AARP Public Policy Institute

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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

In response to the current economic crisis, many state officials are grappling with difficult decisions on budget cuts and reductions in services. This "Great Recession" is the longest downturn in our nation's history since the Great Depression, and it has taken a deep toll on state and local programs aimed at providing home and community-based services (HCBS).

This report is the most comprehensive analysis to date on the budget cuts to both Medicaid and non-Medicaid–funded long-term services and supports (LTSS) in each state. It also illustrates state-by-state how LTSS are financed. In addition, this study provides a very early snapshot of the likelihood of states pursuing some of the LTSS provisions within the Affordable Care Act (ACA). An individual state profile summarizing additional information obtained from each state that participated in the survey is located at www.aarp.org/ppi, www.healthmanagement.com, and www.nasuad.org.

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. This study builds off of NASUAD's and HMA's experience in surveying states on public policy during the economic downturn.

Both the State Unit on Aging (SUA) and the Medicaid agency in each state completed an electronic survey in summer 2010. For the SUAs that administer the Medicaid waiver program within their SUA agency, there was one comprehensive survey. For the states that do not administer the waiver program in their agency, the SUA and Medicaid agencies completed two separate surveys. In addition to providing state data, state administrators were asked to answer open-ended questions to identify promising practices, state challenges, and priorities.

The project teams conducted telephone interviews with each state agency after they completed their survey; each interview was roughly an hour long. The team then conducted follow-up conversations with approximately one-third of states to clarify responses as necessary. The state officials were also sent their state profile to verify the state data in fall 2010.

This study focuses only on programs for older individuals and people with physical disabilities. The mental retardation/developmental disabilities population is not included because, in most states, that would have required an additional state agency to participate in the survey.

This survey focuses primarily on fiscal year (FY) 2010 budgets and the budget outlook for FY 2011, which for most states began on July 1, 2010.[1] This is a point-in-time study that does not reflect state budget cuts that were made in FY 2008 or FY 2009. Also, data reported in this study reflect state officials' perspectives prior to the November 2010 elections. Forty-nine states and the District of Columbia responded to this survey. [2]

Overall Findings

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

1. **Impact of the Great Recession on LTSS Lingers.** The recession remains a sustained and growing concern for the 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.

    - **Cuts in FY 2010 and FY 2011**. Many states cut non-Medicaid LTSS-funded services, which include primarily Older American Act and state-only funded programs. Thirty-one states cut aging and disability services programs (non-Medicaid) in FY 2010. Twenty-eight states were expecting to cut those programs in FY 2011. Fewer states made cuts to Medicaid programs, with most restrictions targeting provider rates. A handful of states, however, did impose cuts to services, most notably personal care services.

    - **Increased Demand**. Requests for services increase during a recession because people have less income and therefore qualify for government programs. More than half of the states reported increased demands for information and referrals, home-delivered meals, respite care, case management, personal care assistance, family caregiver support, transportation, and homemaker services in FY 2010. However, the need for LTSS is a result of declining ability to perform activities of daily living or cognitive decline. Increased Medicaid spending during a recession generally is driven by increased need among parents and children, not people with LTSS needs. Nevertheless, because Medicaid comprises such a significant share of state budgets (generally the second largest line item, after education spending), state policymakers turn to it in the hope of reducing expenditures when their budgets are under stress.

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

[2] States and territories that chose not to participate in the survey included South Dakota, Puerto Rico, and the Virgin Islands. Of the responding states, all state SUAs reported data. Nine state Medicaid agencies did not provide Medicaid data: Delaware, Maryland, North Carolina, North Dakota, Nebraska, Rhode Island, Virginia, Wisconsin, and Wyoming.

2. **Balancing Remains a Priority**. The good news is that many states are using the economic downturn as an opportunity to balance services between institutional and noninstitutional settings. States continued to serve a greater number of Medicaid recipients with LTSS needs in their homes or communities. Of the 41 states responding to Medicaid survey questions, 35 reported that HCBS census increased in 58 waivers from FY 2009 to FY 2010/2011. Concurrently, 22 states reported that they expect the number of Medicaid nursing facility residents to decline and 12 states expect the number to remain unchanged in FY 2011. Only four of the responding states expect the nursing facility census to increase.

3. **The American Recovery and Reinvestment Act (ARRA) Stimulus Funds Preserved Programs.** ARRA provided additional funding to state Medicaid programs by increasing their federal medical assistance percentages (FMAP). When states accepted these funds, they were prohibited from adopting more restrictive eligibility standards, methodologies, and processes, which could reduce the number of Medicaid beneficiaries. The increased funds helped states to temporarily maintain services. Few states reported Medicaid LTSS-related policy restrictions. However, many states expect they will need to make additional cuts in LTSS as the enhanced FMAP phases down and expires. Since many community-based services are optional Medicaid services, they are more susceptible to cost-cutting policy actions.

4. **The Affordable Care Act (ACA) Provides Opportunities and Challenges.** The new health care reform law provides states with new opportunities to expand HCBS, yet many states are reluctant to commit to these programs until further federal guidance is issued. In addition, changing state leadership due to recent elections, and tight state resources—financial and staffing—present challenges to state policymakers as they consider future initiatives.

Conclusion

While most states were "weathering the storm" in FY 2010, three distinct events will have a significant impact on LTSS in FY 2011 and FY 2012.

1. **The Great Recession**. The economy will continue to force many state officials to make difficult and sometimes untenable choices as service demands increase while state revenues continue a faltering recovery. Recent anecdotal evidence suggests that even in the states that had earlier reported little effect from the economic downturn, the tide is now turning, causing additional fiscal stress on systems. As federal ARRA assistance phases down, virtually all states will continue to face daunting budget issues in FY 2012 and beyond. The fiscal pressure on state Medicaid budgets could seriously threaten HCBS. This is because Medicaid nursing

home coverage is an entitlement, which states may not eliminate. Nearly all HCBS are offered at state discretion. Many states have moved toward balancing LTSS toward HCBS that generally are more cost-effective and that consumers prefer. However, budgetary pressures may cause some policymakers to cut these services in order to achieve immediate savings.

2. **The Historic Election of November 2010**. The election of 37 governors is likely to shift state aging and disability policymakers in a record number of states. Of the 37 gubernatorial elections, 26 resulted in a new governor taking leadership. Fourteen state offices changed parties: The shift from a Democratic to Republican governor is taking place in ten states: Iowa, Kansas, Michigan, New Mexico, Ohio, Oklahoma, Pennsylvania, Tennessee, Wisconsin, and Wyoming. Democrats gained in four states: California, Hawaii, Minnesota, and Vermont. Republicans achieved a net gain of six. Republican governors now hold office in 29 states, while Democrats hold 19 state offices, and an independent picked up Rhode Island. The new leadership at the state level will extend to the appointment of key personnel in state Health and Human Service agencies, Medicaid agencies, and other departments. This turnover will likely slow efforts to achieve HCBS goals as the new leadership grapples with budget issues and gets up to speed on policy priorities. Compounding the leadership crisis is the state workforce shortage, with early retirements occurring at record pace in most states, causing serious voids in institutional knowledge.

3. **The Affordable Care Act.** State policymakers will need to devote time and attention to determine ways to leverage the opportunities and tackle the challenges in implementing the ACA. States await federal guidance for many ACA provisions.

As states confront these and many other challenges to advance policy goals around services for seniors and individuals with disabilities, the future will undoubtedly call for creativity and renewed commitment from state policymakers to maintain the critical safety net for their more vulnerable citizens.

Weathering the Storm

Introduction

In response to the current economic crisis, many state officials are grappling with difficult decisions on budget cuts and service reductions. In general, Medicaid comprises the second largest line item in state budgets (after education spending), and thus, is the place to which policymakers often look to reduce spending when their budgets are in crisis. Despite the fact that Medicaid spending for long-term services and supports (LTSS) is not the primary driver of increased Medicaid spending during a recession, it can be a tempting target for spending reductions. In this recession, large Medicaid cuts were temporarily avoided as a result of maintenance-of-effort provisions that were enacted as part of the American Recovery and Reinvestment Act (ARRA) stimulus package. However, this "Great Recession" is the longest downturn in our nation's history since the Great Depression, and it has taken a deep toll on other state and local programs aimed at providing home and community-based services (HCBS).

One of the great challenges facing state policymakers is maintaining a high-quality, cost-effective system of LTSS that will meet the needs of the growing numbers of older adults and adults with disabilities who prefer to live in their own homes and communities. Given the high costs associated with institutional care such as nursing homes, as well as consumer preferences, states have been shifting more resources over the past three decades into generally less-costly HCBS. Because of the high costs of care, often the only places seniors and adults with disabilities can turn for help are publicly funded programs that provide assistance with personal care, home health, adult day care, assisted living, care management, meals, transportation, and other types of services. Yet, because these programs do not have mandatory funding attached to them, state policymakers may reluctantly turn to them when searching for budget areas to cut. It is important to note, however, that it is not increased demand for LTSS that puts pressure on Medicaid budgets during a recession. Increased Medicaid spending during a recession generally is driven by increased need among parents and children, not people with LTSS needs.

This report is the most comprehensive analysis to date on the budget cuts to both Medicaid and non-Medicaid–funded LTSS in each state. It also illustrates state-by-state how LTSS are financed. In addition, this study provides a very early snapshot of the likelihood of states pursuing some of the LTSS provisions within 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. This study builds off NASUAD's and HMA's experience in surveying states on public policy during the economic downturn. The members of NASUAD represent the nation's 56 officially designated state and territorial agencies on aging, often referred to as State Units on

Aging (SUAs). This is NASUAD's fifth survey of its membership on the economy. HMA has a long history of conducting studies on general Medicaid policy, enrollment, and financing.

Through this three-way collaboration among the AARP Public Policy Institute, NASUAD, and HMA, both the SUA and the Medicaid agency in each state completed an electronic survey. For the SUAs that administer their state's Medicaid waiver program, there was one comprehensive survey. For the states whose SUAs do not administer the waiver program, the SUA and Medicaid agencies completed two separate surveys. In addition to providing state data, state administrators were asked to answer open-ended questions to identify promising practices, state challenges, and priorities.

The project teams conducted telephone interviews with each state agency after they completed their survey; each interview was roughly an hour long. Follow-up conversations were conducted with approximately one-third of states to clarify responses as necessary. State officials were also sent their state profile to verify the data.

This study focuses only on programs for older individuals and people with physical disabilities. The mental retardation/developmental disabilities population is not included because, in most states, that would have required an additional state agency to participate in the survey.

This survey focuses primarily on state fiscal year (SFY) 2010 budgets and the outlook for budgets in SFY 2011, which for most states began on July 1, 2010.[3] This is a point-in-time study that does not reflect state budget cuts that were made in FY 2008 or FY 2009. Also, data for this study reflect state officials' perspectives prior to the November 2010 elections. Forty-nine states and the District of Columbia responded to this survey.[4]

This 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. A supplement to this report located at www.aarp.org/ppi, www.healthmanagement.com, and www.nasuad.org provides additional information in individual state profiles. Altogether, the survey response provides a comprehensive snapshot of the status of LTSS for older Americans and adults with physical disabilities.

[3] States that do not have fiscal years beginning on July 1 are Alabama, Michigan, New York, Texas, and the District of Columbia.

[4] States and territories that chose not to participate in the survey are South Dakota, Puerto Rico, and the Virgin Islands. Of the responding states, all state SUAs reported data. Nine state Medicaid agencies did not provide any data: Delaware, Maryland, North Carolina, North Dakota, Nebraska, Rhode Island, Virginia, Wisconsin, and Wyoming.

Overall Findings

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

1. **Impact of the Great Recession on LTSS Lingers.** The recession remains a sustained and growing concern for the 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.

    - **Cuts in FY 2010 and FY 2011**. Many states cut non-Medicaid LTSS-funded services, which include primarily Older American Act and state-only funded programs. Thirty-one states cut aging and disability services programs (non-Medicaid) in FY 2010. Twenty-eight states were expecting to cut such programs in FY 2011. Fewer states made cuts to Medicaid programs, with most restrictions targeting provider rates. A handful of states, however, did impose cuts to services, most notably personal care services.

    - **Increased Demand**. Requests for services usually increase during an economic downturn, and that trend has certainly continued. More than half of the states reported increased demands for information and referrals, home-delivered meals, respite, case management, personal care assistance, family caregiver support, transportation, and homemaker services in FY 2010. However, the need for LTSS is a result of declining ability to perform activities of daily living or cognitive decline. Increased Medicaid spending during a recession generally is driven by increased need among parents and children, not people with LTSS needs. Nevertheless, because Medicaid comprises such a significant share of state budgets (generally the second largest line item, after education spending), state policymakers turn to it in the hope of reducing expenditures when their budgets are under stress.

2. **Balancing Remains a Priority**. The good news is that many states are using the economic downturn as an opportunity to balance services between institutional and noninstitutional settings. States continued to serve a greater number of Medicaid recipients with LTSS needs in their homes or communities. Of 41 states reporting Medicaid data, 35 reported that HCBS census increased in 58 waivers from FY 2009 to FY 2010/2011. Concurrently, 22 states reported that they expect the number of Medicaid nursing facility residents to decline and 12 states expect the number to remain unchanged in FY 2011. Only four of the responding states expect the nursing facility census to increase.

3. **The ARRA Stimulus Funds Preserved Programs.** ARRA provided additional funding to state Medicaid programs by increasing their federal medical assistance

percentages (FMAP). When states accepted these funds, they were prohibited from adopting more restrictive eligibility standards, methodologies, and processes, which could reduce the number of Medicaid beneficiaries. Thus, no states restricted LTSS eligibility criteria. The increased funds helped states to temporarily maintain services. Few states reported Medicaid LTSS-related policy restrictions. However, many states expect they will need to make additional cuts in LTSS as the enhanced FMAP phases down and terminates. Since many community-based services are optional Medicaid services, they are more susceptible to cost-cutting policy actions.

4. **The Affordable Care Act (ACA) Provides Opportunities and Challenges.** The new health care reform law provides states with new opportunities to expand HCBS, yet many states are reluctant to commit to these programs until further federal guidance is issued. In addition, changing state leadership due to recent elections, and tight state resources—financial and staffing—present challenges to state policymakers as they consider future initiatives.

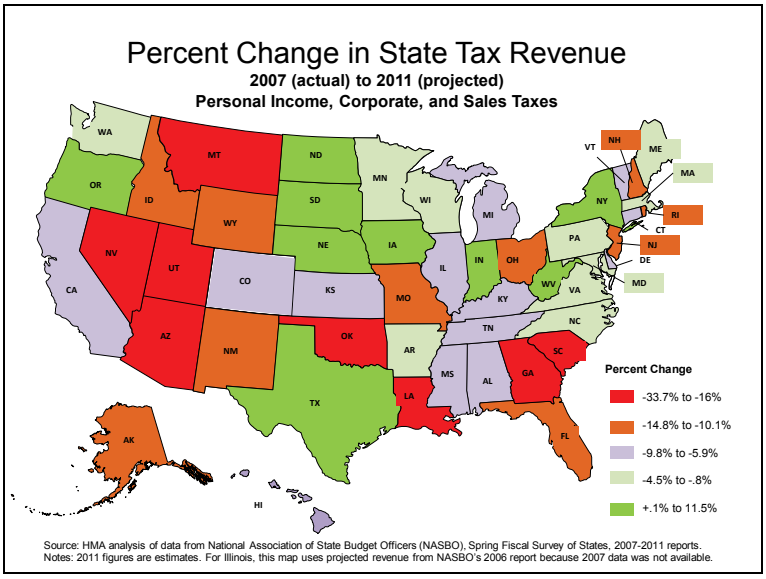
State Budgets and ARRA Stimulus Funds

To understand current state LTSS budgets, it is important to consider the larger state budget and economic context, including the impact of ARRA stimulus funds. The recession, which began December 2007, officially ended in June 2009, lasting 18 months. Unemployment, which is seen as a lagging indicator of economic decline and recovery, was at its highest rate in October 2009, at 10.1 percent. One year later in October 2010, the unemployment rate was still at 9.6 percent. 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.[5]

According to the June 2010 National Governors Association and the National Association of State Budget Officers Fiscal Survey of the States, most states projected 2011 tax revenues from major sources (personal income, corporate, and sales taxes) below prerecession levels. Only nine states and the District of Columbia project revenues above 2007 levels in 2011, and about half of these states project less than a 5 percent increase over prerecession levels. Some states expect to remain significantly below 2007 levels—as much as 30 percent or more (figure 1). These gaps between revenues and expenditures are difficult to close. And, while state tax revenues are down substantially, states must still contend with increasing service demands due to the economic decline.

[5] "Medicaid and State Budgets: From Crunch to Cliff," Kaiser Commission on Medicaid and the Uninsured, October 2009.

Figure 1. Change in State Tax Revenue Levels in 2011 Compared with 2007



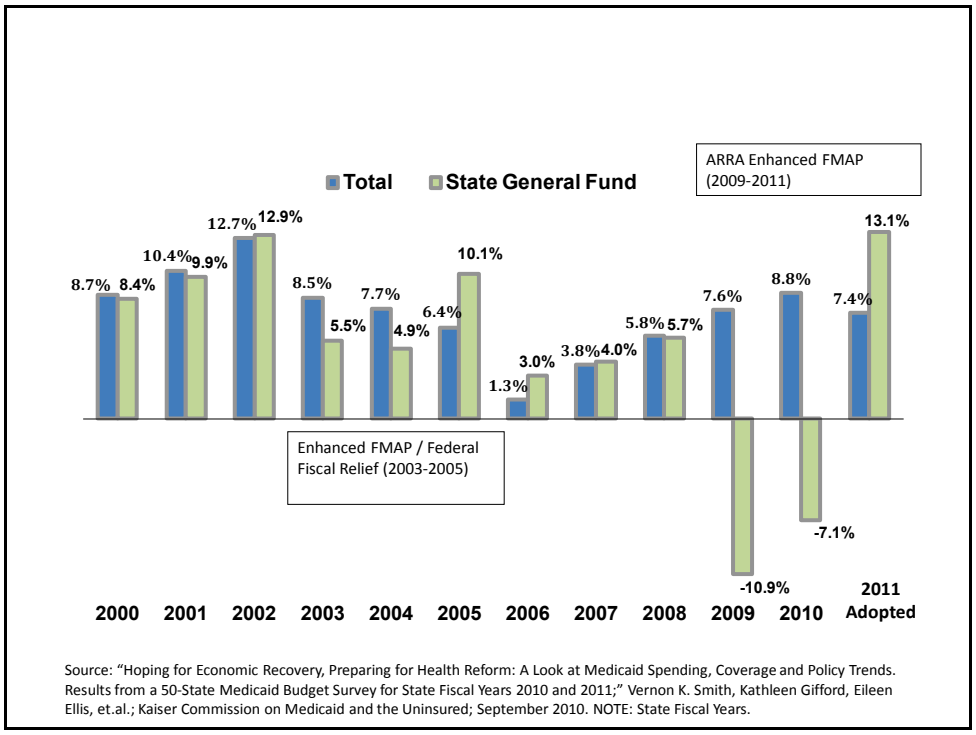
While the impact of the recession is uneven across states, it is widespread. The states with significant revenue gaps seem to be clustered in the West and South. Texas and the Northwest Coast states are the exception to this cluster. In addition, five states—Arizona, Louisiana, Nevada, Oklahoma, and South Carolina—project revenues 25 percent or more below 2007 collections.

The Plains states and the upper Midwest appear to be faring better than most other regions. Nine states project 2011 collections that will exceed 2007 levels. However, in three of the states (Indiana, Nebraska, and West Virginia), the projected increases are less than 1 percent. Only three states—North Dakota, South Dakota, and Texas—project 2011 revenues to exceed 2007 by more than 10 percent. The lower Midwest states and the New England region are mixed but still project lower revenues in 2011 than in 2007.

In response to the economic crisis, the United States Congress enacted ARRA to spur job and economic growth; funding went toward a wide variety of investments, including education, environment, construction, transportation, and health care. The ARRA stimulus funds and their extension of enhanced ARRA FMAP provided a much-needed lifeline to states' Medicaid and non-Medicaid programs. Starting in October 2008, ARRA provided roughly $87 billion to states through an enhanced FMAP to state Medicaid programs, which significantly reduced state Medicaid general fund obligations and allowed states to maintain services or bolster other areas of their budgets (figure 2). This funding was originally slated to expire at the end of December 2010, but Congress extended the ARRA provisions and provided additional funds through June 2011. During these last six months of ARRA funding, however, the enhanced federal Medicaid funds will be phased down (figure 3).

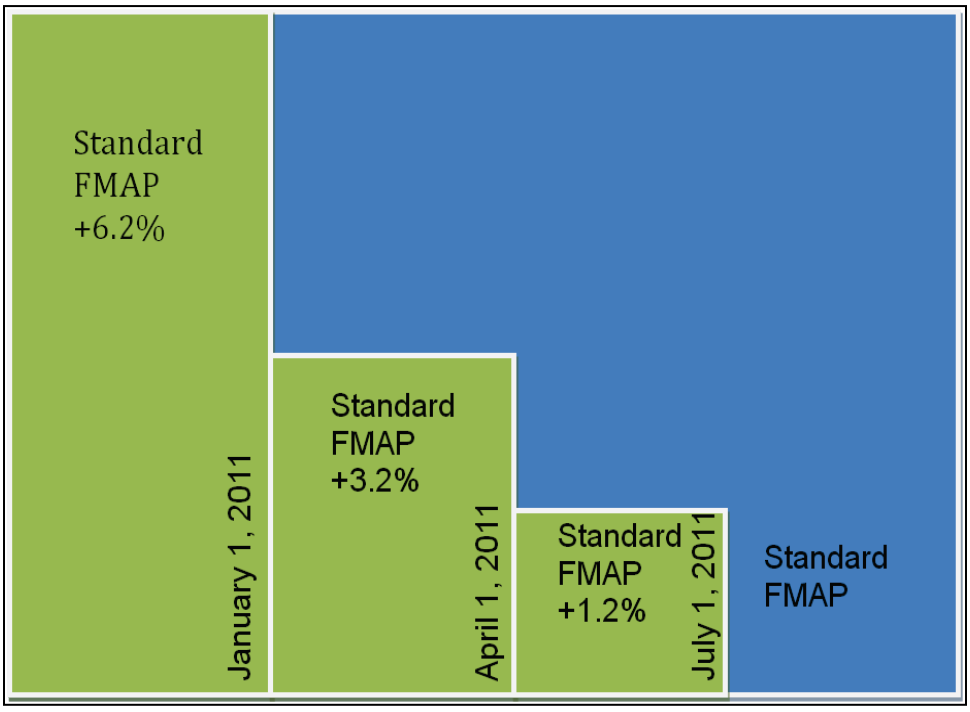
The future remains uncertain for states, given the expiration of ARRA funds. The FMAP enhancement phases down from 6.2 percent through December 2010 to 3.2 percent through

Figure 2. Annual Growth in Total and State Medicaid Spending, 2000–2011



Source: "Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends. Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011;" Vernon K. Smith, Kathleen Gifford, Eileen Ellis, et.al.; Kaiser Commission on Medicaid and the Uninsured; September 2010. NOTE: State Fiscal Years.

Figure 3. Extended ARRA Enhanced FMAP Phase-Down



March 2011, then to 1.2 percent through June 2011. In July 2011 the enhancement expires. Unfortunately, many states actually budgeted for the entire 6.2 percent enhancement through June 30, 2011, and must now go back to address projected budget shortfalls.

State Units on Aging and Disabilities Budgets

States rely on a number of financing strategies to deliver LTSS. In addition to Medicaid (the largest source of funding for LTSS), states fund aging and disability service programs from a combination of resources, including the Older Americans Act (OAA), the Social Services Block Grant (SSBG), the Low-Income Home Energy Assistance Program (LIHEAP), the Community Services Block Grant (CSBG), and other federal sources. The SSBG has become an important source of funding for nearly half of the SUAs. States are using SSBG funding to provide home-delivered meals, transportation, adult protective services, adult day care, housing, and foster care services, among many others. Further, the majority of states provide some funding for programming that is solely financed by the state. In addition to state appropriations for home and community-based programming, other sources of funds for LTSS include targeted taxes, state lotteries, and private grants.[6]

These aging and disability services allow people to stay in their own homes. More than 85 percent of those receiving OAA-funded homemaker services, case management, transportation, and home-delivered meals services said that this assistance helped them remain at home.[7] In addition, people receiving OAA services are at higher risk of nursing home placement than others in their age group nationally.[8]

At the time this survey was fielded in summer 2010, most states had adopted their FY 2011 budgets. Thirty states adopted their budgets with the assumption that the ARRA enhanced FMAP of 6.2 percent would be extended.[9] Because Medicaid is one of the largest expenditures in state budgets, Medicaid funding shortfalls often necessitate decreases in non-Medicaid programs to help cover budget gaps unrelated to LTSS. State agencies have varying degrees of flexibility to transfer LTSS funds appropriated for one purpose or program to offset the cost or increased demand in another LTSS program or other state budget need (see Appendix Table I). By July through September 2010, when project teams were conducting the telephone interviews, many state officials were already saying they would have to

[6] Ten states have a targeted tax, such as tobacco tax, income tax check-offs, or other tax assessments specifically designated for services administered by the SUA. New Jersey, Pennsylvania, and West Virginia receive set-aside funding from the state lottery. Twenty-three states also rely on private grants and foundations for support of their LTSS. All information was gathered from *State of Aging: 2009 State Perspectives on State Units on Aging Policy and Practices*, National Association of States United for Aging and Disabilities, October 2009.

[7] "Aging in Place: Do Older Americans Act Title III Services Reach Those Most Likely to Enter Nursing Homes?" Mathematica Policy Research, Inc., July 2010.

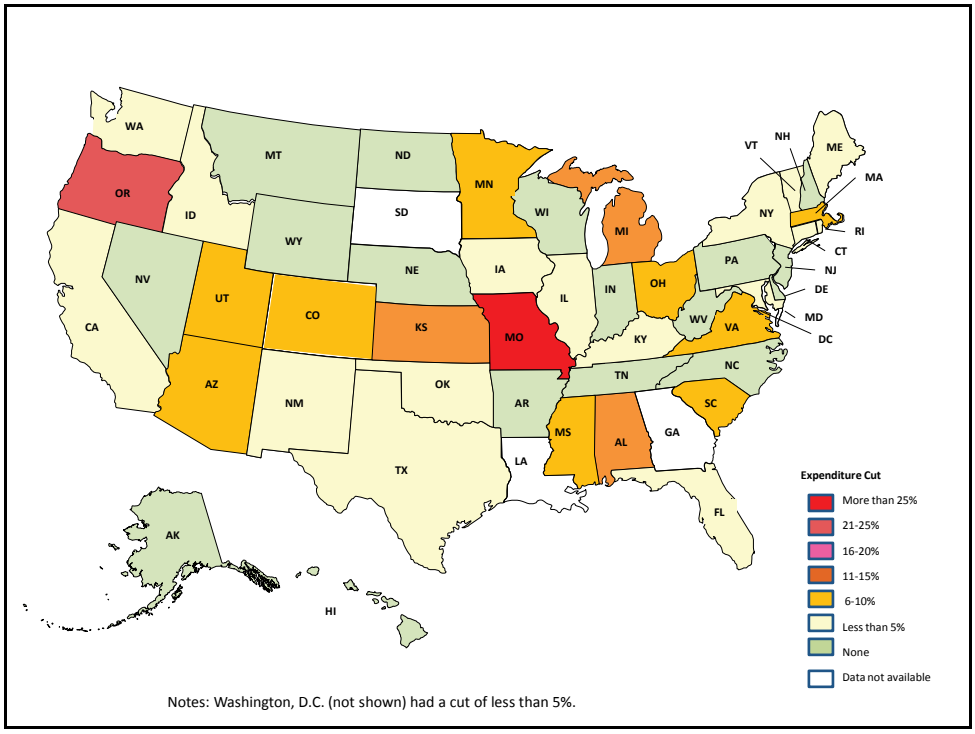
[8] Ibid.

[9] "FMAP Extension and the Impact on States," National Conference of State Legislatures, April 29, 2010.

make adjustments to their FY 2011 budgets based on worsening economic conditions. Therefore, the figures below may actually reflect a much rosier picture than the current reality.

Thirty-one states reported that they would reduce funding for aging and disability services (non-Medicaid) and state-only funded services in FY 2010 (figure 4). No obvious regional patterns emerge in the reductions states reported. The most significant reductions were in Missouri and Oregon, with reductions of more than 25 percent. Alabama, Michigan, and Kansas reported reductions between 11 and 15 percent for FY 2010. Surprisingly, there is limited correlation between states that had significant percent declines in state tax revenue and the size of non-Medicaid expenditure reductions.

Figure 4. Aging and Disability Service Programs (non-Medicaid) Expenditure Cuts, FY 2010



Notes: Washington, D.C. (not shown) had a cut of less than 5%.

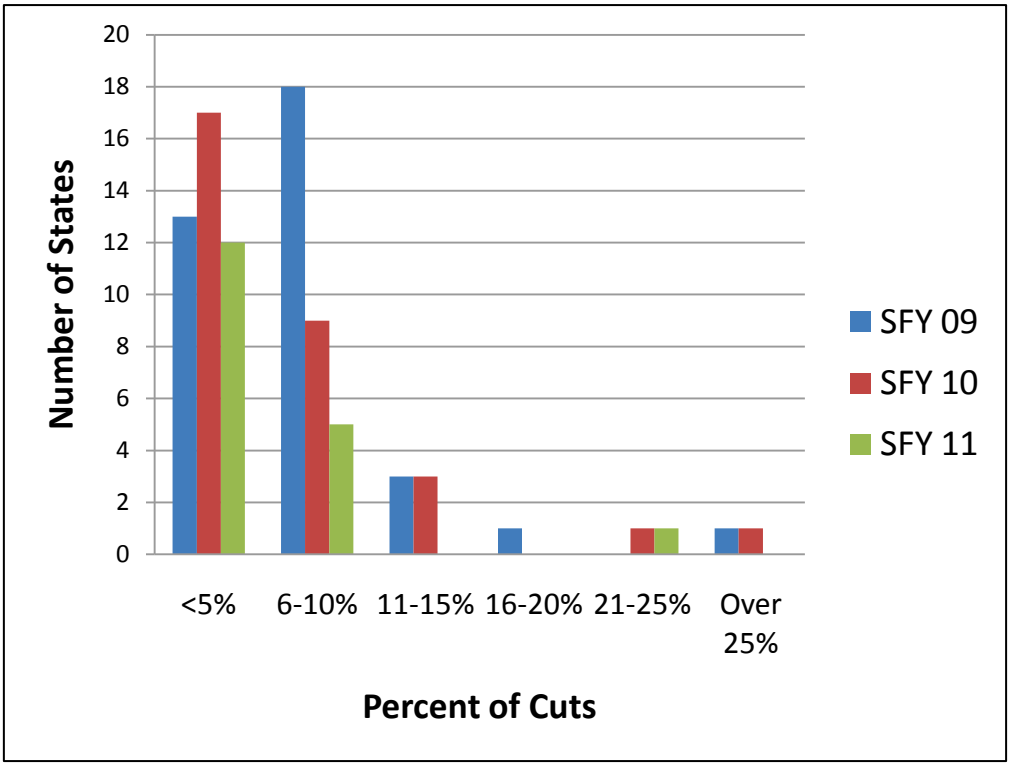
Seven states indicated that they exempted specific populations from the budget reductions when making the decisions on programming. Exempt populations included children in a few states, as well as individuals of any age needing protective services. For example, in Washington, the state exempted reductions in services for children under age 21, and in Missouri, the state exempted emergency, short-term services for protective service clients that serve adults with disabilities age 18 to 59 and seniors over age 60 who are victims of abuse or neglect.

"I feel like I've been 2 to 3 'percented' to death. I just don't have anywhere else to cut," said one state director, expressing his frustration.

Even more important is the fact that the cuts are cumulative. States, for example, are adding a 5 percent cut on top of a 5 percent cut the year prior. In fact, in the

2009 NASUAD Economic Survey, 70 percent of the states had to cut funding in both FY 2009 and FY 2010. And while some of the cuts may appear to be smaller in scope than others, they still can have a real impact on service delivery when they continue to occur year after year (figure 5).

Figure 5. Reductions in Non-Medicaid Expenditures, FY 2009–FY 2011



When calculating ways to make the reductions, states traditionally turned first to administrative cuts such as eliminating out-of-state travel, establishing hiring freezes, and instituting furlough days for state employees. This was proven true in the 2009 NASUAD Economic Survey. However, states indicated during the telephone surveys that they have "run out of administrative cuts to take," forcing them to look to the less desirable areas of reductions to actual programs and services. By FY 2010, states were beginning to show cuts in programs and services. In FY 2011, states indicated a continued trend of cutting programs and services.

This survey identified the following top strategies that states used to reduce their budgets:

- Limiting or eliminating services
- Eliminating programs
- Limiting enrollment
- Freezing provider rates
- Increasing cost sharing
- Delaying implementation of programs
- Cutting state funds to local agencies

To receive federal Older Americans Act funds, states must provide, depending on the program, a nonfederal match ranging from 10 to 25 percent. The ability of states to meet OAA match requirement does not seem to be affected by the economic downturn. Thirty-six states in both FY 2010 and FY 2011 reported that they had no difficulty meeting the match requirement. These states, however, did report that they were using cuts in other state-only funded programs to fund the match in the OAA programs. Five states—Georgia, Hawaii, Iowa, Kentucky, and Rhode Island—reported difficulty meeting the match. Appendix Table II illustrates state-by-state funding trends for non-Medicaid (state only) HCBS expenditures.

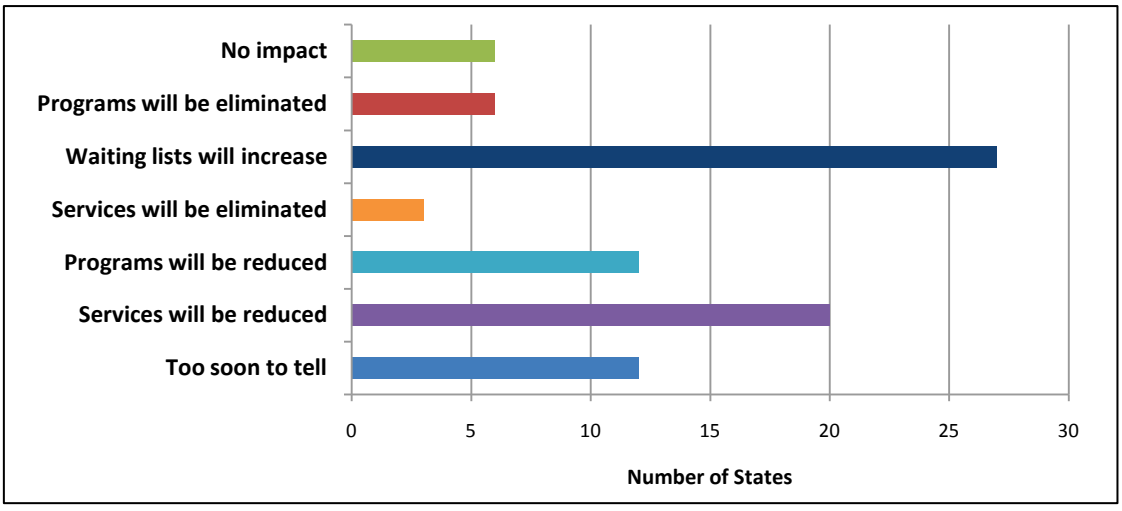
Exhausted ARRA Nutrition Funding

The ARRA stimulus package to states included $100 million in supplemental funds to support congregate and home-delivered meals of the OAA program. The purpose of this funding was to prevent hunger and food insecurity among America's seniors during the economic downturn. That funding has now been exhausted, and was not granted an extension similar to the enhanced Medicaid funding.

While the ARRA stimulus funding for nutrition has ended, the importance of the program for the nation's seniors has not. Even when the supplemental funds were available, 32 states reported increased requests for home-delivered meals, and 20 states reported increased requests for congregate meals.

States indicated that the end of this funding would have a significant impact on their OAA nutritional programs. Twenty-seven states reported that nutritional services' waiting list will increase, and 20 states said that services will be reduced as a result of the cuts in funding. An additional 12 states indicated that programs will be reduced, while 6 states indicated that programs will be eliminated (figure 6; also see Appendix Table III for state-by-state impact).

Figure 6. Impact of the Ending of ARRA Nutritional Funds

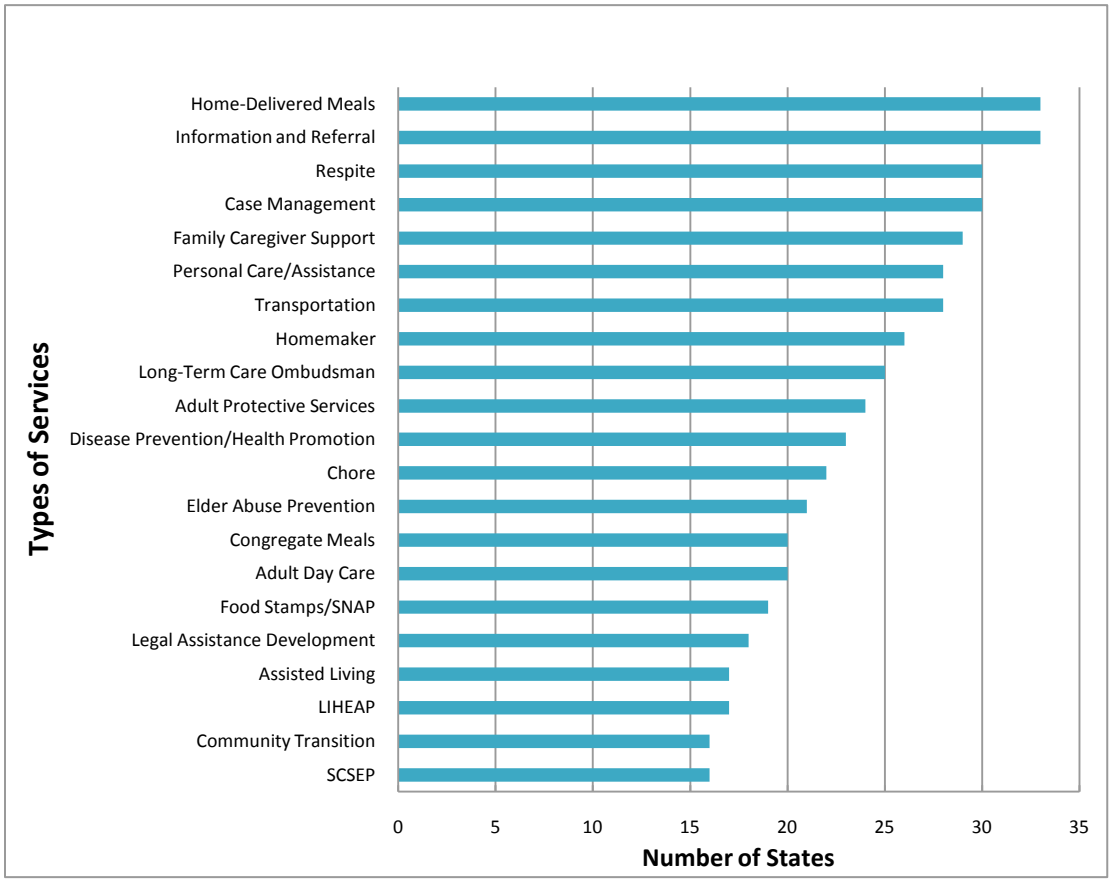


States reported the following strategies to reduce nutrition program costs: adopt regional delivery systems, eliminate meal sites, and eliminate the number of days that congregate or home-delivered meals are offered.

Increased Service Demands

Requests for services usually increase during an economic decline because people have less income, and that trend is clearly documented in this survey. More than half of the states reported increased demands for information and referrals, home-delivered meals, respite care, case management, personal care, family caregiver support, and transportation and homemaker services in FY 2010. In addition to programs listed in figure 7, ten or more states had increased demand for environmental modifications (14), equipment and supplies (13), housing assistance (13), state adult guardianship program (12), state pharmaceutical assistance (10), and supported living (10).[10] Although this survey did not seek information as to the causes of increased service

Figure 7. Programs with Increased Service Demands, FY 2010



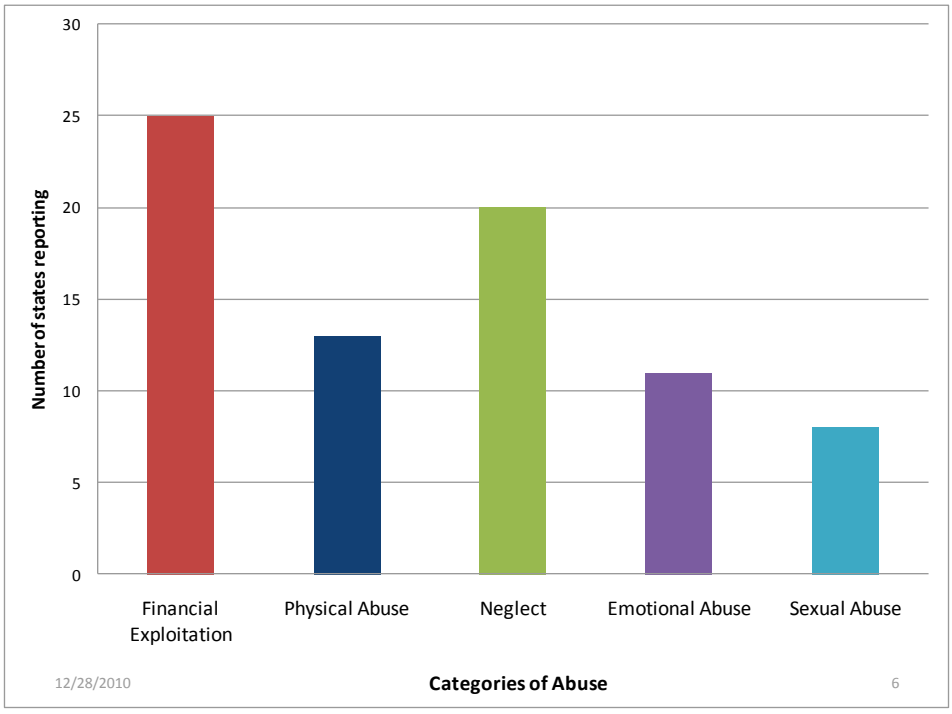
[10] Every state offers a different array of LTSS. For a complete list of programs offered by each State Unit on Aging, see *State of Aging*, Table 12, p. 54.

demands, it is possible that there is a pent-up demand for services resulting from consecutive years of budget reductions.

Adult Protective Service Demands

This survey found a significant and disturbing trend since the beginning of the economic downturn: the number of states that report increased calls for Adult Protective Services (APS).[11] Twenty-five states reported that financial exploitation was the number one cause of such calls. An additional 20 states reported that neglect was a factor in the calls. Even though it was not a survey question, many state officials indicated that the "neglect" calls were most commonly "self-neglect" in which older people, in the judgment of others, are thought to be neglecting their own needs and putting themselves at high risk of harm and serious deterioration. One additional write-in consideration over which state officials voiced concern was the number of adult children with disabilities, primarily with developmental disabilities, who were being abandoned at emergency shelters and emergency rooms since the recession started (see state detail in Appendix Table IV).

Figure 8. Types of Increased Adult Protective Services' Calls

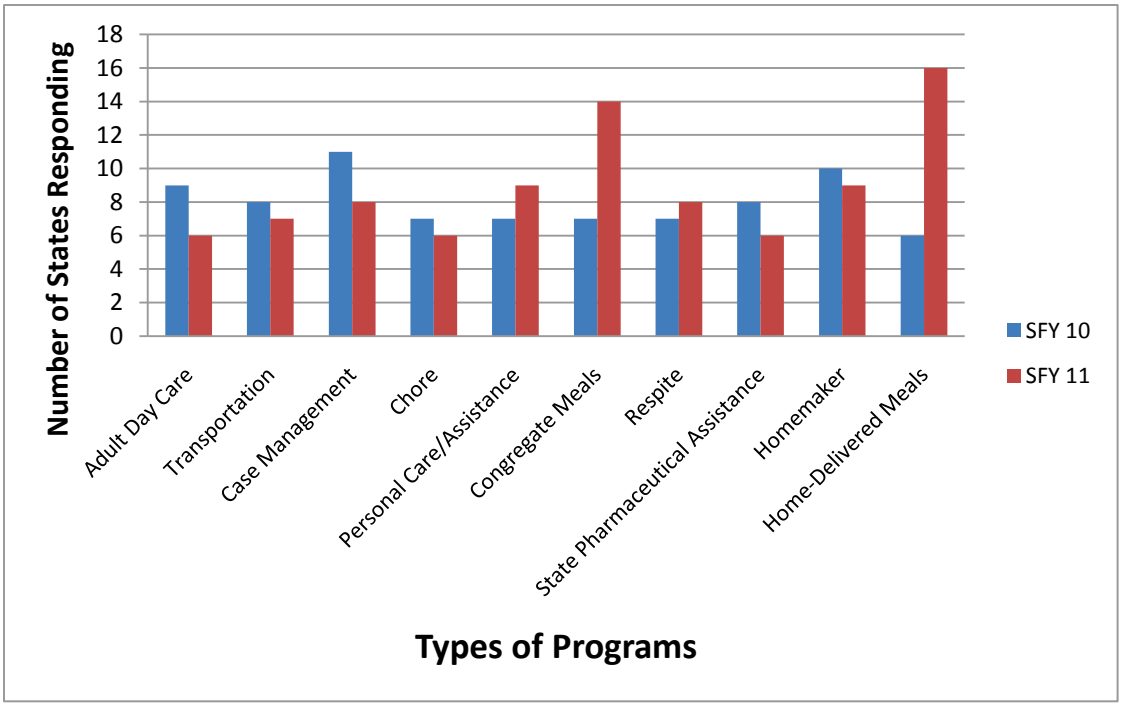


[11] Not every survey respondent administers the state's APS program. For a complete list of the states that do administer the APS program, see *State of Aging*.

Decreased Service Expenditure for Non-Medicaid Programs

Although demand for non-Medicaid LTSS has increased substantially since the beginning of the Great Recession, state funding for these programs has not kept pace and in several areas has decreased (figure 9). States anticipated reductions in expenditures for congregate and home-delivered meals between FY 2010 and FY 2011 even though service demands have increased in more than half of the states during the recession. The reduction in expenditures for home-delivered and congregate meals is largely related to the loss of $100 million in ARRA stimulus funding that had been available to states to help cushion the impact of more seniors needing nutritional support. Other areas where states reported decreases in expenditures are adult day care, transportation, case management, chore services, personal care, respite care, state pharmaceutical assistance, and homemaker services. Each of these service areas is expected to see reductions in expenditures for both FY 2010 and FY 2011. As State Units on Aging grapple with increased demand and decreased expenditures, they were asked how their priorities have changed during the recession. Appendix Table V summarizes priorities in FY 2010 and 2011.

Figure 9. Decreased Service Expenditures for Non-Medicaid Programs

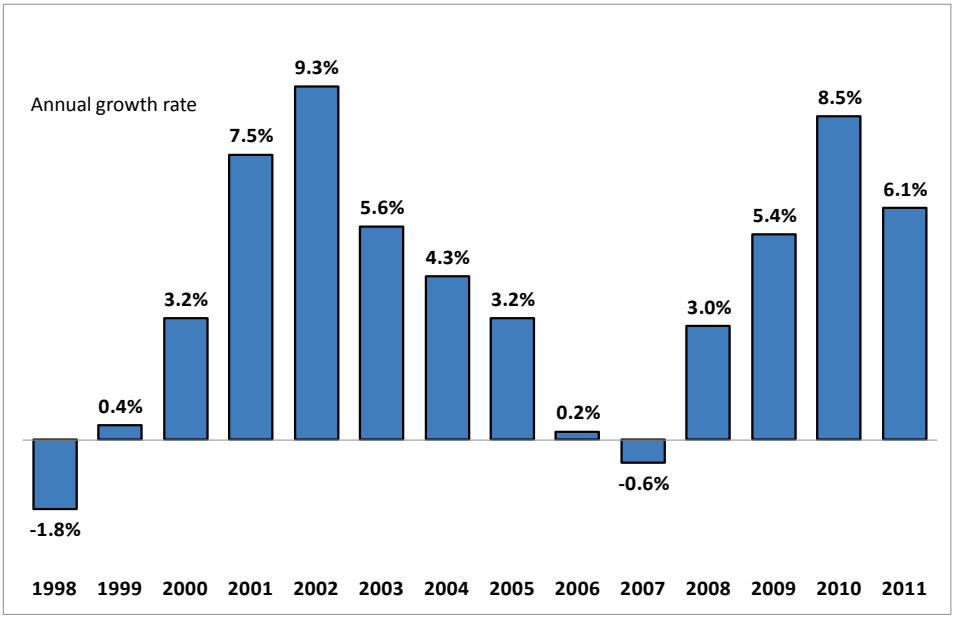


Medicaid

Medicaid, the largest source of funding for LTSS, paid for 43 percent of all nursing facility care[12] in 2007 and more than 40 percent of total LTSS spending in 2006.[13] While comprising about a quarter of total Medicaid enrollees, older Americans and adults with disabilities account for nearly 70 percent of Medicaid expenditures. In addition, states provide many of the services to these vulnerable populations at the state's option. Most HCBS are optional, while institutional care, such as nursing facility services, is mandatory under Medicaid. All state Medicaid programs cover optional HCBS, but when ARRA enhanced FMAP expires, state policymakers could target HCBS for cuts because of their optional status.

While overall Medicaid enrollment increases during economic downturns (figure 10), economic fluctuations generally do not affect the enrollment of older Americans and adults with disabilities. However, increased enrollment and demand for services in other eligibility categories create fiscal stress for states and may prompt them to consider LTSS policy changes to curtail overall Medicaid expenditures, especially since HCBS are optional services.

Figure 10. Annual Medicaid Enrollment Growth, 1998–2011



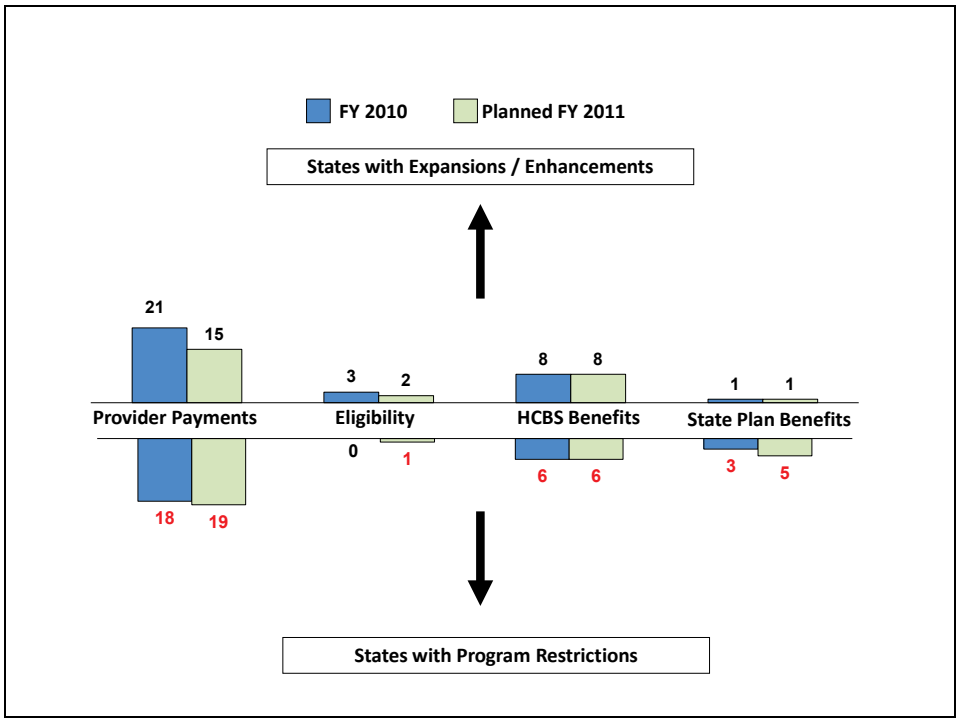
Source: "Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends. Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011;" Vernon K. Smith, Kathleen Gifford, Eileen Ellis, et.al.; Kaiser Commission on Medicaid and the Uninsured; September 2010. Note: Enrollment percentage changes from June to June of each year.

[12] CMS Office of the Actuary, *Brief Summaries of Medicare and Medicaid: Titles XVIII and XIX of the Social Security Act,* November 1, 2009.

[13] Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Long-Term Care Services and Supports; Medicaid Facts*, October 2010. Data include only spending on nursing home and home health services. Expenditures on home and community-based waivers or alternative settings are not included.

In spite of the recession, states were holding steady with Medicaid-funded LTSS. With the exception of provider payments, few states reported implementing policy changes that affect LTSS (figure 11). Policy enhancements slightly outnumber restrictions for eligibility and HCBS policy actions, which likely reflects the infusion of federal funds through the ARRA enhanced FMAP, the maintenance-of-effort (MOE) requirements in ARRA, and state policy priorities. Many state officials noted the importance of the ARRA enhanced FMAP for maintaining the level of services and expressed concern about its impending expiration.

Figure 11. State Medicaid Long-Term Services and Supports Policy Actions



ARRA Restricted Medicaid Eligibility Changes

The MOE provisions under ARRA curtailed state changes to Medicaid eligibility. As a condition for receiving ARRA Medicaid fiscal relief, the MOE prevents states from adopting eligibility standards, methodologies, or procedures more restrictive than those that were in place as of July 1, 2008. The U.S. Centers for Medicare & Medicaid Services (CMS) interpreted the ARRA requirements as preventing states from changing level-of-care criteria for institutional or home and community-based care. CMS guidance also prevented states from reducing HCBS waiver capacity even if slots were unoccupied as of July 1, 2008.[14] The ACA included MOE provisions but also provided states the opportunity to expand Medicaid eligibility by opting for early adoption of its Medicaid expansion provisions.

[14] CMS State Medicaid Director Letter, SMD#09-005; August 19, 2009.

The survey asked state officials to describe changes in Medicaid LTSS eligibility standards for older adults and adults with physical disabilities.[15] Five states reported eligibility expansions, but two of them resulted from states transitioning state-funded programs to Medicaid:

- Connecticut transitioned its state-funded State-Administered General Assistance program to Medicaid with full Medicaid health coverage and benefits, including long-term or skilled nursing facility care, home health care, and nonemergency medical transportation.
- The District of Columbia transitioned its District-funded Health Care Alliance program to Medicaid with full Medicaid benefits, including HCBS beginning July 1, 2010.
- Indiana expanded its post-eligibility income standard for its traumatic brain injury waiver, allowing earlier access to benefits for individuals who spend down their income to become eligible.
- Louisiana changed its medically needy spend-down requirements, allowing more institutionalized Medicaid recipients to become eligible for HCBS waivers, effective November 2010.
- Massachusetts increased the income standard for its traumatic brain injury waiver to 300 percent of the federal benefit rate for Supplemental Security Income (SSI).

Minnesota reported a plan to create and implement a new comprehensive needs assessment called Minnesota COMPASS, a set of standards and protocols to assess the needs of persons for LTSS, including HCBS. The state intended the nursing facility level-of-care criteria for public payment of LTSS to change beginning July 1, 2011, due to 2009 legislative changes. The state had to abandon the plan as the new level-of-care criteria were more stringent, and thus violated the ARRA MOE requirements. Minnesota intends to implement new case mix standards for lower-needs individuals in FY 2011, but will do so only if the changes do not violate MOE requirements.

States Temporarily Holding Steady or Increasing HCBS

States were holding the line with HCBS. Of 38 states reporting on HCBS benefits, 11 noted HCBS benefit reductions, with 6 states reducing benefits in 2010 and 6 planning to reduce benefits in 2011 (see Appendix Table VIa). Three of six states that eliminated services noted that the services eliminated had no utilization. Four states that reduced benefits added other services

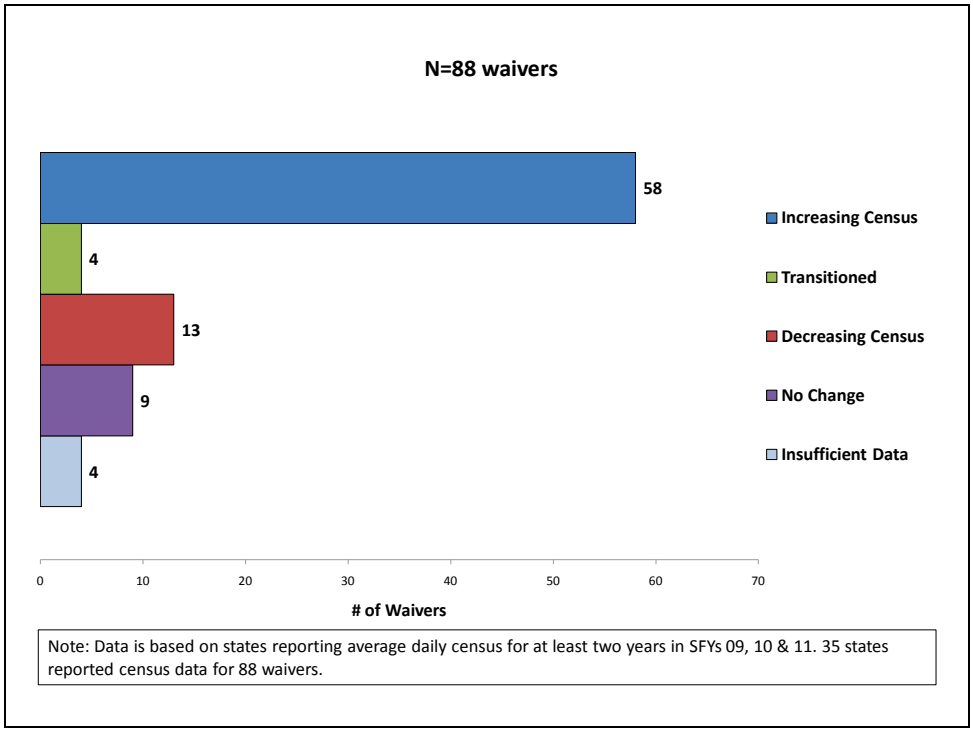
[15] States were asked to include level-of-care criteria, the "special income level" option, spousal impoverishment standards, medically needy standards, or application of institutional eligibility standards to home and community-based waivers.

(Tennessee, Massachusetts, and Iowa), added new waivers (Massachusetts), or plan partial restoration of benefits (Washington).

Eight states reported HCBS benefit increases in FY 2010, and eight states planned increases in FY 2011. States expanded HCBS by increasing the number served or adding services (see Appendix Table VIb for details on state HCBS benefit changes). Most states, however, are holding HCBS benefits steady despite fiscal concerns (25 states and the District of Columbia in FY 2010 and 23 states in FY 2011).

States also continue to expand the number of individuals served through HCBS. Thirty-five states reported census data for 88 waivers. States reported increasing census trends for 58 waivers. The census decreased in 13 waivers and stayed the same in 9 waivers. Two states—Hawaii and Tennessee—transitioned waiver populations to managed care programs. See Appendix Table VII for details of state responses.[16]

Figure 12. HCBS Waiver Census Trends, FY 2009–FY 2010/2011



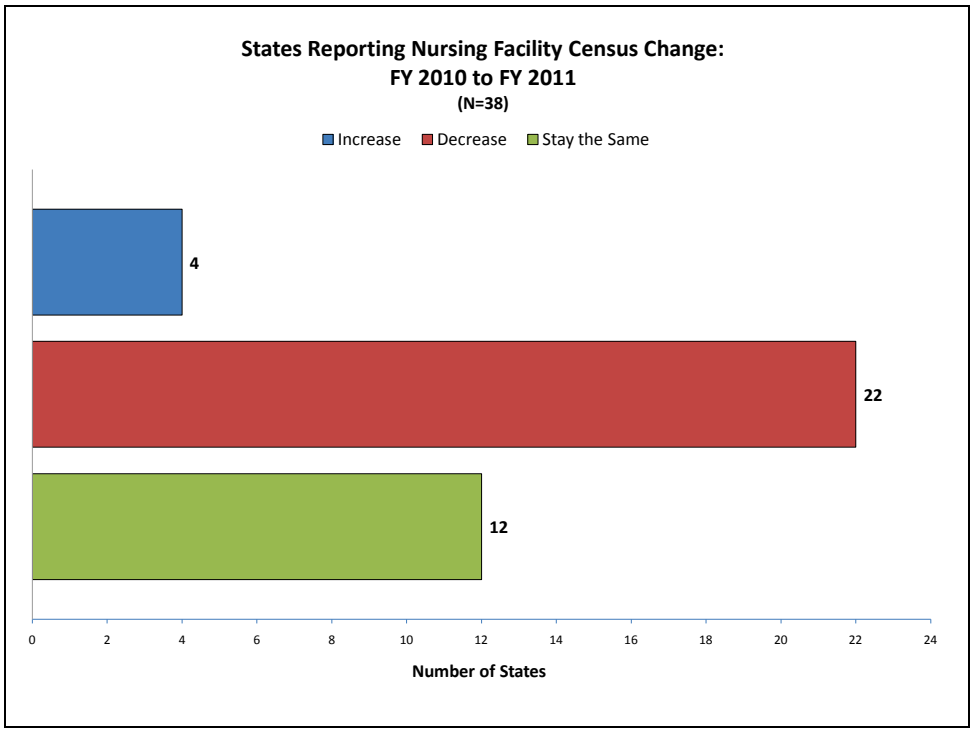
[16] Hawaii transitioned three waivers to managed care, and Tennessee transitioned one waiver to managed care. Florida reported census for four waivers but had insufficient data to determine a census trend.

Decreasing or Static Medicaid Nursing Facility Census in FY 2011

National Nursing Home Survey findings over the past 25 years or more show declining use of nursing home care by persons age 65 and older.[17] Further, 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,[18] possibly due to reductions in disability rates and increases in HCBS options.

In the survey, state officials were asked to report their state's average daily census of Medicaid nursing home residents in FY 2010 and whether they expect the census of Medicaid nursing home residents to increase, decrease, or stay the same in FY 2011. Twenty-two of 38 states responding (58%) expect the average daily census to decline in FY 2011, while 12 states (32%) expect census to stay the same. Only four states—Alaska, Florida, Indiana, and New Mexico—expect the average daily census to grow (figure 13). Alaska cited the lack of a sufficient number of quality HCBS and assisted living providers as the reason for the expected increase. Of those states expecting the average daily census to decrease, three mentioned that the Money Follows the Person (MFP)

Figure 13. Expected Change in Medicaid Nursing Facility Census, FY 2011



[17] National Center for Health Statistics, "An Overview of Nursing Homes and Their Current Residents: Data from the 1995 National Nursing Home Survey," and "The National Nursing Home Survey: 2004 Overview."

[18] "Trends in Nursing Facility Characteristics," American Health Care Association, June 2010 (using CMS Nursing Facility Online Certification and Reporting (OSCAR) standard health survey data).

Rebalancing Demonstration Program[19] had been or was expected to be a factor in reducing the nursing facility census, and five states mentioned HCBS or other alternative placements as factors contributing to the expected decrease. One state mentioned its certificate of need program, and another mentioned its state bed allocation formula as factors.

Few Changes in Noninstitutional LTSS-Related State Plan Benefits

In addition to institutional and HCBS waiver services, states provide services through their Medicaid State plan that are important elements in the LTSS continuum. Home health is a mandatory State plan service, but other services, such as personal care services and adult day health, are provided at the option of the state. Of the 34 states responding to questions about changes to State plan benefits, 25 (76%) have neither made, nor plan to make, changes to LTSS-related State plan benefits. Of the nine states making changes, two reported expanding benefits. Of the five states and District of Columbia (DC) reporting reductions, three states and DC targeted personal care services for restrictions (figure 14). Two of the states (Minnesota and Washington)

Figure 14. Changes to State Plan Benefits Related to Noninstitutional LTSS

Benefit	State Action Taken for State Plan Benefits
Personal Care Services	• (↑) 2011: Pennsylvania plans to add the service in FY 2011. • (↓) 2010: Minnesota implemented more stringent eligibility criteria and reduced authorization limits. Washington and Louisiana reduced the number of hours in the benefit. • (↓) 2011: District of Columbia plans to decrease the number of hours available in the annual benefit. Minnesota plans to implement further restrictions on eligibility for the benefit. Washington plans to further reduce the number of hours available for some individuals based on acuity level.
Adult Day Health	• (↓) 2011: Missouri plans to limit authorizations to five days/week. • (↔) 2011: West Virginia plans to eliminate the State plan benefit and provide the service through the Aged and Disabled waiver.
HCBS State Plan Option	• (↔) No benefit changes reported
Home Health	• (↔) No benefit changes reported
Other	• (↑) 2010: Arkansas allowed consumer direction for Homemaker services for ElderChoices beneficiaries. • (↓) 2011: Michigan will require prior authorization for Private Duty Nursing for individuals in hospice care.

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

[19] The MFP Rebalancing Demonstration Program is a federal initiative established by the Deficit Reduction Act of 2005. MFP is designed to encourage states to transition Medicaid recipients from institutional care to community-based care. See the Health Reform section for further discussion of MFP.

plan to restrict personal care services even further in 2011. West Virginia eliminated adult day health as a State plan service, but is transitioning individuals who need this service to its Aged and Disabled Waiver, so the change is treated as having no policy impact.

Mixed LTSS Provider Rate Changes

A surprising survey result was that in spite of tight budgets, states were nearly as likely to increase LTSS provider rates as to decrease them. Responding to the survey, 39 states indicated whether Medicaid LTSS provider rates increased, decreased, or stayed the same in FY 2010 and 36 gave responses for FY 2011; states were asked to include cost-of-living or inflationary adjustments as rate increases.

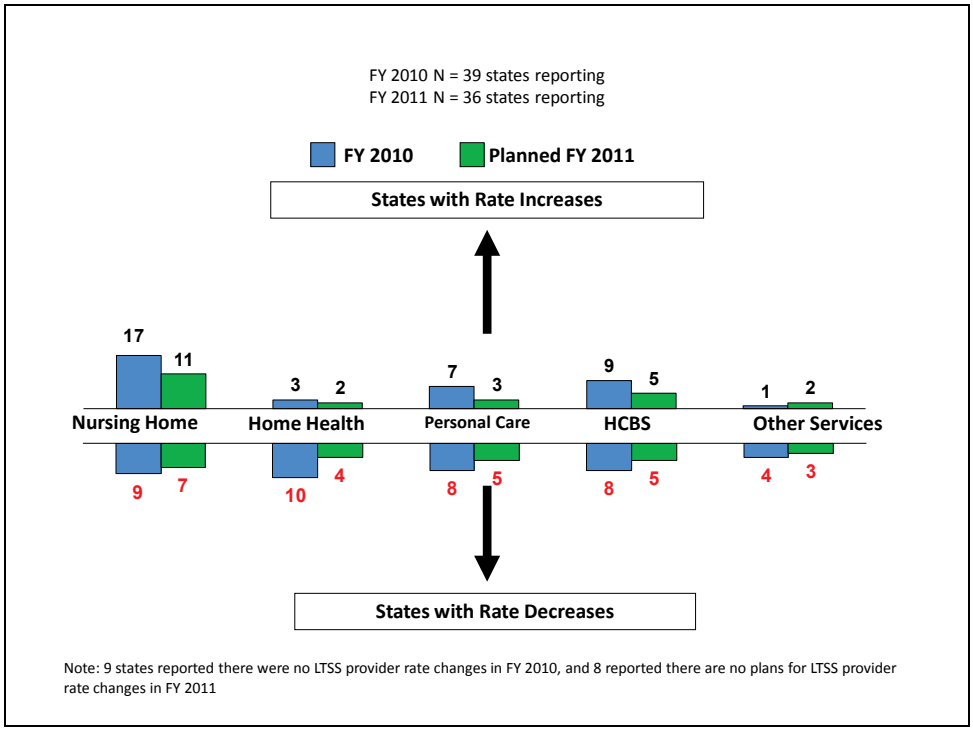
Twenty-one states reported at least one provider rate increase in FY 2010, and 15 states reported at least one provider rate increase in FY 2011. Provider rates are closely associated with provider participation and access to services. Of the 24 states reporting rate increases in either FY 2010 or FY 2011, only 2 noted that the increase was intended to increase provider participation. Eighteen states in FY 2010 and 17 states in FY 2011 reported at least one provider rate decrease. However, only three states indicated that provider participation might be affected by the rate decreases.

Many states appeared to target nursing facilities for rate changes, both increases and decreases (figure 15). Institutional providers such as nursing facilities typically receive cost-of-living (COLA) or inflationary adjustments as an element of reimbursement. Some states have a legal requirement to increase nursing home reimbursement rates. While 12 states reported no change to nursing facility rates in FY 2010 and 13 reported no change to rates in FY 2011, the survey instrument did not ask states to differentiate between "no change" and a "rate freeze." Where states volunteered that nursing facilities did not receive a COLA increase, the authors counted the change as a rate decrease. It is probable that nursing facility rate decreases are underrepresented in the data due to states reporting rate freezes as "no change." A recent survey of Medicaid agencies found that 25 states restricting nursing facility rates in FY 2010 included 14 rate freezes and 11 rate cuts. Twenty-nine states planning nursing facility restrictions in FY 2011 included 20 rate freezes and 9 cuts.[20]

In addition, state decisions on provider rates respond to changing fiscal conditions. In FY 2010, Iowa nursing facility rates were increased approximately 7 percent due to a scheduled rebasing, but then were subsequently reduced 6 to 7 percent due to across-the-board budget reductions. They were then increased when funds became available from Iowa's recently approved nursing facility provider tax. Likewise, some states noted that they may need to reconsider provider rate changes to address

[20] Vernon K. Smith, Kathleen Gifford, Eileen Ellis, et al., *Hoping for Economic Recovery, Preparing for Health Reform; A Look at Medicaid Spending, Coverage and Policy Trends; Result from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011,* prepared for the Kaiser Commission on Medicaid and the Uninsured, September 2010.

Figure 15. LTSS Provider Rate Changes



Note: 9 states reported there were no LTSS provider rate changes in FY 2010, and 8 reported there are no plans for LTSS provider rate changes in FY 2011

the expiration of the ARRA enhanced FMAP in FY 2011. Appendix Tables VIIIa and VIIIb provide additional state detail on provider rate changes.

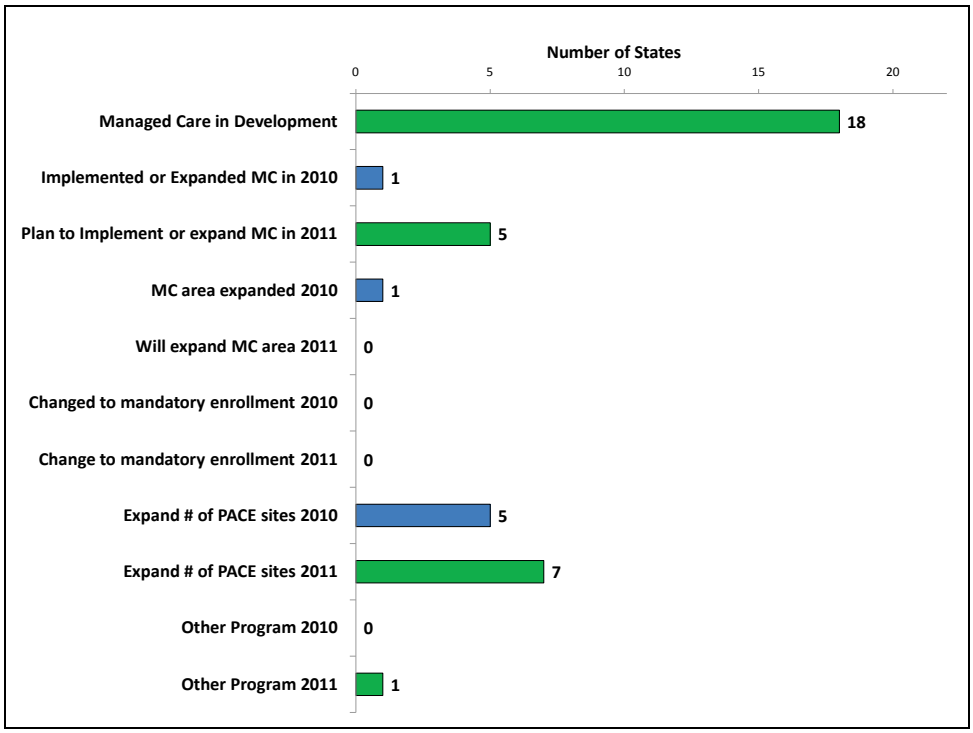
State Interest in Medicaid Managed LTSS

Most states have provided Medicaid LTSS primarily through a traditional fee-for-service model. In 2004, only 70,000 (2.3%) of the 3.1 million Medicaid older and physically disabled enrollees receiving LTSS were in a risk-based managed care arrangement.[21] Fiscal concerns partially drive state interest in managed care for these "higher service usage" populations. 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 can respond.

Eighteen states have a Medicaid managed LTSS program in some stage of development (figure 16). Of the 20 states that have no program in development, 2 (Arizona and Hawaii) already have managed LTSS. One state in FY 2010 (Tennessee) and five states in FY 2011

[21] Paul Saucier, Brian Burwell, and Kerstin Gerst, *The Past, Present and Future of Managed Long-Term Care*, Thomson/MEDSTAT and University of Southern Maine Muskie School of Public Service for the U.S. Department of Health and Human Services, April 2005.

Figure 16. Medicaid Managed LTSS State Actions, FY 2010 and FY 2011



(Connecticut, Illinois, Massachusetts, Pennsylvania, and Tennessee [22]) have or intend to implement or expand Medicaid managed LTSS programs. Several states have expanded Program of All-Inclusive Care for the Elderly (PACE)[23] sites (Colorado, Florida, New Jersey, Pennsylvania, and Washington) in FY 2010, or intend to expand the number of sites in FY 2011 (Florida, Iowa, Massachusetts, Minnesota, Mississippi, New Jersey, Pennsylvania, and South Carolina). Hawaii was the only state reporting a reduction in PACE sites. The state's only PACE site closed July 1, 2011. Appendix Table IX summarizes state LTSS managed care actions.

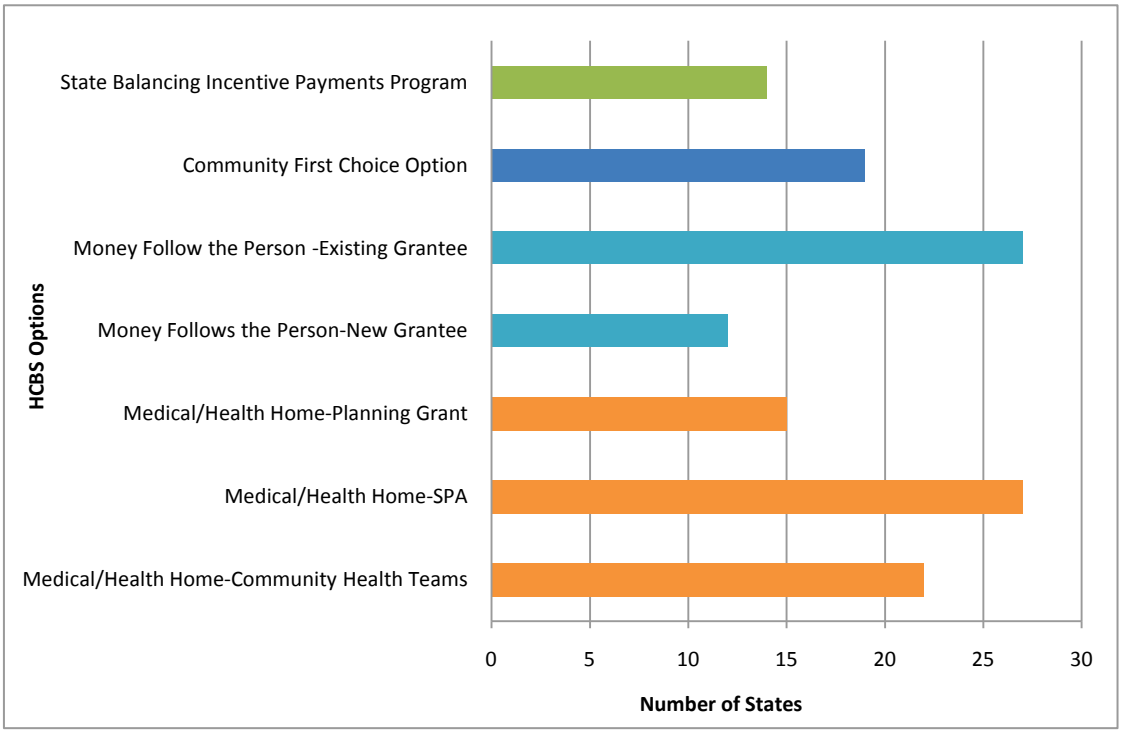
Health Reform

States were asked to signify 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 (figure 17). Many states reported uncertainty due to the lack of federal guidance on each provision, and as a result, either indicated "I Don't Know" or declined to respond to these questions. However, these responses were reported prior to the November 2010 elections, which

[22] Tennessee began implementation in FY 2010 and continued the phase-in in FY 2011.

[23] PACE is an optional benefit under both Medicare and Medicaid that focuses entirely on the elderly who are frail enough to meet their state's standards for nursing home care. PACE offers comprehensive medical and social services that can be provided at an adult day health center, home, or inpatient facility. PACE is available only in states that have chosen to offer PACE under Medicaid.

Figure 17. States' Early Indication of Intent to Pursue Selected HCBS Options in the Affordable Care Act



caused leadership changes in many states. Appendix Table X provides state-by-state responses to questions about states' intent to pursue ACA initiatives.

State Balancing Incentive Payments Program

The State Balancing Incentive Payments Program (BIPP), set to begin October 1, 2011, is a temporary 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 states must agree to make structural changes in order to 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, which the state will use to raise the HCBS spending level to 25 percent. States that spent less than 50 percent, but more than 25 percent, will be eligible to receive a 2 percentage point FMAP increase during the balancing incentive period, which they will use to raise the HCBS spending level to 50 percent.

To qualify for the program, a state must submit an application to the U.S. Department of Health and Human Services describing its plans for expanding Medicaid HCBS and changing its delivery system. These changes must be made within six months of the application date and include establishing a "no wrong door," single-entry-point system; a conflict-free case management system; and a statewide core standardized assessment instrument for determining eligibility for

HCBS. Participating states also must collect data on service utilization, quality, and beneficiary outcomes for HCBS, and are required not 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.

As of this writing, many questions about BIPP implementation still need to be resolved through the regulatory process. Until these questions are answered, most states are likely to take a "wait and see" approach before applying for BIPP funds. Thus, only 14 states expressed early interest in BIPP.

Community First Choice Option

Starting October 1, 2011, the Community First Choice (CFC) Option will allow states to amend their state Medicaid plans to provide home and community-based attendant supports and services. CFC has two eligibility groups: 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 then individuals who have incomes up to 300 percent of SSI, provided they meet the state's nursing facility level of care. States electing to amend their State plans to provide for the CFC option will receive a 6 percentage point FMAP increase for costs associated with this program.

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 expenditures for optional services that it provided to older Americans and individuals with disabilities in the previous fiscal year.

State officials may be concerned about the costs associated with this program because once it is adopted, qualifying individuals are entitled to receive benefits. As a result, only 19 states indicated that they would be considering CFC. As more guidance from CMS is forthcoming and as state officials have the opportunity to assess the costs and benefits of the program, they will be in a better position to determine their willingness to take part in this option.

Money Follows the Person Rebalancing Demonstration Program

The MFP Rebalancing Demonstration Program grant opportunity is an extension of an existing grant program with some modifications. Established by the Deficit Reduction Act of 2005 and originally slated to end in 2011, MFP was designed to encourage states to identify and transition Medicaid beneficiaries who have been living in an institution and want to return to the community. As an incentive to participate, states receive an enhanced federal match for the services provided to Medicaid-eligible individuals for the first 12 months after the beneficiary's transition back to the community.

Effective April 22, 2010, MFP is reauthorized through 2016, and the minimum institutional residency requirement is reduced from six months to 90 days (not counting days solely for Medicare short-term rehabilitation). An additional $2.25 billion is appropriated by the ACA through FY 2016, bringing the total funding for MFP to $4 billion.

Of the 31 states, including the District of Columbia, that are currently MFP grantees, 27 said they would be applying again. Of the states that are not currently MFP grantees, 12 plan to apply for an MFP grant.

Medical/Health Home Incentives

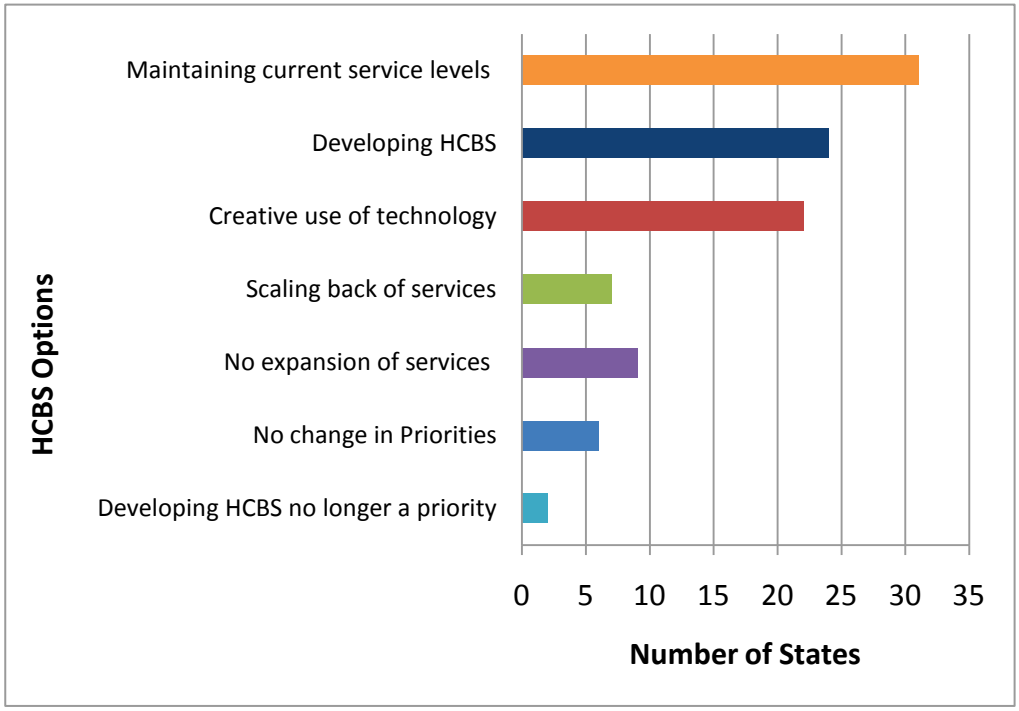
The ACA includes several opportunities for states to provide medical/health homes, and states were asked to respond to three such initiatives. The first, a planning grant to states for the purposes of developing a medical/health home State plan amendment, will begin January 1, 2011. The second would allow 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 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 would provide grants to states to establish community health teams for the purpose of supporting the development of patient-centered medical homes.

Fifteen states indicated that they are considering applying for the planning grant, while 27 states indicated that they are likely to apply for the State plan amendment authorizing the Medical/Health Home. Twenty-two states are considering applying for the community health teams grant.

Outlook and Promising Practices

Not surprisingly, more than half of the states reported that maintaining current service levels is their top priority for the next fiscal year. However, a surprising trend is that 24 states are using the economic decline as an opportunity to develop more HCBS services (figure 18). Another

Figure 18. Changes in State Priorities in the Current Economy



significant priority is the growing use of technology to improve service delivery and achieve economic efficiencies. When asked to explain how they were using the technology, states indicated that they were developing regional delivery systems, utilizing better case management services, and using the Aging and Disability Resource Centers to streamline access to services.

Conclusion

While states have been "weathering the storm" in FY 2010, three distinct events will have a significant impact on LTSS in FY 2011 and FY 2012.

1. **The Great Recession**. The economy will continue to force many state officials to make difficult and sometimes untenable choices as service demands increase while state revenues continue a faltering recovery. Recent anecdotal evidence suggests that even in the states that had earlier reported little effect from the economic downturn, the tide is now turning, causing additional fiscal stress on systems. As federal ARRA assistance phases down, virtually all states will continue to face daunting budget issues in FY 2012 and beyond. The fiscal pressure on state Medicaid budgets could seriously threaten HCBS. This is because Medicaid nursing home coverage is an entitlement, which states may not eliminate. Nearly all HCBS are offered at state discretion. Many states have moved toward balancing LTSS in favor of HCBS that generally are more cost-effective and that consumers prefer. However, budgetary pressures may cause some policymakers to cut these services in order to achieve immediate savings.

2. **The Historic Election of November 2010**. The election of 37 governors is likely to shift state aging and disability policymakers in a record number of states. Of the 37 gubernatorial elections, 26 resulted in a new governor taking leadership. Fourteen state offices changed parties: the shift from a Democratic to Republican governor is taking place in 10 states—Iowa, Kansas, Michigan, New Mexico, Ohio, Oklahoma, Pennsylvania, Tennessee, Wisconsin, and Wyoming. Democrats gained in four states—California, Hawaii, Minnesota, and Vermont. Republicans achieved a net gain of six. Republican governors now hold office in 29 states, while Democrats hold 19 state offices, and an independent picked up Rhode Island. The new leadership at the state level will extend to the appointment of key personnel in state Health and Human Service agencies, Medicaid agencies, and state departments. This turnover will likely slow efforts to achieve HCBS goals as the new leadership grapples with budget issues and gets up to speed on policy priorities. Compounding the leadership crisis is the state workforce shortage, with early retirements occurring at record pace in most states, causing serious voids in institutional knowledge.

3. **The Affordable Care Act**. State policymakers will need to devote time and attention to determine ways to leverage the opportunities and tackle the challenges in implementing the ACA. States await federal guidance for many ACA provisions.

As states confront these and many other challenges to advance policy goals around services for seniors and individuals with disabilities, the future will undoubtedly call for creativity and renewed commitment from state policymakers to maintain the critical safety net for their more vulnerable citizens.

APPENDIX

Table I. State Budget Process for Long-Term Services and Supports

State	Funds for Nursing Facility and HCBS are Appropriated in a Single Account	There are Separate Accounts for Nursing Facility and HCBS (Waiver and State Plan); Legislative Approval is Not Needed to Shift Funds	There are Separate Accounts for Nursing Facility And HCBS; Legislative Approval Must be Obtained to Shift Funds	There are Separate Accounts for Nursing Facility and HCBS; Increases in the HCBS Account Must be Approved through a Supplemental Budget	Comments
Alabama				√	The State Unit on Aging receives a separate appropriation for HCBS only.
Alaska	√				
Arizona	√				Managed care organizations receive a single capitation rate to provide all Medicaid-covered services regardless of placement.
Arkansas			√		
California			√		
Colorado	√				
Connecticut	√				
Delaware		√			
District of Columbia		√			
Florida			√		
Georgia			√		
Hawaii	√				Funds for LTSS are paid to health plans through capitation payments, and funds can be allocated as needed.
Idaho					
Illinois				√	Funds for nursing facility and HCBS are appropriated in a single account for developmental disability services only.
Indiana	√				
Iowa	√				Funds for nursing facility and HCBS are appropriated in a single account; however, nursing facility expenditures are capped at a specific dollar amount.
Kansas			√		
Kentucky					

Table I (continued)

State	Funds for Nursing Facility and HCBS are Appropriated in a Single Account	There are Separate Accounts for Nursing Facility and HCBS (Waiver and State Plan); Legislative Approval is Not Needed to Shift Funds	There are Separate Accounts for Nursing Facility And HCBS; Legislative Approval Must be Obtained to Shift Funds	There are Separate Accounts for Nursing Facility and HCBS; Increases in the HCBS Account Must be Approved through a Supplemental Budget	Comments
Louisiana	√				Although HCBS and nursing facility funds are appropriated in a single account, nursing homes have a dedicated source of funding for increases in rates upon an annual rebasing.
Maine			√		
Maryland		√			
Massachusetts	√				
Michigan			√		
Minnesota	√				
Mississippi					The state has a separate account for HCBS, and it increases the appropriations as a line item supplemental budget.
Missouri			√		Only when supplemental budgets are necessary does the state separate HCBS and nursing facility accounts.
Montana		√			
Nebraska	√				
Nevada				√	The state has no flexibility to transfer funding from one account to the other.
New Hampshire				√	
New Jersey			√		The state requires legislative approval for funding transfers.
New Mexico	√				
New York			√		Although the funds for nursing facility and HCBS are appropriated in a single account, in practice legislative approval must be obtained to shift funds because rates are locked into state law.
North Carolina			√		

Table I (continued)

State	Funds for Nursing Facility and HCBS are Appropriated in a Single Account	There are Separate Accounts for Nursing Facility and HCBS (Waiver and State Plan); Legislative Approval is Not Needed to Shift Funds	There are Separate Accounts for Nursing Facility And HCBS; Legislative Approval Must be Obtained to Shift Funds	There are Separate Accounts for Nursing Facility and HCBS; Increases in the HCBS Account Must be Approved through a Supplemental Budget	Comments
North Dakota		√			The state requires legislative approval to shift more than $50,000 from the nursing facility account to the HCBS account.
Ohio		√			Ohio Controlling Board approval is required for any movement of funds, except Home First, which is a Medicaid HCBS waiver program that allows individuals in nursing facilities, who are Medicaid-eligible, to return to their homes.
Oklahoma			√		
Oregon	√				
Pennsylvania	√				All LTSS spending is in the same budget.
Puerto Rico*					
Rhode Island					
South Carolina		√			State agencies have the latitude to shift funds between accounts for amounts under a certain threshold. Otherwise, they need Budget Office approval or legislative action.
South Dakota*					
Tennessee	√				
Texas			√		
Utah			√		
Vermont	√				
Virgin Islands*					
Virginia					
Washington				√	The state legislature sets the overall operating budget.
West Virginia			√		

Table I (continued)

State	Funds for Nursing Facility and HCBS are Appropriated in a Single Account	There are Separate Accounts for Nursing Facility and HCBS (Waiver and State Plan); Legislative Approval is Not Needed to Shift Funds	There are Separate Accounts for Nursing Facility And HCBS; Legislative Approval Must be Obtained to Shift Funds	There are Separate Accounts for Nursing Facility and HCBS; Increases in the HCBS Account Must be Approved through a Supplemental Budget	Comments
Wisconsin					All LTSS funds are included in the state's managed care cap rate; there is still a fee-for-service Medicaid appropriation for those who choose not to participate in the state's managed care program, Family Care.
Wyoming					
TOTAL	**16**	**7**	**15**	**5**	

*Did not participate in the survey.

Table II. State Units on Aging Non-Medicaid HCBS Expenditures

State	FY 2009	FY 2010 (Estimate)	FY 2011 (Appropriation)	Percent Change 2009–2010
Alabama	NA	NA	NA	
Alaska	$ 3,899,826	$ 3,046,776	$ 3,046,776	-22%
Arizona	$16,076,800	$ 15,397,400	$ 12,924,100	-4%
Arkansas	$ 7,697,578	$ 7,174,606		-7%
California	$ 182,119,000			NA
Colorado	$ 22,000,000	$ 21,000,000	$ 21,000,000	-5%
Connecticut	$ 68,000,000	$ 72,000,000	$ 73,000,000	6%
Delaware	$ 1,581,300	$1,581,300	$ 1,581,300	0%
District of Columbia				
Florida	$ 56,820,000	$ 55,175,000	$ 55,448,000	-3%
Georgia	$17,888,657	$15,311,260	$16,612,143	-14%
Hawaii	$ 5,544,447	$ 5,624,172	$ 5,624,172	1%
Idaho				
Illinois	$ 228,420,800	$ 295,914,750	$275,662,600	30%
Indiana	$ 31,900,000	$ 34,800,000	$ 34,800,000	9%
Iowa	$ 6,669,993	$ 8,107,420	$ 7,375,076	22%
Kansas	$ 7,500,000	$ 6,600,000	$ 6,300,000	-12%
Kentucky	$ 33,586,936	$ 33,600,000	$ 31,920,000	0%
Louisiana				
Maine	$ 16,206,075	$ 16,073,876	$ 16,625,342	-1%
Maryland	$ 12,584,628	$ 12,561,437	$ 12,424,090	0%
Massachusetts	$ 136,452,959	$ 136,375,315	$129,622,457	0%
Michigan				
Minnesota	$ 30,400,000	$ 31,258,000	$ 33,650,000	3%
Mississippi				
Missouri	$ 8,504,642	$ 6,706,909	$ 1,080,796	-21%

Table II (continued)

State	FY 2009	FY 2010 (Estimate)	FY 2011 (Appropriation)	Percent Change 2009–2010
Montana				
Nebraska	$ 2,023,239	$ 2,033,123	$ 2,033,123	0%
Nevada	$ 27,996,989	$ 26,141,467	$ 29,425,681	-7%
New Hampshire	$ 12,180,330	$ 12,180,330	$ 12,180,330	0%
New Jersey	$ 43,144,000	$ 45,077,000	$ 45,148,000	4%
New Mexico				
New York	$ 115,000,000	$ 110,000,000		-4%
North Carolina	$ 39,147,000	$ 40,966,000	$ 40,912,000	5%
North Dakota	$ 800,000	$ 800,000	$ 800,000	0%
Ohio	$ 11,557,000	$ 8,060,400	$ 7,477,400	-30%
Oklahoma	$ 2,574,727	$ 3,024,963	$ 3,299,318	17%
Oregon	$ 6,053,306	$ 4,787,496	$ 4,000,000	-21%
Pennsylvania	$ 219,673,375	$ 223,649,100	$223,649,100	2%
Rhode Island	$ 4,646,603	$ 1,832,301	$ 2,184,811	-61%
South Carolina				
South Dakota				
Tennessee	$ 9,393,400	$ 9,393,400	$ 9,393,400	0%
Texas	$ 12,863,000	$ 15,088,000	$19,832,000	17%
Utah	$ 24,743,119	$ 23,135,711	$ 22,587,900	-6%
Vermont	$ 4,350,000	$ 4,731,000	$ 4,600,000	9%
Virginia	$ 18,011,719	$ 17,224,164	$ 15,793,723	-4%
Washington	$ 17,565,000	$ 17,778,000	$ 17,778,000	1%
West Virginia	$ 12,767,804	$ 15,112,445	$ 16,137,367	18%
Wisconsin				
Wyoming	$ 3,052,886	$ 3,052,886	$ 3,052,886	0%

Table III. Impact of Expiration of ARRA Nutrition Funding

State	Too Soon to Tell	Services Will Be Reduced	Programs Will Be Reduced	Services Will Be Eliminated	Waiting Lists Will Increase	Programs Will Be Eliminated	Waiting Lists Will Decrease	No Impact	Comments
Alabama					√				
Alaska	√								
Arizona		√			√				
Arkansas		√	√	√	√	√			The state's cigarette tax, which helps fund the nutrition program, was also reduced.
California		√	√		√	√			
Colorado	√								
Connecticut		√	√		√				Although it is early, the state expects that services and programs will be eliminated.
Delaware		√							
District of Columbia		√	√		√				
Florida		√		√	√				Through the ARRA funding, the state expanded its services to serve new clients, provide additional meals to existing clients, and open new meal sites—all this will be discontinued when the ARRA funding ends.
Georgia			√		√				
Hawaii	√								
Idaho	√								
Illinois		√			√				
Indiana					√				

Table III (continued)

State	Too Soon to Tell	Services Will Be Reduced	Programs Will Be Reduced	Services Will Be Eliminated	Waiting Lists Will Increase	Programs Will Be Eliminated	Waiting Lists Will Decrease	No Impact	Comments
Iowa		√							
Kansas									The state appropriated additional general funds in SFY 2011 to offset the loss of ARRA funds.
Kentucky		√	√		√	√			
Louisiana					√				
Maine								√	The state's Area Agencies on Aging were able to offset the losses by effectively planning for the loss of ARRA funding.
Maryland		√			√				
Massachusetts	√				√				Although the state does not currently have a waiting list for its nutrition programs, it expects, on average, 50 individuals being placed on a waiting list at each nutrition site in SFY 2011—this would be a total of 1,400 individuals statewide.
Michigan	√				√				Because the state has not received approval for its SFY 2011 budget, it is difficult to predict the impact of the expiration of ARRA nutrition funding.
Minnesota								√	
Mississippi								√	

Table III (continued)

State	Too Soon to Tell	Services Will Be Reduced	Programs Will Be Reduced	Services Will Be Eliminated	Waiting Lists Will Increase	Programs Will Be Eliminated	Waiting Lists Will Decrease	No Impact	Comments
Missouri		√	√		√				The Area Agencies on Aging used the ARRA funding primarily to offset large FY 2010 state funding reductions; therefore, ARRA funding was not used to expand services.
Montana		√							
Nebraska									
Nevada					√				
New Hampshire	√								
New Jersey		√		√	√				
New Mexico			√			√			The state is committed to not having a waiting list for its nutrition programs.
New York		√			√				
North Carolina		√			√				ARRA funding has been gradually expended by service providers over a 7- to 10-month period. The state expects that client attrition will address a portion of the service loss. However, given the increase in service requests, state administrators are concerned about sustaining service levels for home-delivered meals.
North Dakota									

Table III (continued)

State	Too Soon to Tell	Services Will Be Reduced	Programs Will Be Reduced	Services Will Be Eliminated	Waiting Lists Will Increase	Programs Will Be Eliminated	Waiting Lists Will Decrease	No Impact	Comments
Ohio		√			√				The Area Agencies on Aging have planned for the expiration of funding.
Oklahoma		√	√		√				The state is unable to predict the exact impact that the expiration of ARRA nutrition funding will have.
Oregon	√								
Pennsylvania								√	The state did not use the ARRA funding to expand services. As a result, there will not be an impact on the service provision with its expiration.
Puerto Rico*									
Rhode Island	√								
South Carolina		√	√		√				
South Dakota*									
Tennessee					√				
Texas	√								
Utah	√								The state projected that it should be able to maintain meals served, but cannot be certain in this prediction.

Table III (continued)

State	Too Soon to Tell	Services Will Be Reduced	Programs Will Be Reduced	Services Will Be Eliminated	Waiting Lists Will Increase	Programs Will Be Eliminated	Waiting Lists Will Decrease	No Impact	Comments
Vermont	√		√		√	√			The state indicated that one Area Agency on Aging reported, "The ARRA funding allowed us to provide 10,000 increased meals; without that funding, we most likely would have had to stop paying contractors."
Virgin Islands*									
Virginia			√		√				The state indicated that it will be forced to discontinue breakfast programs that were started as a result of the ARRA funds.
Washington		√			√	√			
West Virginia									
Wisconsin								√	
Wyoming								√	
TOTAL	**12**	**20**	**12**	**3**	**27**	**6**	**0**	**6**	

*Did not participate in the survey

Table IV. Adult Protective Services Budget and Service Changes, FY 2010–FY 2011

	Changes in APS Expenditure (+ for increase, - for decrease, 0 if same)		Service Requests for APS			If APS Calls Increased Since SFY 2009, What Type of Complaints Are You Receiving?					
State	SFY 10	SFY 11	Increased Calls	No Increase in Calls	Don't Know	Financial Exploitation	Physical Abuse	Neglect	Emotional Abuse	Sexual Abuse	Comments
Alabama			√			√					The state's Ombudsman program saw an increase in financial exploitation of people in nursing homes who were applying for Medicaid after spending down their personal finances.
Alaska	+	+	√			√	√	√	√	√	The state received an increased number of APS calls concerning individuals with developmental disabilities.
Arizona	-	0		√							
Arkansas	0	0	√			√					
California					√						
Colorado					√						
Connecticut					√						
Delaware	0	0		√							
District of Columbia			√			√		√			
Florida					√						
Georgia			√			√	√	√			

Table IV (continued)

	Changes in APS Expenditure (+ for increase, - for decrease, 0 if same)		Service Requests for APS			If APS Calls Increased Since SFY 2009, What Type of Complaints Are You Receiving?					
State	SFY 10	SFY 11	Increased Calls	No Increase in Calls	Don't Know	Financial Exploitation	Physical Abuse	Neglect	Emotional Abuse	Sexual Abuse	Comments
Hawaii					√						
Idaho	+	+		√							
Illinois					√						
Indiana	0	0	√			√	√		√	√	
Iowa					√						
Kansas					√						
Kentucky					√						
Louisiana							√	√	√	√	The state observed that as other services were cut, more calls came into the state's APS program.
Maine	-	-	√			√	√	√		√	The state observed that as other services were cut, more calls came into the state's APS program.
Maryland					√						
Massachusetts	-	-	√			√		√			The state experienced a dramatic rise in the number of self-neglect cases reported.

Table IV (continued)

	Changes in APS Expenditure (+ for increase, - for decrease, 0 if same)		Service Requests for APS			If APS Calls Increased Since SFY 2009, What Type of Complaints Are You Receiving?					
State	SFY 10	SFY 11	Increased Calls	No Increase in Calls	Don't Know	Financial Exploitation	Physical Abuse	Neglect	Emotional Abuse	Sexual Abuse	Comments
Michigan					√						
Minnesota	0	0	√			√	√	√	√	√	The state observed a significant increase in reports of financial exploitation—family members taking older adults' money in order to take care of their own families.
Mississippi	0	0	√			√	√	√	√		
Missouri	0	0	√			√	√	√	√	√	The state has seen a significant increase in reports of self-abuse/neglect.
Montana			√			√	√	√	√		
Nebraska					√						
Nevada	+	0	√			√					
New Hampshire	0	0	√			√		√			
New Jersey	0	0	√			√		√			The state has experience increased calls regarding adults with developmental disabilities who have been either neglected or abandoned.
New Mexico	-	-	√			√		√			The state has seen a significant increase in calls regarding self-neglect.

Table IV (continued)

	Changes in APS Expenditure (+ for increase, - for decrease, 0 if same)		Service Requests for APS			If APS Calls Increased Since SFY 2009, What Type of Complaints Are You Receiving?					
State	SFY 10	SFY 11	Increased Calls	No Increase in Calls	Don't Know	Financial Exploitation	Physical Abuse	Neglect	Emotional Abuse	Sexual Abuse	Comments
New York					√						
North Carolina	0	0	√			√	√	√	√	√	
North Dakota	0	0	√			√		√			The state has seen a significant increase in reports of self-neglect.
Ohio					√						
Oklahoma					√						
Oregon	0	0	√			√	√	√	√		
Pennsylvania	0	0	√			√					
Puerto Rico*											
Rhode Island	0	0	√			√	√	√	√	√	
South Carolina					√						
South Dakota*											
Tennessee					√						
Texas					√						
Utah	-	-	√			√	√	√	√		The state has experienced increase calls in all areas, especially financial exploitation.

Table IV (continued)

	Changes in APS Expenditure (+ for increase, - for decrease, 0 if same)		Service Requests for APS			If APS Calls Increased Since SFY 2009, What Type of Complaints Are You Receiving?					
State	SFY 10	SFY 11	Increased Calls	No Increase in Calls	Don't Know	Financial Exploitation	Physical Abuse	Neglect	Emotional Abuse	Sexual Abuse	Comments
Vermont	0	0	√			√		√			The state has also seen a significant increase in the number of drug diversion cases.
Virgin Islands*											
Virginia					√						
Washington	0	0	√			√					
West Virginia					√						
Wisconsin			√			√		√			
Wyoming					√						
TOTAL			**25**	**3**	**21**	**25**	**13**	**20**	**11**	**8**	
TOTAL INCREASES	**3**	**2**									
TOTAL DECREASES	**5**	**4**									
STAYED THE SAME	**16**	**16**									

*Did not participate in the survey

Table V. State Aging and Disability Priorities, 2010–2011

State	No Change	Not Expanding Services	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	Creative Use of Technology
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						√	

Table V (continued)

State	No Change	Not Expanding Services	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	Creative Use of Technology
Nebraska			√			√	
Nevada			√				
New Hampshire			√			√	√
New Jersey			√			√	√
New Mexico			√			√	
New York							
North Carolina			√			√	
North Dakota	√						
Ohio	√						
Oklahoma						√	√
Oregon						√	√
Pennsylvania			√			√	√
Puerto Rico*							
Rhode Island			√				√
South Carolina		√			√	√	
South Dakota*							
Tennessee			√				
Texas						√	
Utah	√						
Vermont		√	√		√		√
Virgin Islands*							
Virginia					√		√
Washington						√	√
West Virginia	√						
Wisconsin			√			√	
Wyoming			√				√
TOTAL	**6**	**9**	**24**	**2**	**7**	**31**	**22**

*Did not participate in the survey.

Table VIa. Home and Community-Based Service Waivers: Benefit Restrictions

State	Action Taken 2010
Colorado	• Capped nonmedical transportation to two trips/week for four waivers: Brain Injury, Mental Illness, Persons Living With Aides, and the Elderly, Blind, & Disabled waivers
Kansas	• Eliminated four services from the Frail Elderly waiver, except in crisis circumstances: ○ Sleep cycle support ○ Assistive technology ○ Oral health ○ Comprehensive supports
Louisiana	• Reduced services (individual budget limits based on acuity) in response to the waiver being out of compliance with federal cost neutrality requirements.
Massachusetts	• Eliminated family training service from Traumatic Brain Injury waiver due to no utilization, but added two new services: individual support and community habilitation, and transitional assistance services
Tennessee	• Placed limits on some HCBS benefits in its Section 1115 waiver, CHOICES, based on utilization patterns to minimize impact on participants. The state did not reduce the list of covered services. ○ Homemaker services limited to three visits/week ○ Home modifications limited to $6,000/instance, $10,000/calendar year, $20,000/lifetime ○ Personal care visits limited to four hours/visit, two visits/day.
Washington	• Decreased personal care hours on average five hours/person based on acuity in three waivers: Community Options Entry System, Medically Needy In-Home waiver, New Freedom waiver
	Action Planned 2011
Georgia	• The state may need to place unspecified limits on the Community Care Services Program
Iowa	• Eliminated consumer-directed care in the Elderly waiver
Idaho	• Restricted service coordination in the Aged & Disabled waiver
Missouri	• Eliminated institutional respite services from Aged & Disabled waiver due to no utilization
West Virginia	• Eliminated adult day care from the Aged & Disabled waiver due to no utilization
Washington	• Although 25 percent of 2010 cuts to personal care hours are restored (one hour/person), additional cuts will affect individuals based on acuity. Three waivers affected: Community Options Entry System, Medically Needy In-Home waiver, New Freedom waiver.

Table VIb. Home and Community-Based Services Waivers: Benefit Expansions

State	FY 2010	FY 2011
Arizona		• Added community transition to its Section 1115 waiver
Connecticut	• Personal care assistance added to the Home Care Program for Elders waiver • Assistive technology added to the Personal Care Assistance waiver	• Assistive technology added to the Home Care Program for Elders waiver
District of Columbia		• Added participant direction option to the Elderly and Physically Disabled waiver
Florida	• Nursing home transition services added to four waivers: Assisted Living for the Elderly, Aged and Disabled Adult, Nursing Home Diversion, and Traumatic Brain and Spinal Cord Injury.	• Expanded Assisted Living for the Elderly waiver to include disabled 18 to 59 age group.
Indiana	• Increased the number of slots (39) in Traumatic Brain Injury waiver • Added community transition, home-delivered meals, nutritional supplements, and pest control to Traumatic Brain Injury waiver	
Iowa		• Added consumer-directed care to the Assisted Living waiver
Massachusetts	• Added individual support and community habilitation, and transitional assistance services to the Traumatic Brain Injury waiver • Added two new Acquired Brain Injury waivers	
Minnesota		• Added chore, 24-hr. emergency assistance, adult companion, behavioral programming, caregiver living expenses, and housing access coordination to the Community Alternatives for Disabled Individuals waiver
Montana	• Increased the number of slots (80) in the Elderly & Physically Disabled waiver	
New Hampshire	• Added targeted case management to the Choices for Independence waiver	
Ohio		• Added enhanced community living to the PASSPORT waiver
South Carolina	• Added telemonitoring and adult foster care to the Community Choices waiver	
Tennessee	• Added adult care home and companion care to TennCare II Medicaid Section 1115 waiver	
Washington		• Added personal care hours to three waivers: Community Options Entry System, Medically Needy In-Home waiver, New Freedom waiver

Table VII. Census Change in Medicaid Home and Community-Based Service Waivers, 2009–2010/2011

State	Waiver Name	Census Increase	Census Decrease	Census Transition	No Change	Insufficient Data
		58	**13**	**4**	**9**	**4**
Alabama	• Alabama Dept of Public Health Elderly and Disabled Waiver	√				
	• Alabama Dept of Social Services Elderly and Disabled Waiver	√				
Alaska	• Adults with Physical Disabilities	√				
	• Older Alaskans	√				
Arizona	• Section 1115	√				
Arkansas	• ElderChoices	√				
	• Alternatives for Adults with Physical Disabilities	√				
	• Living Choices/Assisted Living	√				
California	• Multipurpose Senior Services Program Waiver		√			
	• Nursing Facility/Acute Hospital Waiver	√				
	• Assisted Living Waiver	√				
	• AIDS Waiver	√				
	• In-Home Operations Waiver		√			
Connecticut	• Home Care Program for Elders	√				
	• Personal Care Assistance	√				
	• Acquired Brain Injury	√				
Florida	• Aged and Disabled Adult waiver					√
	• Channeling for the Frail Elderly					√
	• Assisted Living for the Elderly					√
	• Nursing Home Diversion Project					√
Georgia	• Community Care Services Program		√			
Hawaii*	• Nursing Home Without Walls			√		
	• Residential Alternative Community Care Program			√		
	• Medically Fragile Community Care Program			√		
	• HIV Community Care Program			√		
Indiana	• Aged & Disabled Waiver	√				
	• Traumatic Brain Injury	√				
Iowa	• Elderly Waiver • Ill & Handicapped Waiver • Physical Disabilities Waiver	√				
Kansas	• Frail Elderly Waiver	√				
	• Physically Disabled Waiver		√			

Table VII (continued)

State	Waiver Name	Census Increase	Census Decrease	Census Transition	No Change	Insufficient Data
Kentucky	• Acquired Brain Injury				√	
	• Model Waiver II (Ventilator Dependent)				√	
	• Acquired Brain Injury Long-Term Care	√				
	• Adult Day Care	√				
	• Home and Community Based Services		√			
Louisiana	• Adult Day Health Care				√	
	• Elderly and Disabled Adult	√				
Maine	• Elders & Adults with Disabilities Waiver	√				
	• Waiver for Physically Disabled	√				
Maryland	• Older Adults Waiver Program	√				
Massachusetts	• Frail Elder Waiver	√				
	• Acquired Brain Injury Waivers (2)	√				
	• Traumatic Brain Injury Waiver				√	
Michigan	• MI Choice	√				
Minnesota	• Traumatic Brain Injury	√				
	• Elderly Waiver	√				
	• Community Alternatives for Disabled Individuals	√				
	• Community Alternative Care	√				
Mississippi	• Elderly & Disabled Waiver	√				
	• Assisted Living Waiver	√				
	• Independent Living Waiver	√				
	• Traumatic Brain/Spinal Cord Injury Waiver	√				
Missouri	• Aged & Disabled Waiver	√				
	• Physical Disabilities Waiver	√				
	• Independent Living Waiver		√			
Nevada	• Adults with Disabilities Waiver				√	
	• Waiver for Elderly Adults in Residential Care				√	
	• Assisted Living Waiver	√				
	• Waiver for the Frail Elderly				√	
New Hampshire	• Choices for Independence Program	√				
New Mexico	• Disabled and Elderly		√			
	• Mi Via (Self-Directed)	√				

Table VII (continued)

State	Waiver Name	Census Increase	Census Decrease	Census Transition	No Change	Insufficient Data
Ohio	• PASSPORT (60+)	√				
	• Assisted Living	√				
	• Choices (Consumer Direction 60+)	√				
Oklahoma	• Advantage Waiver				√	
Oregon	• Aged and Physically Disabled HCBS Waiver	√				
Pennsylvania	• Aging Waiver (60+)	√				
	• Attendant Care (Physically Disabled 18-59)	√				
	• Independence (Physically Disabled 18+)	√				
	• CommCare (Traumatic Brain Injury)	√				
South Carolina	• Community Choice (Aged and Disabled)		√			
	• Mechanical Ventilator				√	
	• Head and Spinal Cord Injury (HASCI)	√				
Tennessee*	• Statewide HCBS Elderly and Disabled Waiver			√		
	• TennCare II Medicaid (Section 1115)	√				
Texas	• Community Based Alternatives (CBA)		√			
	• Community Living Assistance & Support Services	√				
Utah	• Medicaid Aging Waiver		√			
Vermont	• Choices for Care HCBS (highest/high needs)		√			
	• Choices for Care HCBS (moderate needs)		√			
	• Choices for Care Enhanced Residential Care	√				
Washington	• Community Options Entry System	√				
	• Medically Needy Residential Waiver	√				
	• Medically Needy In-home Waiver		√			
	• New Freedom	√				
West Virginia	• Aged/Disabled Waiver	√				

*Hawaii transitioned individuals in three waivers, and Tennessee transitioned individuals in one waiver to mandatory managed care under Section 1115 demonstration waivers. Census data for populations receiving HCBS services through the managed care waiver were not available from Hawaii.

Table VIIIa. Provider Rate Changes in FY 2010

LTSS Provider Rate Changes, 2010						
State	Nursing Home	Home Health	Personal Care Services	HCBS Waiver Services	Other Services	Name of Service
Total States	**36***	**30**	**29**	**36**	**6**	
Increase (+)	17	3	7	9	1	
Decrease (-)	9	10	8	8	4	
No Change (0)	12	17	14	19	1	
Don't Know (DK)	0	0	0	0	0	
Alabama	0	0	0	0		
Alaska	0	0	0	0		
Arizona	0	-	-	-		
Arkansas	+	+	+	+		
California	-		+			
Colorado	0	0	0	0		
Connecticut				+		
Delaware						
District of Columbia	0	0	0	0	0	Adult day health
Florida	+	0	0	0	-	Nursing home diversion
Georgia						
Hawaii	0	0				
Idaho	-	0	0	0		
Illinois	+	-		+		
Indiana	+	-	0	0		
Iowa[1]	+ and -	-		-	-	Targeted case management (TCM)
Kansas	-			-	-	PACE and TCM
Kentucky	+					
Louisiana	+	-	-	+		
Maine	0	0	0	0		
Maryland						
Massachusetts	+	0	+	0		
Michigan	0	0	+	0		
Minnesota						
Mississippi	+		+	+	+	Case management (two waivers only)
Missouri	+	0	0	0		
Montana	+	+	+	+		
Nebraska						

Table VIIIa (continued)

LTSS Provider Rate Changes, 2010						
State	Nursing Home	Home Health	Personal Care Services	HCBS Waiver Services	Other Services	Name of Service
Nevada	0	-	-	0		
New Hampshire		-	-	-		
New Jersey	0	0	0	0		
New Mexico	0	0	0	0		
New York	-	-	-	-		
North Carolina						
North Dakota						
Ohio		-	-	0		
Oklahoma	-			-		
Oregon	+	0	0	0		
Pennsylvania	-	0	0	0		
Rhode Island						
South Carolina	+	0	0	+		
South Dakota						
Tennessee[2]	0			0		
Texas	+	+	+	+		
Utah						
Vermont[1]	+ and -	-	-	-	-	Other Medicaid services
Virginia						
Washington	+		-	-		
West Virginia	-			+		
Wisconsin						
Wyoming	+	0		0		

*Total is less than sum of changes because Iowa and Vermont increased and decreased nursing home rates.

[1]Iowa nursing home rates increased due to a scheduled rebasing effective July 1, 2009. They were subsequently reduced 6–7 percent through across-the-board budget reductions. They were then increased again when funds became available through an approved nursing facility provider tax. Rates were further restored in SFY 2011 due to nursing facility provider tax revenue. Vermont nursing homes were not given the full inflation adjustment increase but received additional funds as a response to two requests for emergency financial relief.

[2]Tennessee managed care organizations negotiate rates with home health agencies.

Table VIIIb. Provider Rate Changes in FY 2011

LTSS Provider Rate Changes, FY 2011						
State	Nursing Home	Home Health	Personal Care Services	HCBS Waiver Services	Other Services	Name of Service
Total	**33***	**24**	**25**	**30**	**8**	
Increase (+)	11	2	3	5	2	
Decrease (-)	7	4	5	5	3	
No Change (0)	13	17	16	19	1	
Don't Know (DK)	3	1	1	1	2	
Alabama	0	0	0	0		
Alaska	0	0	+	+		
Arizona	0	-	-	-		
Arkansas	+	+	0	0		
California	+					
Colorado	0	-	0	0		
Connecticut						
Delaware						
District of Columbia	0	0	0	0	DK[1]	Adult day health
Florida	DK	0	0	0	-	Nursing home diversion
Georgia						
Hawaii	+	0				
Idaho						
Illinois	DK[2]	-		+		
Indiana			0	0		
Iowa	+				+	TCM
Kansas	+			+	+	PACE and TCM
Kentucky	+					
Louisiana	+	0	-	-		
Maine	0	0	0	0		
Maryland						
Massachusetts	0	0	+	0		
Michigan						
Minnesota					-	Assisted living providers for services to elderly waiver participants
Mississippi	0		0	+	0	Case management (two waivers only)
Missouri	DK		-	-		

Table VIIIb (continued)

LTSS Provider Rate Changes, FY 2011						
State	Nursing Home	Home Health	Personal Care Services	HCBS Waiver Services	Other Services	Name of Service
Montana	0	0	0	0		
Nebraska						
Nevada	-	0	0	0		
New Hampshire	-					
New Jersey	0	0	-	0		
New Mexico	0	0	0	0	-	Managed LTSS
New York	-	-	-	-		
North Carolina						
North Dakota						
Ohio		0	0	0		
Oklahoma	0			0		
Oregon	+	0	0	0		
Pennsylvania	-	0	0	0		
Rhode Island						
South Carolina	+	0	0	+		
South Dakota						
Tennessee	-			0		
Texas	+	+	+	-		
Utah						
Vermont	+ and -	DK	DK	DK	DK	Other Medicaid
Virginia						
Washington	-		0	0		
West Virginia						
Wisconsin						
Wyoming	0	0		0		

*Total is less than sum of changes because Vermont increased and decreased nursing home rates.

[1]DC is revising adult day health methodology in 2011 and the impact is not yet determined.

[2]The Illinois legislature established a rate reform work group to study nursing facility rates during SFY 2011 with the goal of developing an evidence-based methodology. Illinois currently uses a hybrid case mix methodology (nursing, capital, and support components). Rates are not Resource Utilization Group-based, but the state will consider that in 2011. The state is currently unsure what the impact on rates will be, but expects that it will result in a reallocation rather than an increase.

Table IX. Medicaid Managed Long-Term Care (MLTC)

State	MLTC in Some Stage of Development	Implement MLTC		Geographic Expansion of MLTC		Change to Mandatory Enrollment		Expand # of PACE Sites	
		2010	2011	2010	2011	2010	2011	2010	2011
	Yes 18 No 20	1	5	1	0	0	0	5	7
Alabama	No								
Alaska	Yes								
Arizona	No[1]								
Arkansas	No								
California	Yes								
Colorado	No							√	
Connecticut	Yes		√						
District of Columbia	No								
Florida	Yes			√				√	√
Georgia	No								
Hawaii	No[1]							*	
Illinois	Yes		√						
Indiana	No								
Iowa	No								√
Kansas	No								
Kentucky	No								
Louisiana	No								
Maine	Yes								
Massachusetts	Yes		√						√
Michigan	Yes								
Minnesota	Yes								√
Mississippi	No								
Missouri	Yes								
Montana	No								
Nevada	No								
New Hampshire	No								
New Jersey								√	√
New Mexico	Yes								
New York	Yes								
Ohio	No								
Oklahoma	No								
Oregon	Yes								
Pennsylvania	Yes		√					√	√
South Carolina	Yes								√
Tennessee	Yes	√	√						
Texas	Yes								
Vermont	No								
Washington	Yes							√	
West Virginia	No								

*Hawaii eliminated its only PACE site in FY 2010.

[1]Arizona and Hawaii have existing operational long-term managed care programs.

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

State	State Balancing Incentive Program	Community First Choice	MFP New Program	MFP Extend Existing Program	Health Home Planning Grant	Health Home State Plan Amendment	Health Home Community Health Teams
Alabama	Somewhat likely	Somewhat likely	Somewhat likely		Somewhat likely	Somewhat likely	Somewhat likely
Alaska	Unlikely	Somewhat likely		Very likely	Very likely	Very likely	Very likely
Arizona	Unknown	Very likely	Unlikely		Unknown	Unknown	Unknown
Arkansas	Unknown	Unknown		Very likely	Unknown	Very likely	Unknown
California	Unlikely	Unlikely		Very likely	Very likely	Very likely	Very likely
Colorado	Unknown	Unknown	Somewhat likely		Unknown	Unknown	Unknown
Connecticut	Somewhat likely	Unknown		Very likely	Unknown	Somewhat likely	Unknown
Delaware							
District of Columbia	Very likely	Unknown		Very likely	Very likely	Very likely	Very likely
Florida	Unlikely	Unknown	Very likely		Unknown	Somewhat likely	Unknown
Georgia	Unlikely	Unknown		Very likely	Unlikely	Unlikely	Unlikely
Hawaii	Unknown	Unlikely		Very likely	Unknown	Unknown	Unknown
Idaho	Unknown	Very likely	Very likely		Very likely	Very likely	Very likely
Illinois	Unlikely	Unlikely		Very likely	Unknown	Unknown	Unknown
Indiana	Unknown	Unknown		Very likely	Unknown	Unknown	Unknown
Iowa	Somewhat likely	Somewhat likely		Very likely	Unknown	Very likely	Very likely
Kansas	Unlikely	Somewhat likely		Very likely			
Kentucky	Unknown	Unknown		Unknown	Unknown	Unknown	Unknown
Louisiana	Unlikely	Somewhat likely		Very likely	Somewhat likely	Somewhat likely	Somewhat likely
Maine	Somewhat likely	Unknown	Very likely		Very likely	Very likely	Very likely
Maryland	Unknown	Unknown		Very likely	Unknown	Unknown	Unknown
Massachusetts	Somewhat likely	Somewhat likely	Very likely		Somewhat likely	Somewhat likely	Somewhat likely

Table X (continued)

	State Balancing Incentive Program	Community First Choice	MFP New Program	MFP Extend Existing Program	Health Home Planning Grant	Health Home State Plan Amendment	Health Home Community Health Teams
Michigan	Somewhat likely	Unlikely		Very likely	Unknown	Unknown	Unknown
Minnesota	Unlikely	Unknown	Somewhat likely		Unlikely	Very likely	Very likely
Mississippi	Unknown	Somewhat likely	Somewhat likely		Somewhat likely	Somewhat likely	Somewhat likely
Missouri	Unknown	Unknown		Very likely	Unknown	Unknown	Unknown
Montana	Unknown	Unknown	Unlikely		Unknown	Unknown	Unknown
Nebraska	Unknown	Unknown		Unknown	Unknown	Unknown	Unknown
Nevada	Unlikely	Unlikely	Somewhat likely		Somewhat likely	Unknown	Somewhat likely
New Hampshire	Unknown	Unknown		Very likely	Unknown	Very likely	Unknown
New Jersey	Very likely	Very likely		Very likely	Unknown	Very likely	Somewhat likely
New Mexico	Unlikely	Somewhat likely	Very likely		Very likely	Very likely	Very likely
New York	Somewhat likely	Somewhat likely		Very likely	Unknown	Very likely	Somewhat likely
North Carolina	Very likely	Somewhat likely		Very likely	Very likely	Very likely	Somewhat likely
North Dakota							
Ohio	Unknown	Unknown		Somewhat likely	Somewhat likely	Very likely	Unknown
Oklahoma	Somewhat likely	Somewhat likely		Very likely	Unknown	Somewhat likely	Somewhat likely
Oregon	Unlikely	Somewhat likely		Very likely	Unknown	Somewhat likely	Somewhat likely
Pennsylvania	Very likely	Very likely		Very likely	Very likely	Somewhat likely	Unknown
Puerto Rico*							
Rhode Island							
South Carolina	Unlikely	Unknown	Unlikely		Unlikely	Somewhat likely	Somewhat likely
South Dakota*							
Tennessee	Somewhat likely	Unlikely	Very likely		Unknown	Somewhat likely	Somewhat likely

Table X (continued)

	State Balancing Incentive Program	Community First Choice	MFP New Program	MFP Extend Existing Program	Health Home Planning Grant	Health Home State Plan Amendment	Health Home Community Health Teams
Texas	Unlikely	Unlikely		Somewhat likely	Unknown	Unknown	Unknown
Utah	Somewhat likely	Somewhat likely	Very likely		Unknown	Unknown	Unknown
Vermont	Unlikely	Unknown	Unlikely		Unknown	Unknown	Unknown
Virgin Islands*							
Virginia	Unknown	Very likely		Very likely	Unknown	Unknown	Unknown
Washington	Unlikely	Somewhat likely		Very likely	Unknown	Somewhat likely	Somewhat likely
West Virginia							
Wisconsin	Unlikely	Unlikely		Very likely	Unlikely	Unknown	Unknown
Wyoming	Unknown	Unknown	Unlikely		Very likely	Very likely	Somewhat likely

* Did not participate in the survey.