Rhode Island, and Wisconsin) have received CMS approval.

- Two states (Iowa [2nd State Plan Amendment (SPA)] and Vermont) have their SPA officially submitted to CMS.
- Eight states (Illinois, Massachusetts, Maryland, Oklahoma, Rhode Island [3rd SPA], South Dakota, Washington, and West Virginia) have submitted a draft SPA, which are under CMS review.
- Sixteen states (Alabama, Arkansas, Arizona, California,[31] the District of Columbia, Idaho, Kansas, Maine, Minnesota, Mississippi, Nevada, New Jersey, New Mexico, North Carolina, West Virginia, and Wisconsin) have a planning grant to coordinate health homes with Medicaid managed LTSS.
- Ten states (Colorado, Delaware, Georgia, Hawaii, Indiana, Michigan, Minnesota, North Dakota, New Hampshire, and Texas) are in the conceptualization phase.

Section 1915(i) provisions allow states to provide LTSS in the community similar to Medicaid HCBS 1915(c) waivers, but with three major differences: (1) the individual does not need to meet an institutional level of care in order to qualify; (2) states may not cap enrollment;

[31] According to a state official, California's Health Homes project has been put on hold.

Figure 25
States with or Pursuing Section 1915(i) HCBS State Plan Amendments



and (3) the program must operate statewide. Twenty-two states either have, are pursuing, or are considering section 1915(i) HCBS State Plan Amendments under Medicaid:[32]

- CMS has approved section 1915(i) state plan amendments in nine states (California, Colorado, Connecticut, Idaho, Iowa, Louisiana,[33] Nevada, Oregon, and Wisconsin).
- Two states (Indiana and North Carolina[34]) have submitted proposed section 1915(i) state plan amendments to CMS.
- Eleven states (Alaska, Arkansas, the District of Columbia, Illinois, Ohio, Kentucky, Massachusetts, Nebraska, North Dakota,[35] South Carolina, and Washington[36]) are in the conceptualization phase or considering section 1915(i) state plan amendments.

[32] This summary does not include 1915(i) state plan amendments that focus on children with serious emotional disturbances (such as in Florida and Montana).

[33] In the 2012 LTSS and Economic Trends Survey, Louisiana responded that their 1915(i) SPA was approved. NASUAD State Medicaid Integration Tracker© specifies that it was submitted.

[34] North Carolina submitted two 1915(i) state plan amendments to CMS.

[35] North Dakota will begin with a focus on children with severe mental illness, with plans to expand to the adult population with mental health needs.

[36] Washington State had a 1915(i) state plan amendment for adult day health, but these services have been moved to a Medicaid HCBS waiver. The state is unsure whether they will pursue another 1915(i) SPA.

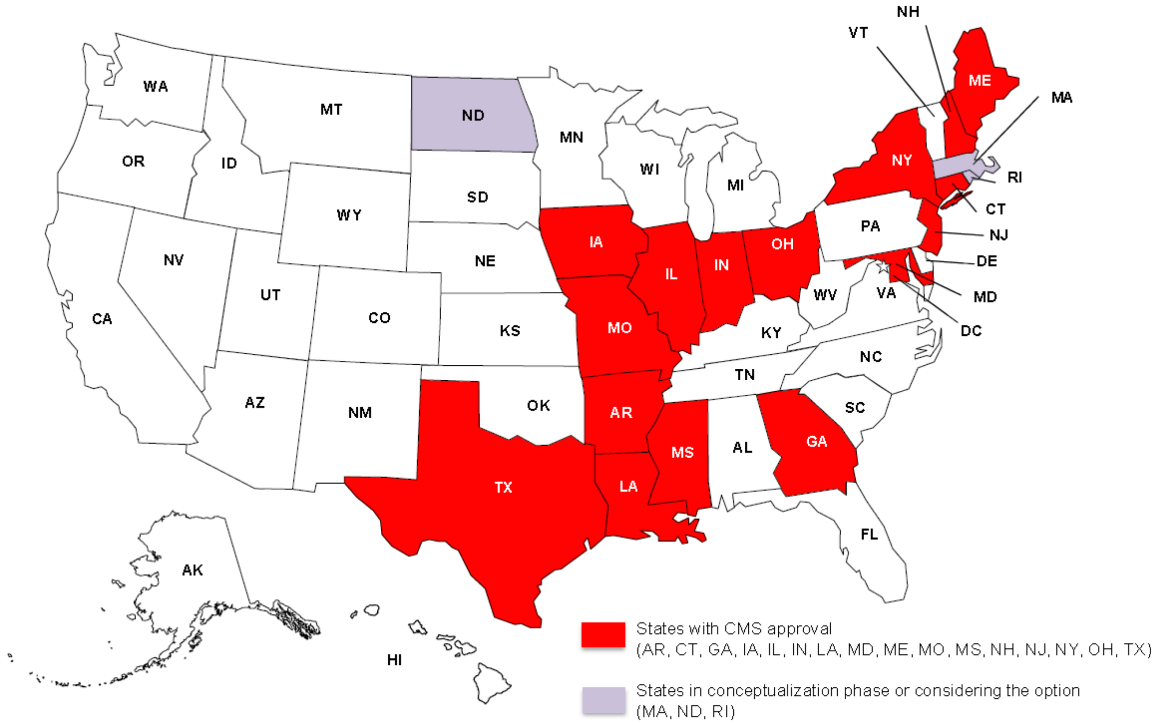
Populations and services that are the focus of 1915(i) state plan amendments include:

- Services for people with mental illness—13 states (Alabama, Arkansas, the District of Columbia, Florida, Indiana, Iowa, Kentucky, Louisiana, North Carolina, North Dakota, Oregon, South Carolina, and Wisconsin).
- Personal care services or other HCBS for older adults, adults with physical disabilities, or both—six states (Connecticut, the District of Columbia, Idaho, Massachusetts, North Carolina, and Nevada).
- Services for people with intellectual/developmental disabilities—six states (Alabama, California, Colorado, the District of Columbia, Idaho, and North Carolina).
- Not sure; still under consideration—two states (Nebraska and Ohio).

Balancing Incentive Program (BIP) is a temporary, noncompetitive grant program designed to encourage states to balance their Medicaid spending toward HCBS. To be eligible, a state must have spent less than 50 percent of its total Medicaid LTSS dollars on noninstitutional services in FY 2009. Nineteen states are participating in, pursuing, or considering BIP:

- CMS has approved 16 states for participation in BIP (Arkansas, Connecticut, Georgia, Indiana, Illinois, Iowa, Louisiana, Maine, Maryland, Missouri, Mississippi, New Hampshire, New Jersey, New York, Ohio, and Texas).
- Three states are in the conceptualization phase or considering BIP (Massachusetts, North Dakota, and Rhode Island).

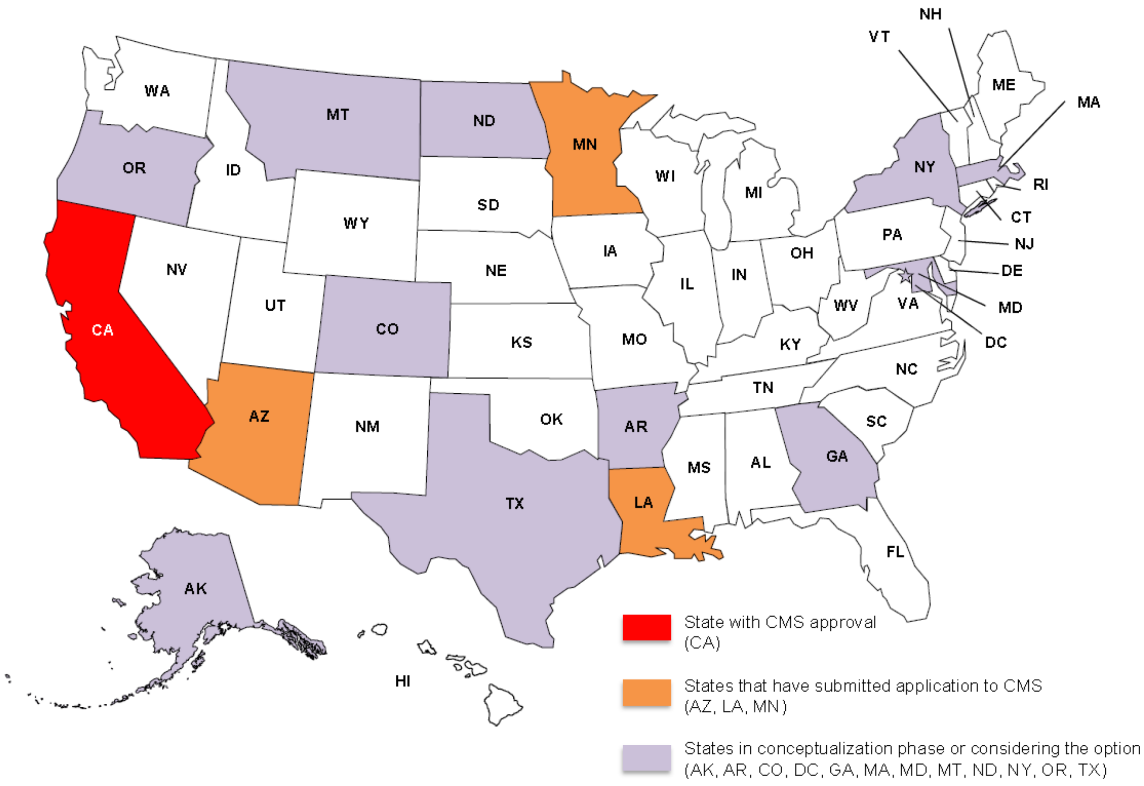
Figure 26
States Involved in Balancing Incentive Program



Community First Choice Option (CFCO) gives states the option to add a new participant-directed state plan HCBS attendant services and supports benefit. Sixteen states are participating or considering CFCO:

- One state's CFCO application has been approved by CMS (California).
- Three states (Arizona, Louisiana, and Minnesota) have submitted a CFCO application to CMS.
- Twelve states (Alaska, Arkansas, Colorado, the District of Columbia, Georgia, Massachusetts, Maryland, Montana, North Dakota, New York, Oregon, and Texas) are in the conceptualization phase or are considering CFCO.

Figure 27
States Involved in Community First Choice Option



CONCLUSION

Although state fiscal conditions continue to improve into FY 2013, many state budgets are not fully restored to pre-recession levels. Unprecedented budgetary declines in FY 2009 and FY 2010 put states well below historical growth trends in general fund spending and revenue. States also continue to reduce the number of FTE state employees.

Cost containment and delivery reform strategies for people with LTSS needs are at the forefront of health policy actions. With the increased demand for publicly funded LTSS, state policy makers are transforming the ways in which LTSS are financed, delivered, and administered. Many states are moving toward risk-based managed care and emphasizing better integration of care for people who are dually eligible for Medicare and Medicaid services.

States are continuing to prioritize access to HCBS and to further target limited resources. Many states are now beginning to implement the LTSS options within the ACA, most of which provide additional revenue for implementing states. State officials were waiting for more guidance from CMS and the historic Supreme Court decision in June 2012 that resolved the constitutionality of the ACA. Although many of the non-Medicaid LTSS programs are still sustaining cuts or flat budgets despite increased demand, most states continue to make administrative reductions rather than reduce benefits or services.

APPENDIX I

Methodology

This 2012 Survey of LTSS and Economic Trends is the third annual study of the AARP Public Policy Institute, the National Association of States United for Aging and Disabilities, and Health Management Associates. Building on the research findings from 2010 and 2011, this 2012 survey asked additional questions in new areas such as eligibility and access to LTSS. As a result, findings from the 2012 survey are being released in a series of papers, including this one.

Officials from both state Medicaid agencies and the state aging and disability agencies completed an electronic survey from late August into the fall of 2012. Forty-nine states plus the District of Columbia participated. Forty-eight state Medicaid agencies responded, and 48 state aging and disabilities agencies responded.[37] Authors conducted follow-up telephone interviews with state Medicaid officials from 34 states and state aging and disability officials from 35 states to ask clarifying questions about survey responses and to gather more in-depth information. Each interview was approximately 1 hour long.

In addition to conducting interviews, the authors made many more contacts through phone calls and emails, as needed, to ensure the accuracy and completeness of information provided. LTSS programs for older adults and adults with physical disabilities are the subject of this report. The survey did not address LTSS programs for people with intellectual disabilities or for children.

[37] State Medicaid agencies in North Carolina, South Dakota, and Wisconsin did not participate. State aging and disabilities agencies in Florida, West Virginia, and Wisconsin did not participate.

APPENDIX II

Non-Medicaid Expenditures

Figure 28
Increased Service Expenditures for Non-Medicaid Programs
(SFY 2011–2012 and SFY 2012–2013)

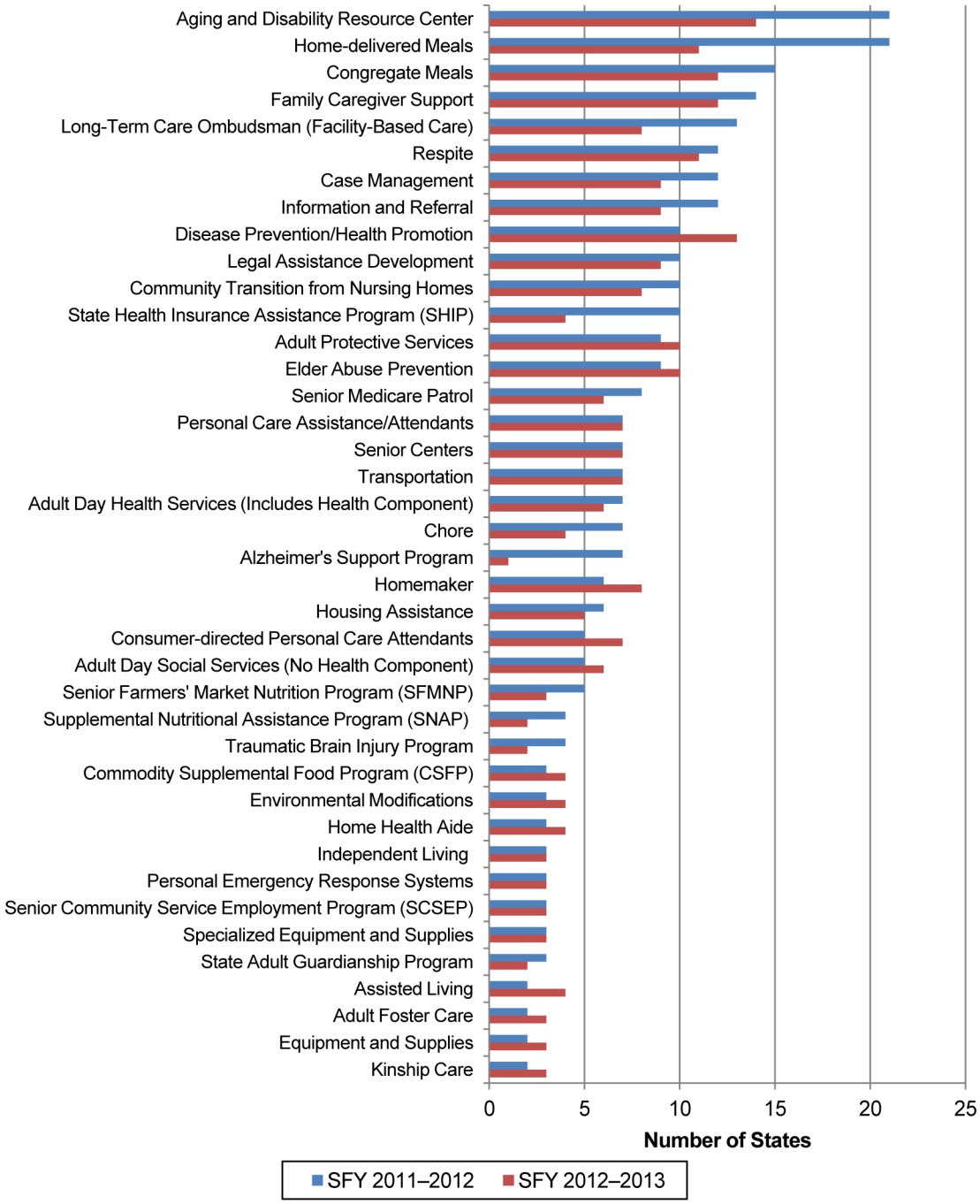
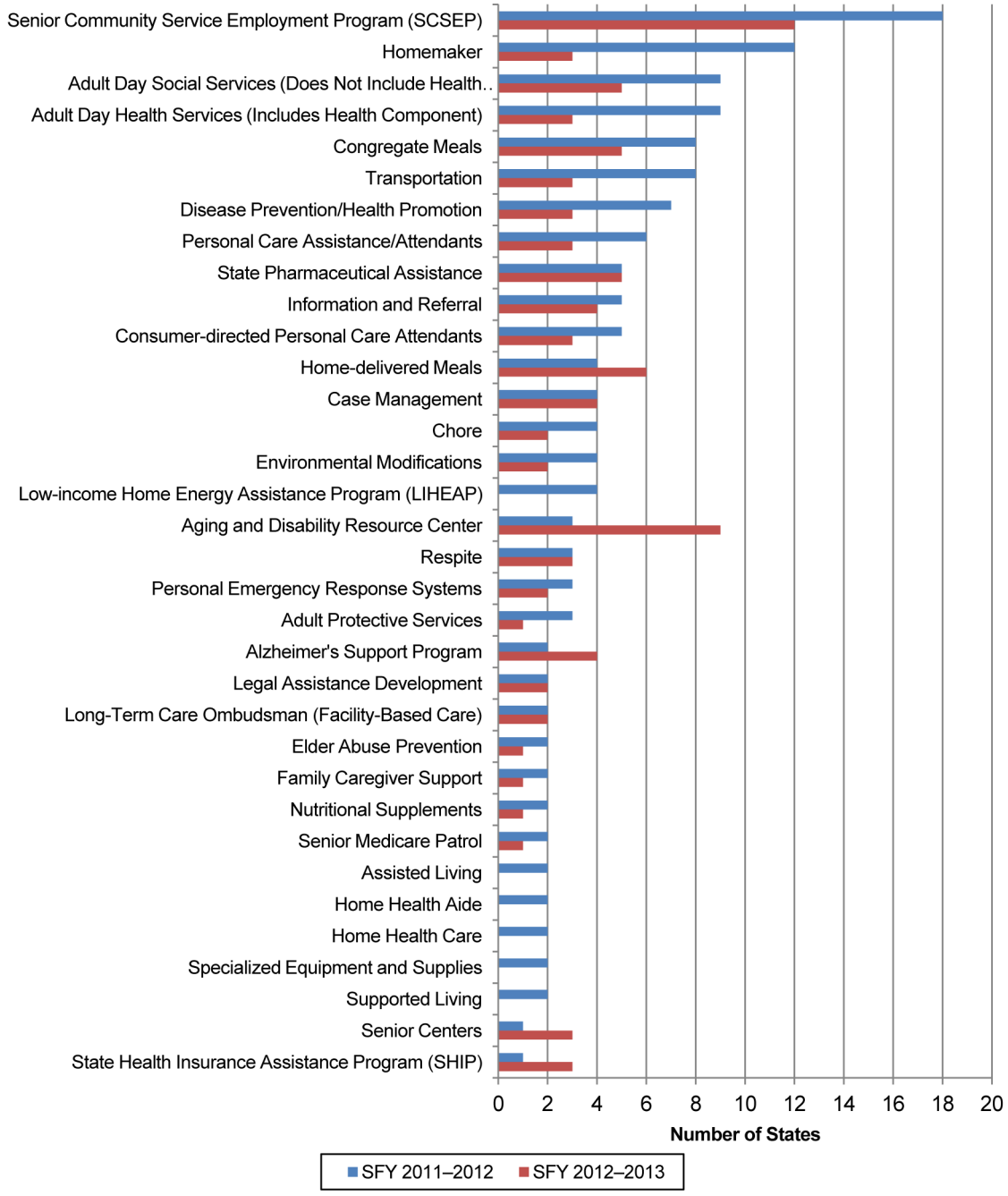


Figure 29
Decreased Service Expenditures for Non-Medicaid Programs
(SFY 2011–2012 and SFY 2012–2013)



APPENDIX III

States Have Stepped up Changes to HCBS Benefits

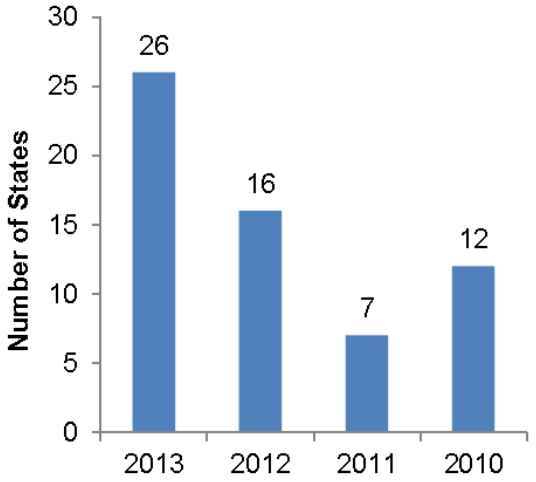
A large number of states have made or plan to make policy changes to their HCBS programs in 2012 and 2013. This is a striking change from previous survey results, when only a few states made program changes (Figure 30). A majority of the changes have had or will have a positive impact on benefits, or a neutral effect (Figure 31). Only four states placed or plan to place restrictions on HCBS in 2012 and 2013. These results illustrate that states are actively refining and redefining their HCBS programs.

Forty-seven states responded to questions about HCBS benefit changes. Appendix V provides detail about specific state changes.

Of the states that made changes to HCBS benefits in 2012 and 2013:

- Fourteen expanded HCBS services or benefits.
- Eight expanded HCBS waiver capacity.
- Two added new HCBS waivers.
- Three placed limits on services or capped expenditures for services.
- One initiated utilization management on HCBS services.
- One terminated a waiver program.

Figure 30
Number of States with HCBS Policy Changes 2010–2013
(planned)

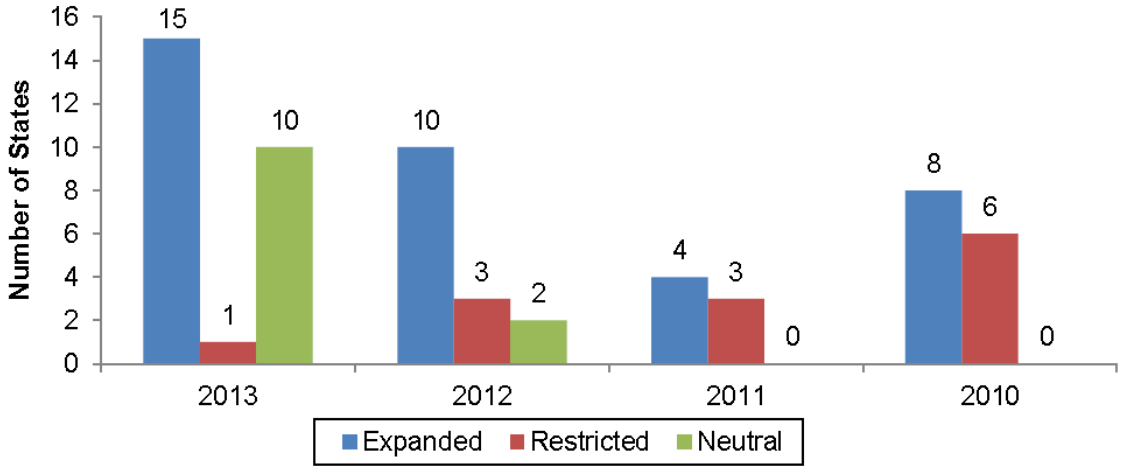


N = 47 for 2012 and 2013
N = 37 for 2011
N = 38 for 2010

While some states made HCBS changes with no direct impact on benefits, the changes nonetheless have implications for service delivery:

- Five states merged waivers, or required waiver participants to transition to another waiver.
- Five states shifted services from or to state plan services (often to free up additional waiver funds).
- Two states moved waiver recipients into managed care.
- Two added consumer direction to HCBS services.

Figure 31
Number of States with HCBS Changes by Impact on Benefits
2010–2013



N = 47 for 2012 and 2013
N = 37 for 2011
N = 38 for 2010

More States Are Making Changes to State Plan LTSS Benefits

Forty-nine states and the District of Columbia responded to survey questions about Medicaid state plan benefits. Although the vast majority of states made no changes, similar to HCBS, the survey found an increase in the number of states making changes compared with previous years. In 2010 and 2011, only five states reported making changes to state plan benefits over the 2 years. In 2012, the number of states increased to 7, and in 2013, 12 states plan to make changes.

Unlike HCBS policy changes, the impact of state plan changes is somewhat mixed. In FY 2012, most states placed restrictions on state plan benefits, and in FY 2013, most of the changes were described as expansions (Figure 32).

Of the seven states[38] reporting state plan benefit expansions over the 2 years:

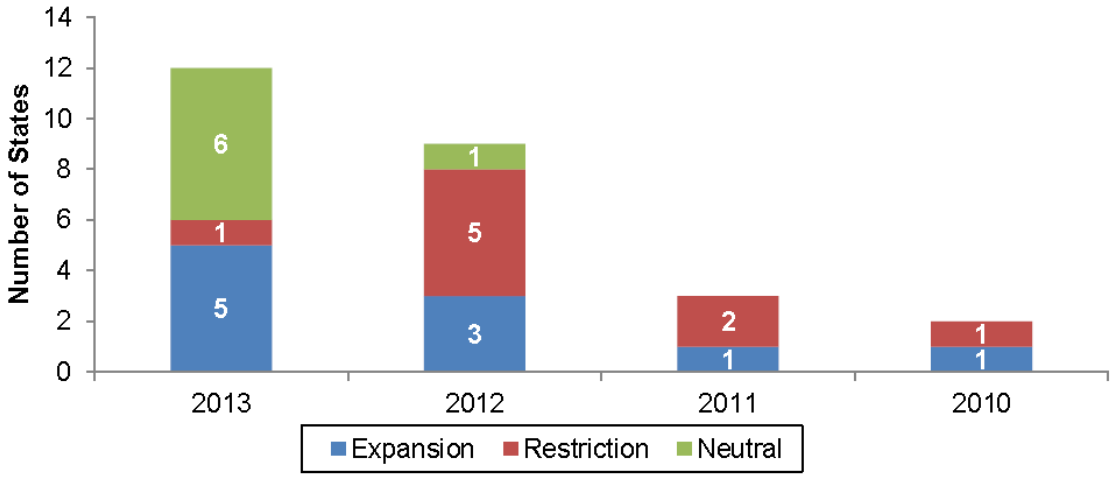
- Three are adding 1915(i) HCBS services, and one is adding 1915(k).
- Two expanded the type of providers eligible to provide services.
- One added consumer direction.

Six states placed restrictions on LTSS state plan benefits in 2012 and 2013:

- Two states placed restrictions on service utilization.
- Two states transitioned state plan services to waivers.
- One state eliminated a state plan service.
- One state increased eligibility requirements for a state plan service.

[38] California expanded state plan benefits in both 2012 and 2013.

Figure 32
Number of States Making LTSS State Plan Changes



N = 47 for 2012 and 2013
N = 43 for 2011
N = 34 for 2010

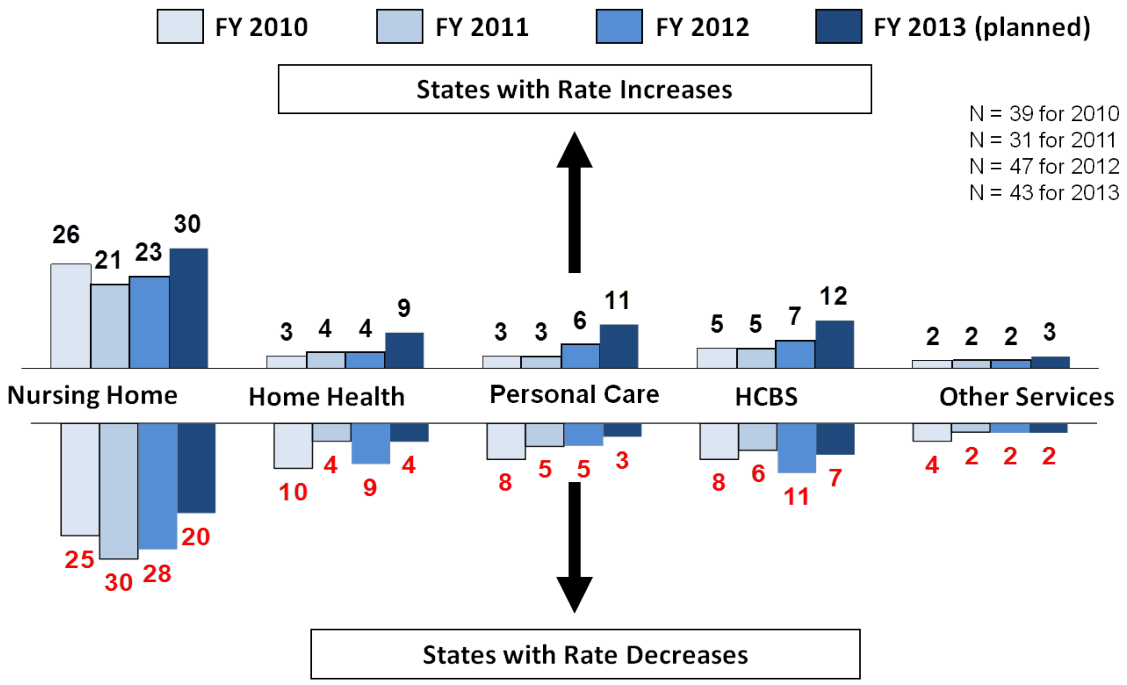
Some states made or plan to make LTSS state plan changes that have a neutral impact. These changes include: consolidating services for greater efficiency, policy changes to reflect actual practice, and transitioning services to managed care. Figure 35 in Appendix V provides detail around state plan changes.

APPENDIX IV

Provider Reimbursement

After 3 years of generally flat or declining LTSS provider reimbursement, more states are planning increases in FY 2013 (Figure 33). Forty-two states and the District of Columbia answered questions concerning LTSS provider reimbursement. Disregarding nursing home reimbursement, 28 states adjusted reimbursement rates for one or more LTSS provider types in FY 2012 or FY 2013. See Appendix V for the state-by-state data.

Figure 33
LTSS Provider Reimbursement Rate Changes



Nursing Home provider rate change data source: "Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment and Policy Trends. Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013"; 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 2012.

APPENDIX V

Figure 34
LTSS Balancing

State	HCBS Waiver Recipient Change		HCBS Expenditure Change		Nursing Facility Resident Change	
	2011–2012	2012–2013	2011–2012	2012–2013	2011–2012	2012–2013
Alabama	0	↑	0	+ 8% to 15%	↓	↓
Alaska	↑	↑	+ 8% to 15%	+ 8% to 15%		
Arizona	↑	↑				
Arkansas	↑	↑	+<5%	+<5%	↓	0
California	↑	0	+5% to 8%	+5% to 8%	↑	↓
Colorado	↑	↑	+5% to 8%	+5% to 8%		
Connecticut	↑	0	+	+	↓	↓
Delaware	↑	↑	+	+	↑	0
District of Columbia	↑	↑	- (<5%)	+<5%	0	0
Florida					↓	↓
Georgia	↑	0	0	0	0	0
Hawaii	↑	↑	+<5%	+<5%	↓	↑
Idaho	↑	↑	0	+<5%	0	0
Illinois	0	↓			0	0
Indiana	↑	↑	- (5% to -8%)	+5% to 8%	0	0
Iowa	↑	↑	+<5%	+<5%	↑	↑
Kansas	↓	0	- (8% to -15%)	+<5%	↑	0
Kentucky	↓	0	+<5%	0	↑	0
Louisiana	0	↑	+<5%	+ 8% to 15%	↑	0
Maine	0	0			0	0
Maryland	↑	↑	+=>15%	+ 8% to 15%	0	0
Massachusetts	↑	↑	+=>15%	+=>15%	↓	↓
Michigan	↑	↑	+ 8% to 15%	+ 8% to 15%	↓	↓
Minnesota	↑	↑	+<5%	+<5%	↓	↓
Mississippi	↑	↑	+=>15%	+=>15%	0	0
Missouri	↑	↑	- (<5%)	- (<5%)	↑	↓
Montana	↑	0	+5% to -8%	0	↓	↓
Nebraska	0	0	- (5% to -8%)	+<5%	↓	0
Nevada	0	0	+ 8% to 15%	+ 8% to 15%	0	0
New Hampshire	↑	↑	+<5%	+5% to 8%	↑	↑
New Jersey	↑	↑	+5% to 8%	+<5%	↓	↓
New Mexico	↑	↑	- (<5%)	+ 8% to 15%	↑	↓
New York	↓	↓	- (<5%)	- (<5%)	↑	0
North Carolina						

Figure 34 (continued)

State	HCBS Waiver Recipient Change		HCBS Expenditure Change		Nursing Facility Resident Change	
	2011–2012	2012–2013	2011–2012	2012–2013	2011–2012	2012–2013
North Dakota	↑	↑	+<5%	+<5%	↓	↓
Ohio	↑	↑	+<5%	+5% to 8%	0	0
Oklahoma	↑	↑	+5% to 8%	+5% to 8%	0	↓
Oregon	↑	↑	+5% to 8%	0	↑	↓
Pennsylvania	↑	↑	+	+	0	0
Rhode Island	↑	↑	+5% to 8%	+5% to 8%	↑	↑
South Carolina	↑	↑	+5% to 8%	+5% to 8%	↓	↑
South Dakota	↑	↑	+=>15%	+5% to 8%	0	↓
Tennessee	↑	↑	+=>15%	+=>15%	↓	↓
Texas	↓	↓	+<5%	+<5%	↑	↑
Utah	↑	↑	+<5%	+<5%	↓	↓
Vermont	↑	↑	+<5%	+<5%	↓	↓
Virginia	↑	↑	+ 8% to 15%	+ 8% to 15%	↓	
Washington	↑	↑	+5% to 8%	+5% to 8%		
West Virginia					0	0
Wyoming	0	0	+<5%	0	↓	0

↑ = increase; ↓ = decrease; 0 = no change; + = expenditure increase; -() = expenditure decrease

Figure 35
State Actions Taken on State Plan LTSS Benefits 2012–2013

Benefit	State Action Taken for State Plan Benefits
Personal Care Services	• (↓) 2012: Arizona reduced the total number of allowable respite care hours from 700 to 620 hours annually. • (↑) 2013: Louisiana is adding consumer direction to personal care assistant services. • (↔) 2013: Maine will be consolidating personal care services programs to increase administrative efficiency and to provide more choices and less confusion for consumers.
Adult Day Health	• (↓) 2012: California eliminated Adult Day Health from the state plan and transitioned services to Community-Based Adult Services offered under an 1115 waiver. • (↔) 2013: Missouri plans to eliminate Adult Day Health from the state plan and offer the services under a new waiver in June 2013.
State Plan Options	• (↑) 2012: California added a Community First Choice 1915(k) option. • (↑) 2012: Connecticut plans to add 1915(i) services. • (↓) 2012: Washington eliminated 1915(i) Adult Day Health and moved the services to the WA COPES 1915(c) waiver (Aged and Disabled). • (↑) 2013: California applied for the 1915(i) HCBS option to provide managed care delivery to newly enrolled duals living in eight counties. • (↔) 2013: The District of Columbia is planning to transition Adult Day Treatment to a 1915(i) option. • (↑) 2013: Indiana is planning to adopt a 1915(i) option to provide services for the seriously mentally ill.
Targeted Case Management	• (↔) 2012: Alabama revised Targeted Case Management to add transitional services to certain target populations. • (↓) 2012: Indiana eliminated Targeted Case Management. • (↑) 2012: North Dakota expanded the entities that can qualify to provide Targeted Case Management to include social workers and Indian tribal organizations. • (↔) 2013: Arkansas reduced the cap on service hours for Targeted Case Managers, which greatly exceeded actual hours used, such that no consumers were affected. This occurred in tandem with a provider rate increase.
Other	• (↓) 2012: Connecticut limited eyeglass replacement to once every other year. • (↓) 2012: Connecticut limited routine adult dental exams to one cleaning and one set of X-rays per year. • (↑) 2013: Iowa will allow providers to serve as health homes for members with chronic conditions. • (↔) 2013: Kansas is transitioning the Medicaid program to a managed care delivery system. • (↔) 2013: New Hampshire will transition the Medicaid program to managed care. LTSS will transition in 2014. • (↓) 2013: Tennessee will raise the nursing facility level-of-care criteria to target services with the greatest need. • (↑) 2013: Vermont did not specify expansion.

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

Figure 36
Home and Community-Based Services: Benefit Expansions

State	FY 2012	FY 2013
Alabama	• Expanded level of care criteria for Technology Assisted waiver	• Expanding services for Money Follows the Person (MFP) target group (pending approval)
Connecticut	• Added personal care assistant as a covered service to the Elder waiver	• Plan to add adult family living as a covered service in the Elder waiver • Plan to add adult family living as a covered service in the Personal Care Assistant waiver
Delaware	• Moved 1915(c) Elderly and Physically Disabled waiver and Individuals with AIDS waiver to 1115 waiver and increased HCBS benefits	
District of Columbia	• With 1915(c) Elderly and Physically Disabled waiver renewal, reserved additional capacity for MFP and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program	• Will include participant-directed services in the Elderly and Physically Disabled waiver
Idaho		• Added dental service for all waiver participants aged 21 or older in the Aged and Disabled waiver
Indiana		• Will add assisted living services to the TBI waiver
Iowa		• Increased the monthly cap for the Elderly, Physical Disability, and Ill and Handicapped waivers to reduce waiting lists
Kansas	• Added telehealth services to the Frail Elderly waiver	
Louisiana	• Added services to the Community Choices waiver including: nursing, skilled maintenance therapies, respite, home delivered meals, and in-home sensor monitoring systems	• Will add additional waiver slots and services to the Community Choices waiver
Massachusetts		• Adding a new 1915(c) Money Follows the Person Residential Supports waiver for eligible people in need of residential support • Adding a new 1915(c) Money Follows the Person Community Living waiver for eligible people who do not need 24/7 supports

Figure 36 (continued)

State	FY 2012	FY 2013
Michigan		• Will add nursing and supports coordination as services, and consolidate some personal care services in the MI Choice waiver • Also will add reserved capacity and medication management.
Mississippi	• Removed the limit (of 50) to the number of caseloads for case managers, which allows for serving more individuals (average caseloads are 60–64)	• Adding personal care services and deleting homemaker services in the Elderly and Disabled waiver to expand the types of services that can be offered • Adding fiscal management services to the Independent Living waiver
Missouri		▪ Adding a new Adult Day Care waiver
North Dakota		▪ Adding personal care with supervision to the HCBS waiver
South Carolina		▪ Adding assisted living services to the Community Choices waiver
South Dakota	• Added adult companion and environmental adaptation services to the HCBS waiver for South Dakotans	
Utah	• Lowered the eligibility age for the New Choices waiver from 21 to 18, and increased the number of clients served	
Vermont		• Adding adult family care to the Choices of Care waiver
Virginia		• HIV/AIDs recipients will be transitioned to the Elderly or Disabled with Consumer Direction (EDCD) waiver with no loss of services. Approximately 30% will be served in the Duals Financial Integration Demonstration
Washington	• Expanded the service area for WA.0443	

Figure 37
Home and Community-Based Service Waivers: Benefit Restrictions

State	FY 2012	FY 2013
Kansas	• Initiated utilization management in the Physical Disability and Frail Elderly waivers	
Oregon*	• Reduced in-home service maximum monthly hours for instrumental activities of daily living by 10%	
Tennessee		• Will place a cap of $15,000 on the cost of services for individuals that do not meet the new nursing facility level of care criteria in the CHOICES waiver. The cap does not apply to those that meet nursing facility level of care.
Texas	• Implemented service limits for certain services within the Community Based Alternatives waiver • Terminated the Consolidated Waiver Program	

* See http://www.dhs.state.or.us/policy/spd/rules/notice/411_030_notice.pdf.

Figure 38
Home and Community-Based Service Waivers: Actions with Neutral Impact

State	FY 2012	FY 2013
California		• The Multipurpose Senior Services Program will integrate services for duals through a managed care delivery system in eight counties
Colorado		• The benefit package will change for the Community Mental Health Supports waiver to offer services that better support community living and complement the state plan mental health services. • Add consumer directed services to the Supported Living waiver
Connecticut		• Will require individuals in the Personal Care Assistant waiver to transition to the Elder waiver upon attaining age 65
Idaho		• Eliminated psychiatric consultation and behavior consultation in the Aged and Disabled waiver. Services were not used, and waiver participants can access these mental health services offered in Idaho's Enhanced Plan.
Kansas		• Move the Frail Elderly and the Physically Disabled waivers into managed care
Kentucky		• Unbundling consumer directed services. The change affects processes and not benefits.
Maine		• The Elders and Adults with Disabilities waiver and the Adults with Physical Disabilities waiver will be consolidated into a single waiver
Maryland	• Transitioned case management from administrative service to waiver service in the Older Adults waiver	
Mississippi		• Removing assisted transportation as a service in the Elderly and Disabled waiver. The state plan provides nonemergency transportation services, so removing the duplicate service from the waiver frees up waiver funds by shifting cost to state plan services.
Missouri		• Transitioning Adult Day Care from a state plan service to a covered benefit in the Elders and Adults with Physical Disabilities waiver • Creating a new Adult Day Care waiver

Figure 38 (continued)

State	FY 2012	FY 2013
New Jersey		• Global options for Long-Term Care waiver will transition to a Section 1115 waiver
New Hampshire	• Adopted program rule changes for the Elderly and Chronically Ill (ECI) waiver	
Nevada	• The Elderly in Adult Residential Care waiver was allowed to expire in order to merge it with the Frail Elderly waiver	
Oklahoma		• Add self-direction to the Medically Fragile waiver • Create a new ADvantage waiver to provide assisted living services. Individuals currently receiving these services will transition to the new waiver.
Oregon		• Unspecified 1915(c) services moved to 1915(k) state plan option
Rhode Island		• Initiate administrative review of utilization and authorization of HCBS for the Section 1115 Global waiver
Tennessee		• Homemaker services will be blended with personal care visits and attendant care (rather than offered as a stand-alone service) consistent with current practice of providing the services.
Utah		• Lowered the length of stay requirement for deinstitutionalization of ABI waiver participants. This is a technical change to eligibility requirements so they align with actual practice, and has no effect on eligibility.
Virginia	• Did not renew HIV AIDS 1915(c) waiver	
Washington	• Combined WA.0390 and WA.0419 waivers into WA.0049	

Figure 39
LTSS Provider Rate Changes in FY 2012 and FY 2013

State	Home Health		Personal Care Services		HCBS Waiver Services		Other Services		Name of Service
	2012	2013	2012	2013	2012	2013	2012	2013	
Total	40	40	37	37	43	41	8	7	
Increase (+)	4	9	6	11	7	12	2	2	
Decrease (-)	9	4	5	3	10	7	2	0	
No Change (0)	27	27	26	23	26	22	4	5	
Alabama	0	0			0	0			
Alaska	0	0	↑	↑	↑	↑			
Arizona									
Arkansas	0	0	0	0	0	0	0	0	Targeted Case Management for Adults
California	0	0	0	0	0	0	0	0	Community-Based Adult Services
Colorado	0	0	0	0	0	0			
Connecticut									
Delaware	0	↓	0	↓	0	↓			
District of Columbia	0	0	0	0	0	0	0	0	Hospice Care
Florida	0	0	0	0	0	↓			
Georgia	0	0	0	0	0	0			
Hawaii	↓	↑	↓	↑	↓	↑			
Idaho	↑	↑	0	0	0	0			
Illinois									
Indiana	↓	↓	0	0	0	0			
Iowa	0	0	0	0	0	↑	0	0	1915(i)
Kansas	0	0	0	0	0	0			
Kentucky	0	0			0	0			
Louisiana	0	↓	0	↓	0	↓			
Maine	0	0	0	0	0	0			
Maryland	↓	↑	0	↑	↓	↓			
Massachusetts	0	0	↑	↑	0	0			
Michigan	0	0	0	0	↑	↑			
Minnesota	↓	↓	↓	↓	↓	↓			
Mississippi									
Missouri			↑	0	↑	0	↑		Adult Day Health Care
Montana	0	0	0	0	0	0			
Nebraska	↓	↑	↓	↑	↓	↑	↓	↑	All LTSS providers including Hospice
Nevada	↑	0	0	0	0	0			

Figure 39 (continued)

State	Home Health		Personal Care Services		HCBS Waiver Services		Other Services		Name of Service
	2012	2013	2012	2013	2012	2013	2012	2013	
New Hampshire	0	0	0	0	0	0			
New Jersey	0	0	0	0	0	0			
New Mexico	0	0	0	0	0	0			
New York	0	0	0	0	↓	0			
North Carolina									
North Dakota	↑	↑	↑	↑	↑	↑			
Ohio	↓	0			↓	0			
Oklahoma	↑	↑	↑	↑	↑	↑			
Oregon			↑		↓				
Pennsylvania					↑				
Rhode Island	0	0	0	0	0	0			
South Carolina	↓	0			↓	↑	↑	0	Optional State Supplementation
South Dakota	↓	↑	↓	↑	↓	↑	↓	↑	Nutrition and Adult Day Health
Tennessee	↓	0		0	0	↓			
Texas									
Utah	0	↑	0	↑	↑	↑			
Vermont	0	↑	0	↑	0	↑			
Virginia	0	0	↓	↑	↓	↑			
Washington	0	0	0	0	0	↓			
West Virginia									
Wisconsin									
Wyoming	0	0	0	0	0	0			

↑ = increase ↓ = decrease 0 = no change