RAISING EXPECTATIONS

2014
SECOND EDITION

A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers

Susan C. Reinhard, Enid Kassner, Ari Houser, Kathleen Ujvari, Robert Mollica, and Leslie Hendrickson

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We seek opportunities for change that are bold, catalytic, and transformational to better connect health care and supportive services. These innovations put people first by helping them stay in their homes and communities whenever possible in order to advance aging with dignity, choice, and independence.

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ABSTRACT

This *State Long-Term Services and Supports (LTSS) Scorecard* is a multidimensional approach to measure state-level performance of LTSS systems that assist older people, adults with disabilities, and their family caregivers. This second edition of the *State LTSS Scorecard* measures LTSS system performance across five key dimensions: (1) affordability and access, (2) choice of setting and provider, (3) quality of life and quality of care, (4) support for family caregivers, and (5) effective transitions.

Performance varies tremendously across the states, with LTSS systems in leading states having markedly different characteristics than those in lagging states. LTSS performance is gradually improving, both nationally and in most states. Progress is notable in many areas where public policy has a direct impact, including performance of the Medicaid safety net and legal and system supports for family caregivers. But the pace of improvement must accelerate as the Baby Boom Generation moves toward advanced ages.

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Preface

The AARP Foundation, The Commonwealth Fund, and The SCAN Foundation are pleased to sponsor this second edition of the *State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers.* We hope it will build on the success of the first *Scorecard* by offering policymakers, stakeholders, and advocates a way to analyze state long-term services and supports (LTSS) systems and target areas for improvement.

Long-term services and supports help older people and adults with disabilities perform activities of daily living that would be difficult or impossible for them to perform on their own. Services and supports are delivered in a variety of settings, but nearly everyone prefers to remain at home. Family caregivers often provide the support to help their loved ones remain at home and the oversight to ensure that the care they receive in nursing homes, assisted living, or hospitals is appropriate and addressing their needs. But family caregivers also need services and supports to avoid burnout.

Most Americans will eventually rely on the LTSS system, either as consumers or as caregivers providing support to family and friends. An aging population, changing demographics, the rising cost of LTSS, and tight federal and state budgets are driving a growing national concern about LTSS for both consumers and policymakers.

Comprehensive information about state and national LTSS systems is hard to find. Public financing of LTSS programs allows people with low or modest incomes access to services that would otherwise be unaffordable. But too many Americans deplete their life savings and end up paying out of pocket for services.

States play an important role in increasing the choices available to consumers, ensuring those choices meet high-quality standards, and increasing access to LTSS for those who would otherwise be left behind. While the federal Commission on Long-Term Care released a report last year with goals for LTSS reform, individual states remain the centers of innovation and progress.

State and national leaders must build on the incremental gains observed so far. We hope it will build on the success of the first Scorecard by offering policymakers, stakeholders, and advocates a way to analyze state LTSS systems and target areas for improvement.

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On the Scorecard National Advisory Panel, we would like to thank Lisa Alecxih of The Lewin Group; Robert Applebaum of Miami University of Ohio; Shawn Bloom of the National PACE Association; Jennifer Burnett of the Centers for Medicare & Medicaid Services; Brian Burwell of Truven Health Analytics; Penny Feldman of the Visiting Nurse Service of New York; Mike Fogarty of the Oklahoma Health Care Authority; Charlene Harrington of the University of California, San Francisco; Lauren Harris-Kojetin of the National Center for Health Statistics; Bob Hornyak of the U.S. Administration on Aging; Carol Irvin of Mathematica Policy Research; Rosalie Kane of the University of Minnesota; Ruth Katz of the U.S. Department of Health and Human Services; Kathleen Kelly of the National Center on Caregiving, Family Caregiver Alliance; Mary B. Kennedy of the Association for Community Affiliated Plans; Alice Lind of the Washington State Health Care Authority; Kevin Mahoney of Boston College; Vince Mor of Brown University; Lee Page of Paralyzed Veterans of America; Pamela Parker of the State of Minnesota Department of Human Services; D.E.B. Potter of the Agency for Healthcare Research and Quality; Martha Roherty of the National Association of States United for Aging and Disabilities; Elaine Ryan from AARP State Advocacy & Strategy Integration; Paul Saucier of Truven Health Analytics; William Scanlon of the National Health Policy Forum; Mark Sciegaj of Penn State University; James Toews of the U.S. Department of Health and Human Services, Administration for Community Living; and Jed Ziegenhagen of the Colorado Department of Health Care Policy and Financing.

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We would like to thank the members of the 2010 National Advisory Panel, who developed a working definition of long-term services and supports (LTSS) and a vision of what would constitute a high-performing LTSS system, as well as the members of the 2010 Technical Advisory Panel, who helped develop a list of indicators to include in the ***Scorecard***. A full list of those panel members can be found in Appendix B1.

We would also like to thank the following individuals who provided expert consultation during the development of the report: Carrie Blakeway of The Lewin Group; Alice Bonner of the Centers for Medicare & Medicaid Services; Katherine Brown of the MIT AgeLab; Joy Cameron of the National PACE Association; Eric Carlson of the National Senior Citizens Law Center; Joseph F. Coughlin of the MIT AgeLab; Cheryl L. Fletcher of APS Asset Preservation Strategies; Steve Eiken of Truven Health Analytics; Dana Ellis of the MIT AgeLab; Ilene Henshaw of AARP State Advocacy & Strategy Integration; Alice Hogan of the Centers for Medicare & Medicaid Services; Gail Hunt of the National Alliance for Caregiving; Gavin Kennedy of the U.S. Department of Health and Human Services; Anne Montgomery of the U.S. Senate Special Committee on Aging; Ed Mortimore of the Centers for Medicare & Medicaid Services; Terence Ng of the University of California, San Francisco; Mary Beth Ribar of the Centers for Medicare & Medicaid Services; Robert Rosati of the Visiting Nurse Service of New York; Diana Scully, formerly of the National Association of States United for Aging and Disabilities; Manisha Sengupta of the National Center for Health Statistics; and Anita Yuskauskas of the Centers for Medicare & Medicaid Services.

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LIST OF EXHIBITS

EXECUTIVE SUMMARY

Our nation faces an unprecedented public policy challenge: how to transform our system of long-term services and supports (LTSS) to promote independence among older adults and people with disabilities, and provide support for the family members who help them. In just 12 years, the leading edge of the Baby Boom Generation will enter its 80s, placing new demands on the LTSS system. This generation, and those that follow, will have far fewer potential family caregivers to provide unpaid help. Despite this looming care gap, we lack a national solution to providing LTSS. That job still falls mainly to the states. Where you live really matters because there are very large differences across the states in how well they do this job. While many policymakers and advocates are working hard to improve their state LTSS systems and making important incremental changes, the pace of change is slow. A few states stand out for leading the way. We need to learn from these states, bring more national solutions to the table, and pick up the pace of change.

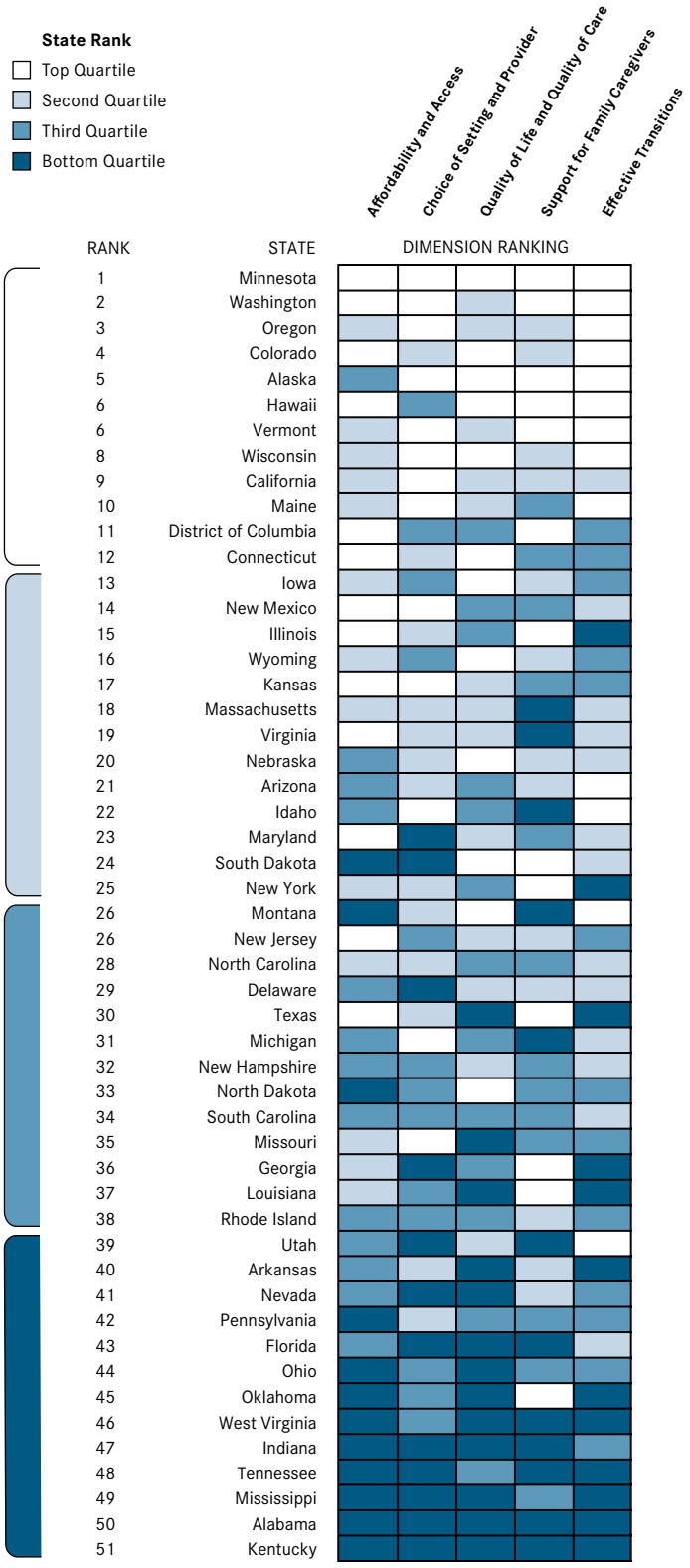
One way to accelerate progress is to articulate a vision of a high-performing LTSS system, operationalize that vision in a way that can be measured, develop a baseline of indicators, track changes over time, and use this information to focus on policies and other strategies to advance further and faster toward that vision. This second *State LTSS Scorecard* aims to do just that by building on the vision and starting set of indicators published in the 2011 edition. It measures state LTSS system performance across five dimensions: (1) affordability and access, (2) choice of setting and provider, (3) quality of life and quality of care, (4) support for family caregivers, and (5) effective transitions.

Exhibit 1 shows each state's rankings as well as its quartile of performance in each of the five dimensions. Within the five dimensions, the *Scorecard* includes 26 indicators. Exhibit 2 lists the indicators that compose each dimension, giving previous (or "baseline") data and the most recent performance, including the range of performance and the median. Thus, this *Scorecard* not only takes the pulse of the nation for how well we are doing on providing services and supports to people who use the LTSS system, but it also assesses change on the 19 indicators for which comparable data are available to show trends.

Many aspects of performance measured by the 26 indicators are related. When costs are high for people who pay privately and do not have long-term care insurance, they will more quickly deplete their life savings and turn to the public safety net. If that safety net is inadequate, people may rely so heavily on family caregivers that those caregivers damage their own health and well-being. States that have not built an infrastructure of services and care settings that offer residential alternatives will strain their own resources by paying more for costly nursing homes. The *Scorecard* shows that states that rely heavily on nursing homes for LTSS also demonstrate less effective transitions across care settings. This means that people with complex needs getting care at home or in nursing homes are more likely to experience inappropriate and costly hospitalizations and inadequate support in moving from a nursing home back into the community. And poor quality of care, in all settings, leads to worse health outcomes that contribute to higher costs for both the medical and LTSS systems.

Exhibit 1

State Scorecard Summary of LTSS System Performance Across Dimensions



Note: Rankings are not entirely comparable to the 2011 Scorecard rankings in Exhibit A2. Changes in rank may not reflect changes in performance, and should not be interpreted as such.
Source: State Long-Term Services and Supports Scorecard, 2014.

Major Findings

Minnesota, Washington, Oregon, Colorado, Alaska, Hawaii, Vermont, and Wisconsin, in this order, ranked the highest across all five dimensions of LTSS system performance. These eight states clearly established a level of performance at a higher tier than other states—even other states in the top quartile. But even these top states have ample room to improve.

The cost of LTSS continues to outpace affordability for middle-income families, and private long-term care insurance is not filling the gap.

A major finding of the 2011 *Scorecard* is that the cost of LTSS was unaffordable for middle-income families in all states, even for those in the top states. Nationally, this situation did not improve; in three states, nursing home costs became even less affordable.

- On average, nursing home costs would consume 246 percent of the median annual household income of older adults. Even in the five most affordable states, the cost averages 171 percent of income, and in the least affordable states it averages an astonishing 382 percent of income.
- Home care generally is more affordable than nursing home care, allowing consumers to stretch their dollars further. But at an average of 84 percent of median income, the typical older family cannot sustain these costs for long periods.

This finding has profound implications for the entire LTSS system. States have limited ability to control the costs of care for those who pay privately. However, when the cost of such care far exceeds families' ability to pay it, more people will face spending down their life savings and ultimately qualify for Medicaid, which is funded through state and federal dollars. Despite national campaigns to encourage people to purchase private long-term care insurance, very few people do, usually citing its high cost. Only 10 percent of Americans aged 50 and older have these policies.[1] With instability in this insurance industry, coverage is not increasing. People are on their own, with a state's Medicaid program providing the only safety net.

Public policy makes a difference.

The private sector can do much to help achieve the vision of a high-performing LTSS system, such as developing more affordable care options, employing more people with disabilities, and promoting more effective transitions between care settings. But public policy directly influences many key indicators that have a clear road map toward improved performance. These include measures of several Medicaid policies, resource centers to help people of all incomes access information, supports for family caregivers (especially those who are employed), and laws that permit nurses to delegate tasks to direct care workers to help maintain consumers' health.

Several of these measures appear to drive overall LTSS state system performance, particularly two that had the strongest relationship to overall performance. The first is the states' efforts to provide LTSS to low- and moderate-income adults with disabilities through their Medicaid or other state-funded programs. The second is balancing spending on LTSS, shifting funds away from an overreliance

Exhibit 2

List of 26 Indicators in State Scorecard on Long-Term Services and Supports

Indicator	Most Recent Data				Baseline Data			
	Data Year	Median Value	Bottom Value	Top Value	Data Year	Median Value	Bottom Value	Top Value
Affordability and Access								
Median annual nursing home private pay cost as a percentage of median household income age 65+	2013	234%	456%	168%	2010	224%	444%	166%
Median annual home care private pay cost as a percentage of median household income age 65+	2013	84%	111%	47%	2010	89%	125%	55%
Private long-term care insurance policies in effect per 1,000 population age 40+	2011	44	26	130	2009	41	28	300
Percent of adults age 21+ with ADL disability at or below 250% of poverty receiving Medicaid or other government assistance health insurance	2011-12	51.4%	42.3%	78.1%	2008-09	49.9%	38.7%	63.6%
Medicaid LTSS participant years per 100 adults age 21+ with ADL disability in nursing homes or at/below 250% poverty in the community	2009	42.3	16.3	85.2	2007	36.6	15.9	74.6
Aging and Disability Resource Center functions (composite indicator, scale 0-70)	2012	54	14	67	2010	***	***	***
Choice of Setting and Provider								
Percent of Medicaid and state-funded LTSS spending going to HCBS for older people and adults with physical disabilities	2011	31.4%	14.5%	65.4%	2009	29.8%	10.7%	64.6%
Percent of new Medicaid aged/disabled LTSS users first receiving services in the community	2009	50.7%	21.6%	81.9%	2007	49.8%	21.8%	83.3%
Number of people participant-directing services per 1,000 adults age 18+ with disabilities	2013	8.8	0.03	127.3	*	*	*	*
Home health and personal care aides per 1,000 population age 65+	2010-12	33	13	76	2007-09	29	16	80
Assisted living and residential care units per 1,000 population age 65+	2012-13	27	11	125	2010	28	7	78
Quality of Life and Quality of Care								
Percent of adults age 18+ with disabilities in the community usually or always getting needed support	2010	71.8%	66.6%	79.1%	2009	68.5%	61.3%	78.2%
Percent of adults age 18+ with disabilities in the community satisfied or very satisfied with life	2010	86.7%	82.5%	92.1%	2009	85.0%	80.2%	92.4%
Rate of employment for adults with ADL disability ages 18–64 relative to rate of employment for adults without ADL disability ages 18–64	2011-12	23.4%	13.8%	37.2%	2009-10	24.2%	16.7%	44.4%
Percent of high-risk nursing home residents with pressure sores	2013	5.9%	9.0%	3.0%	*	*	*	*
Nursing home staffing turnover: ratio of employee terminations to the average number of active employees	2010	38.1%	72.0%	15.4%	2008	46.9%	76.9%	18.7%
Percent of long-stay nursing home residents who are receiving an antipsychotic medication	2013	20.2%	27.6%	11.9%	**	**	**	**
Support for Family Caregivers								
Legal and system supports for family caregivers (composite indicator, scale 0-14.5)	2012-13	3.00	0.50	8.00	2008-10	***	***	***
Number of health maintenance tasks able to be delegated to LTSS workers (out of 16 tasks)	2013	9.5	0	16	2011	7.5	0	16
Family caregivers without much worry or stress, with enough time, well-rested	2011-12	61.6%	54.3%	72.8%	2010	60.8%	53.3%	66.6%
Effective Transitions								
Percent of nursing home residents with low care needs	2010	11.7%	26.7%	1.1%	2007	11.9%	25.1%	1.3%
Percent of home health patients with a hospital admission	2012	25.5%	32.3%	18.9%	*	*	*	*
Percent of long-stay nursing home residents hospitalized within a six-month period	2010	18.9%	31.1%	7.3%	2008	18.9%	32.5%	8.3%
Percent of nursing home residents with moderate to severe dementia with one or more potentially burdensome transitions at end of life	2009	20.3%	39.5%	7.1%	**	**	**	**
Percent of new nursing home stays lasting 100 days or more	2009	19.8%	35.0%	10.3%	**	**	**	**
Percent of people with 90+ day nursing home stays successfully transitioning back to the community	2009	7.9%	4.8%	15.8%	**	**	**	**

* Baseline data not comparable to current data.
** Baseline data not available.
*** Change over time data for these composite indicators are based on a partial baseline (data not shown); see Exhibits A6 and A14 in Appendix A for additional detail.
Source: State Long-Term Services and Supports Scorecard, 2014.

on nursing homes to support more funding of home- and community-based services (HCBS). Both are key indicators of performance, with dramatic variation as discussed below.

The *Scorecard* emphasizes several key findings related to public policy:

- Tremendous variation exists in the adequacy of the states' Medicaid LTSS safety nets.

  The *Scorecard* finds substantial variation in the reach of the Medicaid LTSS safety net to people with low and moderate incomes and a disability. The average rate of coverage in the top five states (68 per 100 adults) was more than three times the average in the bottom five states (22 per 100 adults). As highlighted above, this basic measure of program access is the indicator most strongly associated with overall LTSS state system performance.

- Once people access Medicaid, shifting service delivery toward home- and community-based services is critical.

  Regardless of age or type of disability, the desire to remain in one's home is nearly universal. Balancing Medicaid LTSS by shifting more resources from institutions to care in homes and other community-based settings has been the centerpiece of advocacy efforts for decades. The range of state variation is enormous. The top five states allocated an average of 62.5 percent of LTSS dollars for older people and adults with physical disabilities for HCBS, nearly four times the proportion in the bottom five states, which allocated an average of just 16.7 percent. The national average was 39.3 percent.

  Another measure of balancing Medicaid looks at where a person who is newly approved by the state to receive LTSS services under Medicaid initially receives those services—in an institution or in their home or other community setting. States that are committed to serving people in their own homes (or a homelike option) develop policies and procedures to make that possible. When that infrastructure is not in place, people have no choice but to enter an institution because they cannot wait weeks or months for services to be approved and delivered. In the top five states, 77.6 percent of new LTSS users were served in HCBS settings—more than three times the performance of the bottom five states, in which only 25.6 percent of new LTSS users were served in HCBS.

- Few HCBS consumers have the choice to direct their own services.

  Hiring the people who will help you bathe, dress, eat, use the toilet, and move from one place to another is fundamental to having more personal control over what happens to you on a daily basis. Many consumers who need LTSS want that basic control over their lives; yet in most states, few consumers have this option. By far, California leads the nation in the proportion of people with disabilities that self-direct their services (127 people per 1,000 adults with a disability in the state) compared to the lowest states, in which less than 1 person per 1,000 has this option.

- Greater efforts are needed to increase the employment of adults with disabilities.

Across the nation, adults with disabilities are far less likely to be employed than are those without a disability. But the relative rate of employment of adults with disabilities in the top five performing states was double that found in the bottom five states: 32 percent compared to 16 percent. In addition to the obvious benefit of income gained through employment, workforce participation enhances social connection, identity, and sense of purpose.

- States play a key role in minimizing the inappropriate use of antipsychotic medications in nursing homes.

  As states have dramatically reduced the use of physical restraints in nursing homes, some appear to have substituted the inappropriate use of sedating antipsychotic medications. There is a substantial range of performance in this area, and all states must work to eliminate inappropriate prescribing for vulnerable nursing home residents.

- More states or jurisdictions are enacting laws that support family caregivers.

  Given the critical role that caregivers play in support for people with LTSS needs, support for family caregivers is an area of great public policy interest. The range of performance was substantial, and new provisions sometimes extended only to select jurisdictions within a state. Among the components measured in this indicator are the extent to which the state exceeds federal requirements under the Family and Medical Leave Act, the state's paid family leave and mandatory paid sick day provisions, and its policies to prevent discrimination toward working caregivers. Many of these policies to support family caregivers extend to actions in the private sector. Because most family caregivers are employed, ensuring access to leave and protection from discrimination is critical to helping them avoid burnout and keep working—factors that can help caregivers maintain their own health and financial security.

- Allowing nurses to delegate health maintenance tasks to direct care workers in home settings helps family caregivers and is more cost-effective for public programs.

  Many LTSS consumers need help with such health maintenance tasks as taking medications, giving tube feedings, or managing bowel and bladder care (for example, giving enemas or changing catheters). For many people with disabilities, performing these tasks is as routine as other activities of daily living, like bathing and dressing. In all states, nurses can teach family caregivers to perform these health maintenance tasks. But in many states nurses are not allowed to delegate such tasks to a paid direct care worker assisting a consumer at home with other activities of daily living. In those states, the family caregiver often becomes the only person who can do this work. Looking at 16 specific tasks, the *Scorecard* found that some states allow nurses to delegate all 16, whereas other states do not permit any delegation. Changing nurse practice laws can help family caregivers and potentially save public dollars by broadening the type of workers who can capably perform these tasks.

States with more effective transitions have lower use of nursing homes and generally score better on both choice and quality.

The addition of the effective transitions dimension in this *Scorecard* is important. Changes between such care settings as home, hospital, and nursing home involve transitions that can be critical points in maintaining the continuity of care. We find that the top-ranking states in overall system performance generally ranked in the top quartile of performance on this new dimension. High-performing states tend to minimize disruptive transitions among care settings and make efforts to return nursing home residents to home- and community-based settings that most people prefer.

- As nursing home alternatives have flourished, individuals who can remain in less restrictive environments generally prefer to do so. Therefore, states in which a relatively high proportion of nursing home residents have low care needs may not be taking appropriate steps to transition these individuals to HCBS settings. In the top five states, just 4.6 percent of nursing home residents had low care needs, compared to the bottom five states, in which 23 percent of residents had such needs—a level five times higher.
- Excessive transitions between nursing homes and hospitals are disruptive to patients and their families and costly to the system. States can minimize these transitions by providing better care in nursing homes, addressing residents' needs before acute conditions develop, or treating them in the nursing home rather than sending them to a hospital. In the top five states, 10.3 percent of nursing home residents were hospitalized, almost a third the level in the bottom five states, which averaged 27.9 percent.
- Vulnerable nursing home residents at the end of life should not be subjected to excessive hospitalizations or other unnecessary transfers, referred to here as "burdensome transitions." In the top five states, an average of 9.3 percent of nursing home residents with moderate to severe dementia experienced a potentially burdensome transition at end of life, while the bottom five states averaged 34.8 percent, almost four times as high.
- People who enter nursing homes and remain for 100 or more days are far less likely to return to the community than are those who have shorter stays. In the top five states, 12.9 percent of nursing home residents remained for 100 or more days, less than half the average (27.9 percent) in the bottom five states.
- A measure of high performance is the states' continuing efforts to help nursing home residents who would prefer to reside in the community make this transition. On average, the top five states transitioned 13.1 percent of long-stay nursing home residents to HCBS settings, compared to only 5.3 percent in the bottom five states.

Some states have made progress on important indicators, but there are persistent differences in state performance.

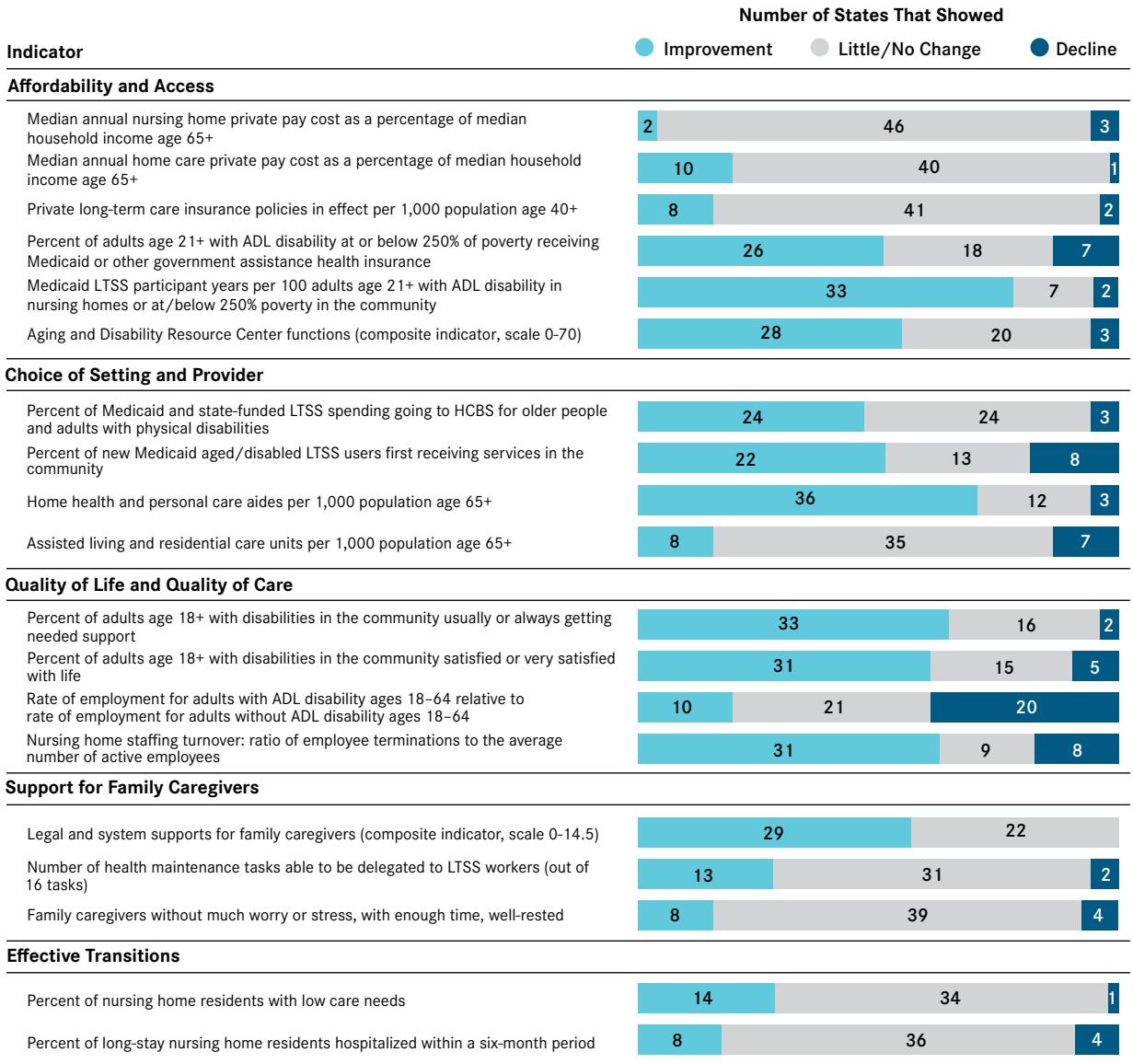
On many indicators, there was little to no change in most states. But when states did show substantial change (more than 10 percent), they more often improved than declined (see

Exhibit 3). Although most improvements were modest, some are noteworthy, especially during the difficult budget years following the Great Recession. Two noteworthy accomplishments:

- More than half of the states (26) improved their Medicaid safety net for low-income people with disabilities, many of whom had already spent all they had saved in their lifetimes to pay for services before they applied to Medicaid for help.
- More than half of the states (28) improved the functioning of Aging and Disability Resource Centers that help people of all

Exhibit 3

Change in State Performance by Indicator



Notes: Improvement or decline refers to a change between the baseline and current time periods of at least 10 percent or equivalent (see Appendix B5 for detail). Showing trend for the 19 of 26 total indicators–trend data are not available for all indicators.
Source: State Long-Term Services and Supports Scorecard, 2014.

incomes find the services they need. The Federal Administration for Community Living and the Centers for Medicare & Medicaid Services have invested both funding and technical assistance to stimulate this infrastructure development, which takes considerable collaboration across state departments to create.

Despite these improvements, where you live is still the best predictor of the services you will receive when and where you need them. (See Appendix A3 for a breakdown of state performance on all indicators by quartile.) The variation between states remained tremendous on most indicators. High-performing states had indicator scores that doubled or tripled (or more) the rates attained by lower-performing states. While improvement of 10 percent (the threshold used to show meaningful change) is a notable achievement, it is not enough to cross the gap between low- and high-performing states, where differences routinely exceed 200 percent. (See Exhibit 2 for the range of performance on each indicator and Appendix A4 for the count of indicators improving, declining, and staying about the same for every state.)

Impact of Improved Performance

What would significant improvement in a state's performance look like? What would it mean to older people, adults with physical disabilities, and family caregivers? One way to capture the potential impact of improved performance is to benchmark the top-performing state in a specific indicator and measure what would happen if the rest of the states could match that performance. For example:

- People cannot have the option of remaining at home if there aren't enough workers to provide services. If all states rose to Minnesota's level of performance, 1.5 million more personal care, home care, and home health aides would be available to provide LTSS in communities nationwide.
- States that effectively serve new LTSS users in their homes or other community settings honor consumer preferences and save the costly public expense of unnecessary nursing home use. If all states rose to Alaska's level of performance on this measure, approximately 200,000 more people per year would first receive services in the community instead of in a nursing home.
- Some states continue to have people with low care needs receive services in nursing homes. If all states achieved the rate found in Maine, over 150,000 more people per year would be served in home and community settings.
- States vary in the extent to which nursing home residents are able to make a transition back to the community. If all states achieved the level found in Utah, more than 100,000 individuals per year would be able to leave a nursing home for a more homelike setting.

The Need for Action

The *Scorecard* clearly shows that where one lives has a tremendous impact on the experience that people and their families are likely to have when the need for LTSS arises. (See Exhibit 4.) Positive trends exist, but enormous variation among the states continues to affect the millions of people

who encounter the LTSS system. We still have very far to go.

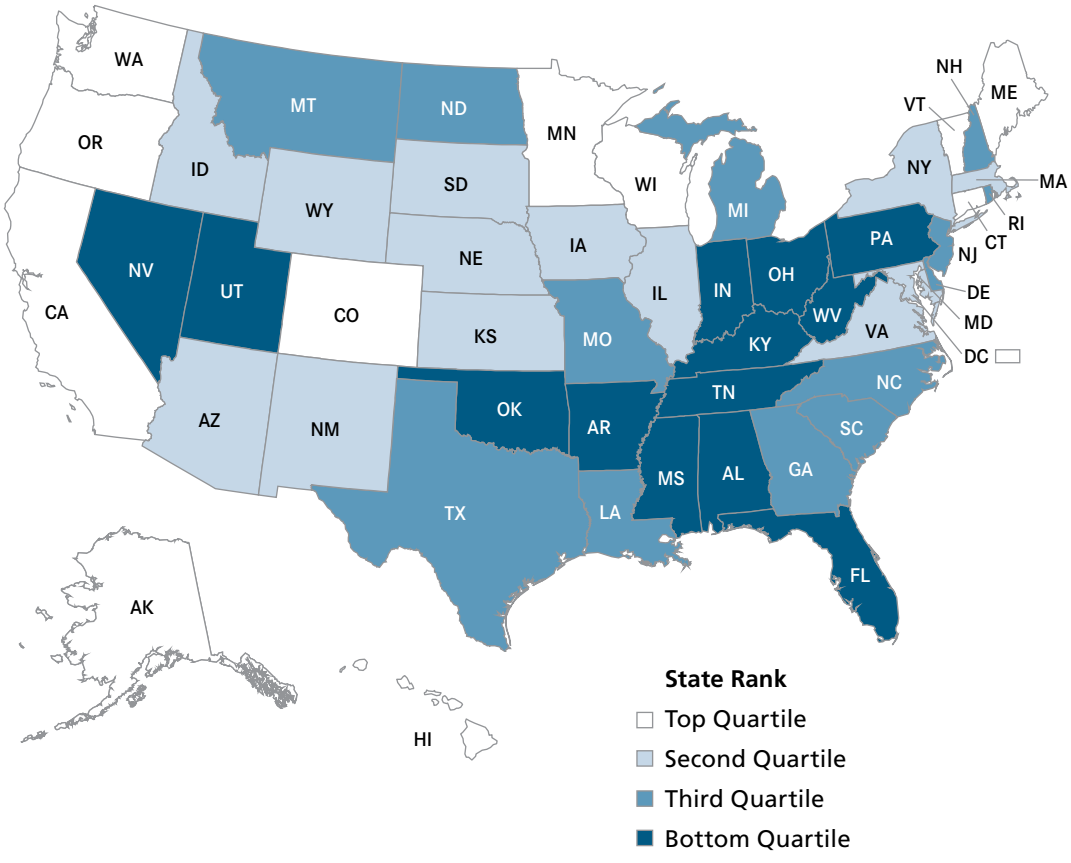
Despite decades of effort, the private insurance market for long-term care reaches very few people, even in leading states. For most middle-income families, care is unaffordable. As a result, families are on their own, often spending down to Medicaid eligibility or placing unrealistic and unsustainable demands on family caregivers to manage all of their complex needs.

Two things are clear. First, *we need a rational approach at the federal level to guide the states and to establish standards for LTSS system performance below which no state should fall*. The 2013 federal Commission on Long-Term Care began a discussion of the steps necessary to support family caregivers, improve quality of services, and establish mechanisms for financing LTSS. Until our nation improves, middle-income families will continue struggling to pay for LTSS, often impoverishing themselves—at great personal and family distress—to get the services they need.

Second, despite the lack of strong federal solutions, *state leadership and vision make a difference*. Willingness to experiment, innovate, and challenge the status quo are the hallmarks of successful states. Leading states combine these characteristics with a commitment to the rights of people with disabilities and older people to live with dignity in the setting of their

Exhibit 4

State Ranking on Overall LTSS System Performance



Source: State Long-Term Services and Supports Scorecard, 2014.

choice, supported by the services they and their family caregivers need to maximize their independence. They build Medicaid programs that serve as a safety net.

Slow and steady progress has started the nation's move toward better LTSS system performance. But this gradual rate of progress will not be adequate to meet the needs of aging baby boomers. While large numbers of boomers are not likely to need LTSS for 20 or so years, major system changes cannot be accomplished overnight. It's time to pick up the pace.

Our hope is that this *Scorecard* will help provide targets for improvement and motivate state action in a more positive direction. With concerted work across the multiple dimensions, it should be possible to accelerate the pace of change. Success depends on states taking initiative and making a commitment to do better. In partnership with federal initiatives and private-sector actions, states have the capacity to improve the delivery of LTSS, thereby improving the lives of older adults, people with disabilities, and their family caregivers. In the future, where you live should matter less than it does today when it comes to having choices and receiving high-quality, well-coordinated care.

INTRODUCTION

Across the United States, older adults, people with disabilities, and family caregivers are struggling to find and afford the services and supports they need to maintain their independence and quality of life. We need to transform our system of long-term services and supports (LTSS), and we need to do it now. The population is growing older, more people are developing disabilities at younger ages, and family caregivers are walking a high-wire tightrope in trying to balance family and work responsibilities. LTSS issues touch all segments of society: individuals of all ages and incomes, state and federal policymakers, and providers of services.

WHAT DOES THE SCORECARD DO?

The *Scorecard* measures system performance from the viewpoint of the users of services and their families. State policymakers often have direct control over key indicators measured, and they can influence other indicators through oversight activities and incentives. Other indicators are affected by private-sector policies and practices. Our goal is for the *Scorecard* to stimulate a dialogue among key stakeholders, encouraging them to collaborate on strategies for improving the state's LTSS system.

Building on the first edition in 2011, this second *State LTSS Scorecard* seeks to provide states with a uniform set of performance benchmarks against which they can compare themselves to other states and measure their progress toward meeting the needs of older people, adults with disabilities, and their family caregivers.

The first edition of *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* was jointly released by the AARP Public Policy Institute, The Commonwealth Fund, and The SCAN Foundation. It established a framework for assessing state LTSS system performance by defining and measuring the components of a high-performing system. Using this framework, the second edition adds new indicators that focus on care transitions, a key dimension of performance. It compares the states' performance across 26 indicators using the most recent data available. This report also assesses

changes in state LTSS system performance between the first and second *Scorecards* on the 19 indicators for which we have time trends, generally covering a period of 2 to 3 years.

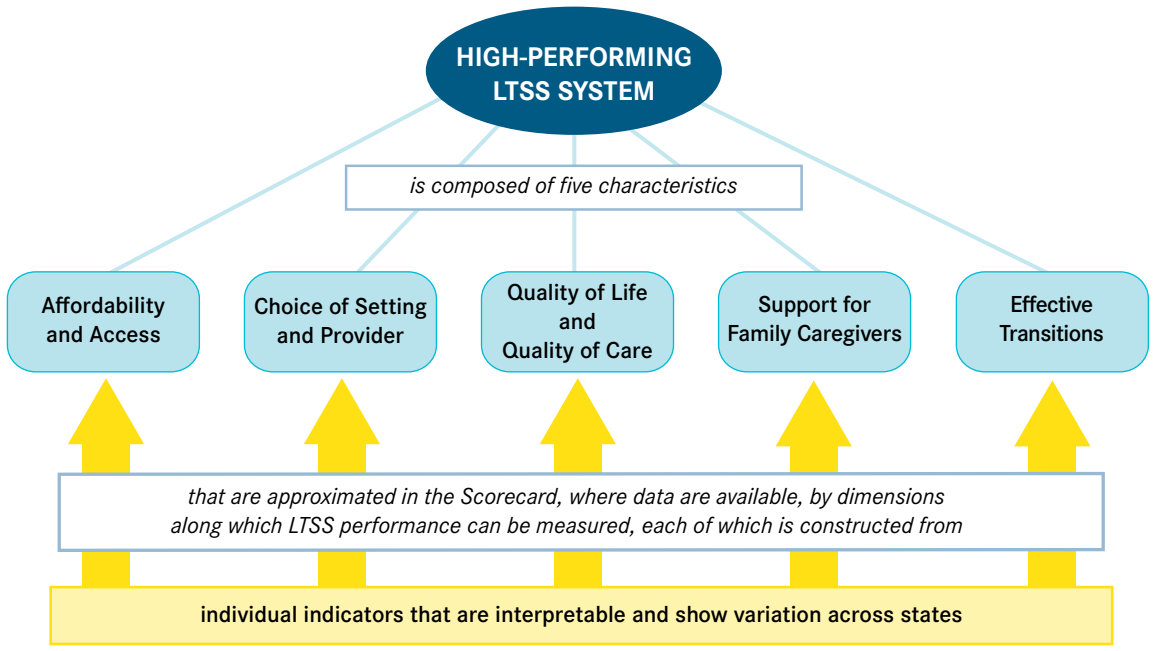
The 2011 *Scorecard* identified five key characteristics of a high-performing system but was missing sufficient indicators on transitions to assess performance in that area. By adding indicators, this *Scorecard* now captures performance on key aspects of all five areas (see Exhibit 5) defined as:

1. **Affordability and access:** consumers can easily find and afford the services they need, and there is a safety net for those who cannot afford services.
2. **Choice of setting and provider:** a person-centered approach to LTSS places high value on allowing consumers to exercise choice and control over where they receive services and who provides them.
3. **Quality of life and quality of care:** services maximize positive outcomes and consumers are treated with respect. Personal preferences are honored when possible.
4. **Support for family caregivers:** family caregivers' needs are assessed and addressed so that they can continue in their caregiving role without being overburdened.
5. **Effective transitions:** LTSS are arranged to integrate effectively with health care and social services, minimizing disruptions such as hospitalizations, institutionalizations, and transitions between settings.

The framework for assessing LTSS system performance and identifying the data to measure it initially were developed in consultation with a National Advisory Panel

Exhibit 5

Framework for Assessing LTSS System Performance



Source: State Long-Term Services and Supports Scorecard, 2014.

and Technical Advisory Panel as part of the development of the first edition of the *Scorecard* (see Exhibit 5). Refinements to the starting set of indicators were developed in consultation with a Scorecard National Advisory Panel (SNAP). The expert members of all advisory panels are listed in Appendix B1. The SNAP was instrumental in providing and evaluating the merits of the data indicators that populate each of the five dimensions. All indicators met the selection criteria: data had to be clear, unambiguous, important, meaningful, and available for all states. Several indicators were constructed from a range of data in a related area, enabling us to rank states in areas of performance that would otherwise be difficult to assess. Appendices B2 to B4 describe each indicator and how the indicators were developed, including any changes in indicators between the first and second *Scorecards*. Appendix B5 describes how we measured change in performance over time.

WHAT ARE HOME- AND COMMUNITY-BASED SERVICES?

Home- and community-based services (HCBS) refer to assistance with daily activities that generally helps older adults and people with disabilities remain in their homes. Many people with LTSS needs (also see "What Are Long-Term Services and Supports?" box) require individualized services or supports to live in a variety of settings: their own homes or apartments, assisted living facilities, adult foster homes, congregate care facilities, or other supportive housing.

All 50 states and the District of Columbia are ranked on each of the five dimensions. Except for a few instances where data were missing, all states also were ranked on each individual indicator (see "A Note on Methodology" box). The ranks indicate relative performance among the states, not an absolute measure of how well a state performs. Low-ranking states can see what already has been accomplished elsewhere,

WHAT ARE LONG-TERM SERVICES AND SUPPORTS?

Long-term services and supports (LTSS) may involve, but are distinct from, medical care for older people and adults with disabilities. Definitions of the term vary, but in this report we define LTSS as:

Assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) provided to older people and other adults with disabilities who cannot perform these activities on their own due to a physical, cognitive, or chronic health condition that is expected to continue for an extended period of time, typically 90 days or more.

LTSS include human assistance, supervision, cueing and standby assistance, assistive technologies and devices and environmental modifications, health maintenance tasks (e.g., medication management), information, and care and service coordination for people who live in their own home, a residential setting, or a nursing facility. LTSS also include supports provided to family members and other unpaid caregivers.

Individuals with LTSS needs may also have chronic conditions that require health or medical services. In a high-performing system, LTSS are coordinated with housing, transportation, and health/medical services, especially during periods of transition among acute, post-acute, and other settings.

For the purpose of this project, people whose need for LTSS arises from intellectual disabilities (ID) or chronic mental illness (CMI) are not included in our assessment of state performance. The LTSS needs for these populations are substantively different than the LTSS needs of older people and adults with physical disabilities. Including services specific to the ID and CMI populations would have required substantial additional data collection, which was beyond the scope of this project.

A NOTE ON METHODOLOGY

Dimensions and Indicators: The *Scorecard* measures LTSS system performance using 26 indicators, grouped into five dimensions:

Affordability and Access includes the relative affordability of private pay LTSS, the proportion of individuals with private long-term care insurance, the reach of the Medicaid safety net and the Medicaid LTSS safety net to people with disabilities who have modest incomes, and the ease of navigating the LTSS system.

Choice of Setting and Provider includes the balance between institutional services and HCBS, the extent of participant direction, and the supply and availability of alternatives to nursing homes.

Quality of Life and Quality of Care includes level of support, life satisfaction, and employment of people with disabilities living in the community, and indicators of quality in nursing homes.

Support for Family Caregivers includes legal and system supports available in states and localities, the extent to which registered nurses are able to delegate health maintenance tasks to non–family members, and aspects of caregiver well-being.

Effective Transitions includes measures of hospitalization and institutionalization that should be minimized in a high-performing LTSS system.

For each of the five dimensions, the *Scorecard* uses specific indicators that are important, meaningful, conceptually valid, and unambiguous in regard to directionality; these are combined to obtain state rankings at the dimension level. In some cases, composite indicators have been formed from thematically related program and policy data. Indicators are based on data that are expected to be updated regularly so that change can be observed over time. (See Exhibit 2 in the Executive Summary for a complete list of the indicators.) Appendix B2 describes the methodology for the development of each composite indicator.

The five measured dimensions of system performance approximately correspond to the five key characteristics of a high-performing LTSS system (see Exhibit 5). However, the correspondence is not complete, as data are not currently available to measure important aspects of some of the characteristics. Notable data gaps include coordination of LTSS with other services (medical, housing, transportation, and more), consumer reports of quality of HCBS, and consistent definition and measurement of respite for family caregivers.

All indicators are subject to definitional and measurement issues; these 26 were selected because they represented the best available measures at the state level. While no single indicator may fully capture state performance, taken together they provide a useful measure of how state LTSS systems compare across a range of important dimensions.

Ranking Methodology: The *Scorecard* ranks the states from highest to lowest performance on each indicator. We averaged rankings across all indicators within each of the five dimensions to determine each state's dimension ranks, and then averaged the dimension ranks to arrive at an overall ranking. This approach gives each dimension equal weight in the overall rankings, and within dimensions gives equal weight to each indicator. In the case of missing data or ties in rank for an indicator, minor adjustments were made to values used in the average so that all indicators were given equal weight.

- For ties: the average rank is given for the computation of the dimension or overall average (e.g., two states tied at third; both get a score of 3.5 for the calculation of the dimension average).
- Missing data: a constant value is added to all ranks so that the average rank for the indicator is 26 (e.g., if there were 4 missing values, the scores would run from 3 to 49 instead of 1 to 47 for the calculation of the dimension average).

This approach was chosen for ease of understanding and interpreting the results, and for consistency with the 2011 *State LTSS Scorecard.* The methodology was based on the approach used by The Commonwealth Fund's 2007, 2009, and 2014 *State Scorecards on Health System Performance*.

and high-ranking states need to work toward continued improvement.

The 2014 *Scorecard* measures change in state LTSS performance by comparing current performance with prior performance at the indicator level, referred to as the "baseline." Because of indicator and dimension changes between the first and second *Scorecards,* it is *not* appropriate to compare dimensions and overall ranks in the published 2011 *Scorecard* with those reported here (see the "Measuring Change in Performance" box). To enable such comparisons, we include a baseline in Appendix A1.

The assessment of recent change and the comparison of current performance to other states can help each state assess where it is moving in the right direction and where greater effort is needed. National policymakers can use the *Scorecard* to evaluate where federal actions could bolster state efforts.

In some cases, states may have made changes to their LTSS systems that are not reflected in the most current data available to us (2009 to 2013). Data years for each indicator—both the most current data to measure recent performance and prior year data to establish a baseline for change over time—are shown in Exhibit 2 in the Executive Summary.

The *Scorecard* analyzes data and reports on change in performance between two periods in time. The discussion of indicators by dimension provides contextual information to help the reader understand both state and national trends that contribute to performance, but it does not address factors contributing to change or failure to change in each state. To follow up the *Scorecard,* several case studies will

MEASURING CHANGE IN PERFORMANCE

Baseline year data (typically 2 to 3 years prior to the most current data) are available for 19 of the 26 indicators in the *Scorecard*. For these 19 indicators, the *Scorecard* reports both current data and baseline data, and identifies meaningful change (either positive or negative).

Of the 19 indicators with trends, 12 are repeated from the first *Scorecard* with no change in data definition; the baseline data are the 2011 *Scorecard* data. Another 6 indicators are repeated from the first *Scorecard* but have a change in methodology so that the baseline data do not exactly match the data in the 2011 *Scorecard*, and 2 new indicators have baseline data available and can show trends. More detail about the differences between this *Scorecard* and the previous version can be found in Appendix B4.

Comparison of state LTSS system performance relative to the state's own established baseline at the indicator level is the best way to understand changes in system performance (as an improvement in rank does not necessarily correspond to an improvement in the absolute level of performance). If one must make rank comparisons over time at the level of overall performance, a comparable baseline can be found in Appendix A1. Aggregated baseline data are calculated to be a statistically valid reference for the current data. The overall and dimension-level ranks from the 2011 *Scorecard* are included in Appendix A2.

To aid in the interpretation of indicator-level change, appendix data tables not only show current and baseline values for each indicator, but also indicate the magnitude of changes by a green checkmark for a substantial improvement, a red "X" for a substantial decline, and a gray two-headed arrow for about the same. For consistency, a threshold of +/– 10 percent in the indicator value or odds ratio is used for most measures to identify substantial change; policy composite indicators have indicator-specific thresholds to identify states with any real changes in policy. More detail about how change over time is measured may be found in Appendix B5.

look more deeply into the reasons behind key *Scorecard* findings.

Summary exhibits illustrate state performance on each indicator, the range of variation, state rankings, and performance by dimension. Exhibit 6 presents the overall rankings and where each state ranks in each of the five dimensions. Additional exhibits illustrate change in performance over time on select indicators. Appendices at the end of the report contain data for each indicator, relevant demographic data, and detailed descriptions of the sources of data used. All data are available at www.longtermscorecard.org. The website also contains state-specific fact sheets and interactive tools to compare the states' performance. It will be updated periodically with case studies and ongoing discussions to promote dialogue within and across states.

Exhibit 6

State Ranking on LTSS System Performance by Dimension

Overall Rank*	State	Affordability & Access Rank	Choice of Setting and Provider Rank	Quality of Life & Quality of Care Rank	Support for Family Caregivers Rank	Effective Transitions Rank
50	Alabama	47	51	44	47	46
5	Alaska	38	3	2	4	8
21	Arizona	31	24	33	23	7
40	Arkansas	28	23	47	16	49
9	California	14	2	24	24	22
4	Colorado	5	14	7	16	11
12	Connecticut	4	22	6	30	39
29	Delaware	27	47	18	26	14
11	District of Columbia	1	29	30	2	35
43	Florida	35	41	43	40	14
36	Georgia	26	44	36	5	40
6	Hawaii	2	36	9	1	9
22	Idaho	38	9	27	42	3
15	Illinois	9	21	28	10	43
47	Indiana	44	42	45	51	33
13	Iowa	19	27	4	20	38
17	Kansas	11	10	20	35	37
51	Kentucky	51	50	50	46	42
37	Louisiana	24	30	41	7	51
10	Maine	23	12	23	29	6
23	Maryland	6	45	16	33	20
18	Massachusetts	17	14	15	41	26
31	Michigan	32	13	26	44	18
1	Minnesota	3	1	1	3	12
49	Mississippi	49	48	42	28	50
35	Missouri	21	11	46	32	34
26	Montana	41	18	11	49	10
20	Nebraska	37	25	10	18	25
41	Nevada	32	40	40	24	32
32	New Hampshire	29	39	13	38	19
26	New Jersey	13	37	21	22	36
14	New Mexico	12	6	38	37	17
25	New York	22	20	34	6	45
28	North Carolina	24	19	35	31	21
33	North Dakota	48	34	3	27	29
44	Ohio	42	32	39	39	27
45	Oklahoma	45	27	51	9	48
3	Oregon	20	5	13	14	1
42	Pennsylvania	46	25	37	36	28
38	Rhode Island	36	38	31	19	31
34	South Carolina	29	35	29	34	16
24	South Dakota	40	43	5	13	24
48	Tennessee	43	49	31	48	44
30	Texas	10	16	49	11	47
39	Utah	34	46	25	50	2
6	Vermont	15	8	17	12	5
19	Virginia	8	17	22	45	23
2	Washington	7	4	19	7	4
46	West Virginia	50	30	48	43	41
8	Wisconsin	18	7	7	14	13
16	Wyoming	16	33	12	21	30

*Final rank for overall LTSS system performance across five dimensions.
Source: State Long-Term Services and Supports Scorecard, 2014.

SCORECARD FINDINGS BY DIMENSION

Dimension 1: Affordability and Access

Many Americans mistakenly believe that Medicare will cover their LTSS needs should they develop chronic health conditions or disabilities that result in a need for help with daily activities.[2] Medicare does cover limited post-acute home health care and skilled nursing facility services that follow a hospitalization—both under very specific circumstances—but these distinctions often are not clear to consumers. Medicare and other forms of health insurance cover only *health* services, not LTSS (see box on page 20 for our definition of LTSS). Because of this confusion, many people have no idea where to turn or how to pay for the services they or a family member require. This dimension evaluates how affordable services are for people of moderate and higher incomes, how effective the safety net is for those who cannot afford services, and how easily consumers of all incomes can find the LTSS they need.

Paying out-of-pocket for services can deplete a family's life savings. In 2013, the median national cost of a private room in a nursing home was nearly $84,000 per year, and a semiprivate (shared) room was about $75,400. In high-cost markets, the annual price often exceeds $100,000 per year. The base cost for a year in an assisted living facility averaged $41,400, and residents often incur additional expenses above the basic charge. People who need home care typically use 30 hours per week of services. At a median hourly cost of $19.44 per hour, a year of home care would cost about $30,326.[3] Thus, the cost of LTSS is a major source of financial risk for middle-class families. One report found that middle-income households aged 75 and older had median assets of just $64,000—an amount that would cover only about 9 months in a private nursing home room.[4] Appendix B2 contains full descriptions and definitions of each indicator. Data tables are available in Appendices A5 to A8. Exhibit 7 illustrates the states' rankings by quartile.

Private Pay Affordability

The cost of LTSS can easily overwhelm a family's finances. On average, a 65-year-old couple can expect to incur $63,000 in lifetime costs for nursing home services, a figure that does not include payments for assisted living or home care.[5] But the need for LTSS is not distributed evenly across the population. Many people will never pay out-of-pocket for services, but one in five will need 5 or more years of care.[6] Because the risk of needing services is impossible to predict, all should prepare for unanticipated expenses, yet few know how to effectively plan for their future or have the resources to do so.

Nursing Home Costs

A major finding in this dimension is that the cost of nursing home care remains far out of reach for middle-income Americans in every state. This is one of the few areas in which the 2014 *Scorecard* shows more states declining in performance rather than improving. In three states (Hawaii, Vermont, and Washington), nursing homes became even less affordable, compared to two states (Maine and Texas) that showed an improving trend. Even in the most affordable state (Oklahoma), nursing home costs would consume 168 percent of the income

of the typical older family. The national average was 246 percent of median income.

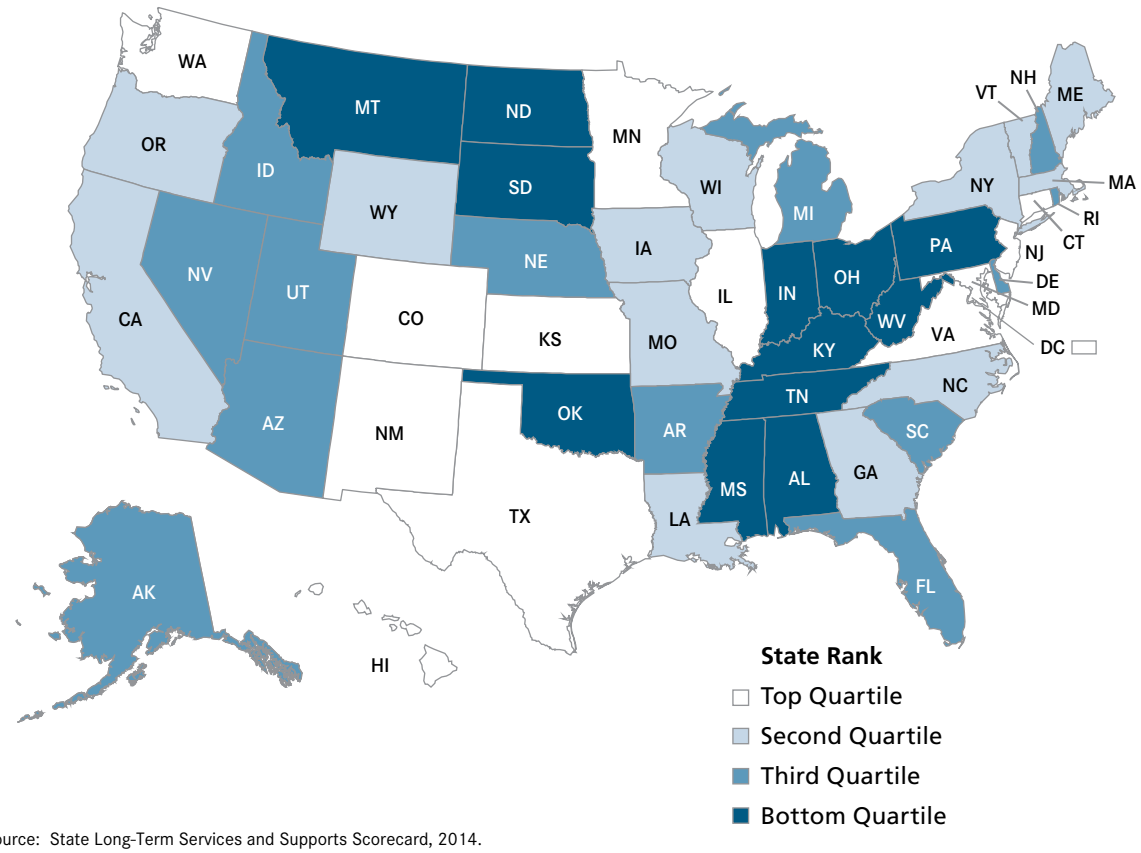
Top-ranked states on this indicator were Oklahoma, the District of Columbia, Utah, Kansas, and Missouri, where on average the cost of a nursing home would consume 171 percent of an older household's median income. While even these states cannot be considered affordable, they are in sharp contrast to the five lowest-ranked states, in which nursing home costs would consume on average 382 percent of income—more than twice as much.

Home Care Costs

The cost of home care services would consume nearly the entire income of the typical older middle-income family in most states. The most affordable jurisdiction was the District of Columbia, in which home care costs would consume 47 percent of median income for an older household. The relatively high income of the District of Columbia metropolitan area, coupled with comparatively lower costs, accounts for Maryland and Virginia also showing relatively more affordable home care (65 percent of income). The other states comprising the top five performers were Hawaii and Georgia. The least affordable state for home care was Rhode Island, where average costs would consume 111 percent of median income. The national average was 84 percent. Exhibit 8 illustrates the range in nursing home and home care affordability.

AFFORDABILITY AND ACCESS Exhibit 7

State Ranking on Affordability and Access Dimension



Source: State Long-Term Services and Supports Scorecard, 2014.

Because home care is, in general, more affordable than nursing home care, the process of exhausting a lifetime of savings and turning to the public safety net generally happens more slowly when people can stay at home. Not only can people afford to support themselves in their homes for a longer duration, but those who do so also are less costly to Medicaid. On average, the Medicaid program can pay for three people in home- and community-based care for the cost of one person in a nursing home.[7] Detailed information on LTSS private pay costs and the income of the older population in each state can be found in Appendix A7.

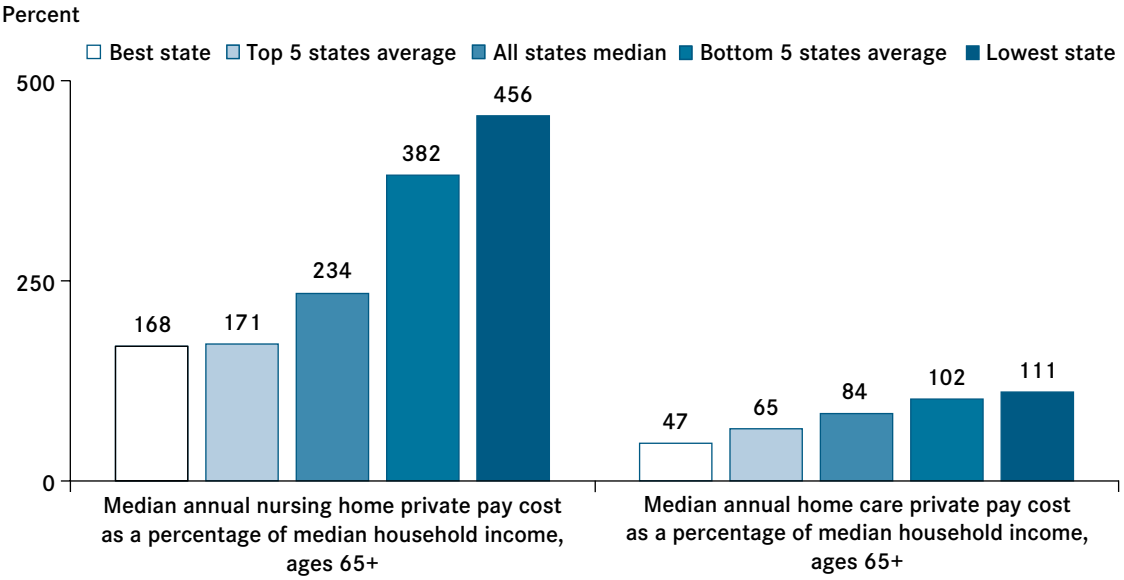
Private Long-Term Care Insurance

Private long-term care insurance (LTCI) can be a great benefit to those who have policies. One study reported that policies generally covered 60 percent to 73 percent of an individual's care costs at any given time.[8] Just over one-third (35 percent) of LTCI claims paid for home care, while 40 percent paid for care in assisted living.[9] These are the settings most people prefer. Only 10 percent of Americans aged 50 and older have these policies,[10] which pay for just 3 percent to 10 percent of the nation's LTSS bill. The reason most people don't purchase LTCI is the high price.[11]

The *Scorecard* finds a broad range of LTCI penetration, not surprising given the very different income demographics of the states.

AFFORDABILITY AND ACCESS Exhibit 8

State Variation: Private Pay Nursing Home and Home Health Cost



Top 5 states

1	Oklahoma	1	District of Columbia
2	District of Columbia	2	Maryland
3	Utah	2	Virginia
4	Kansas	4	Hawaii
4	Missouri	5	Georgia

Data: AARP Public Policy Institute analysis of Genworth 2013 Cost of Care Survey data and 2012 American Community Survey Public Use Microdata Sample.
Source: State Long-Term Services and Supports Scorecard, 2014.

The lowest level was in Nevada, in which only 26 policies per 1,000 people aged 40-plus were in force, compared to the District of Columbia, in which 130 policies per 1,000 were in force, followed by South Dakota, Hawaii, Maine, Nebraska, and North Dakota. The national average was 46 policies per 1,000 people aged 40-plus. The range between the top and bottom states was substantial, with coverage in the top five states averaging 112 policies per 1,000, compared to 29 in the bottom five states—almost one-fourth the level. Nevertheless, even in the leading states, penetration is low and fails to protect a meaningful proportion of the population. In lagging states, coverage is negligible. Moreover, sales of LTCI policies are not on the rise, and the industry is struggling to remain viable.

The Publicly Funded Safety Net

Medicaid is the largest source of public payment for LTSS. People with disabilities have on average lower incomes than those without a disability,[12] but even people with moderate incomes can become impoverished by high

MEDICAID

Medicaid is a federal and state program that provides health care and LTSS to people with low incomes and few assets. The federal share, referred to as the federal medical assistance percentage (FMAP), is based on the state's median income. It ranges from 50 percent in wealthier states to 73 percent in the poorest state.[17] In 2011, Medicaid LTSS (including nursing home and home- and community-based services) spending totaled $136 billion, which is about one-third of all Medicaid spending.[18] Within broad federal rules, states have considerable flexibility in determining who may qualify for Medicaid and what services they will receive. To qualify for LTSS, individuals must meet three major criteria.

Income: A state may use numerous income-eligibility pathways. In nearly all states, individuals may qualify for Medicaid if they have incomes that do not exceed the federal Supplemental Security Income (SSI) level ($721 per month for a single person in 2014 and $1,082 for a couple). Several states have extended eligibility up to 100 percent of the federal poverty guidelines (about $973 per month for a single person in 2014 and $1,311 for a couple). More than 40 states allow people with LTSS needs to have incomes of up to 300 percent of SSI. All states either allow beneficiaries with higher incomes to qualify after "spending down" their incomes paying for health and LTSS costs or use the 300 percent of SSI threshold.

Medicaid beneficiaries in nursing homes generally must contribute all of their income (except for a small "personal needs allowance"—usually $30 to $50 per month) to pay for the services they receive, and Medicaid pays the remainder of the cost. Married beneficiaries also may protect some income to support a spouse who lives in the community.

Assets: In most states, an individual may not have more than $2,000 in assets to qualify for Medicaid LTSS, although the home is generally considered an exempt asset (equity limit varies from state to state, ranging between $543,000 and $814,000 in 2014). Many people enter a nursing home paying for services out-of-pocket. After exhausting their life savings, they may qualify for Medicaid. Married beneficiaries also may protect some assets for a community-residing spouse.

Functional Criteria: To qualify for LTSS, an individual must meet the state's "level of care" (LOC) criteria. Each state develops its own standards. In some states, LOC is based primarily on limitations in activities of daily living (ADL) or measures of cognitive impairment. In other states, specific medical criteria must be met. While it is difficult to compare the states' LOC criteria, it may be harder for low- or modest-income people with LTSS needs to qualify for services in states that use medical criteria than in states that use only ADL criteria.

medical and LTSS expenses. Because LTSS are so costly, nearly a third of older people are projected to deplete their savings and ultimately turn to Medicaid.[13]

Although broad federal rules govern the program, each state has extensive flexibility with regard to eligibility and services provided by the Medicaid safety net, including both the level of income and assets a beneficiary can retain and still qualify for coverage. Some 4.4 million people with LTSS needs—1.6 million in institutions and 2.8 million in the community—get help from Medicaid,[14] a "program of last resort"[15] because it requires beneficiaries to have low incomes and few assets.

Many people with low incomes and disabilities also have high out-of-pocket costs for health care. A recent study found that just more than half (54 percent) of people aged 65 and older who spent down to Medicaid eligibility over a 10-year period did so for LTSS; the remaining 46 percent spent down paying for health costs.[16] Therefore, the reach of a state's overall Medicaid program is an important factor in system performance.

The next two indicators are measures of the state's Medicaid safety net. They illustrate the percentage of people who have a disability and low income and receive basic Medicaid services, and in particular, Medicaid LTSS. These measures do not reveal the robustness of the services provided by Medicaid, which varies considerably from state to state; rather they demonstrate how likely it is that the target population receives any Medicaid services. The two measures are correlated—meaning, in general, states that provide more people with basic Medicaid services also provide more Medicaid LTSS.

Low-Income Adults with Disabilities Receiving Medicaid

States have broad latitude in defining the financial eligibility criteria for Medicaid participation. Because people with disabilities often have low incomes, access to basic health coverage through Medicaid is especially critical. This indicator measures the likelihood that adults with ADL disabilities and low to moderate incomes qualify for Medicaid.

The *Scorecard* finds the highest coverage in the District of Columbia, in which 78.1 percent receive Medicaid, compared to South Dakota, where just 42.3 percent of the target population has Medicaid access. The other top states were Massachusetts, New York, Alaska, and Maine. The national average was 53.7 percent. A trend to watch will be state implementation of the Medicaid expansion authorized by the *Patient Protection and Affordable Care Act* (commonly referred to as the ACA), which allows states to provide Medicaid to people under age 65 whose incomes do not exceed 138 percent of the poverty level, a provision of particular benefit to childless adults who often were precluded from coverage. States are allowed to offer a limited benefit package to the expansion population. Data in this *Scorecard* are for 2011–2012, prior to implementation of the Medicaid expansion. As of this writing, 26 states and the District of Columbia were expanding Medicaid coverage and another 3 states were considering doing so.[19] The remaining 21 states were not considering Medicaid expansion.

Low-Income Adults with Disabilities Receiving Medicaid LTSS

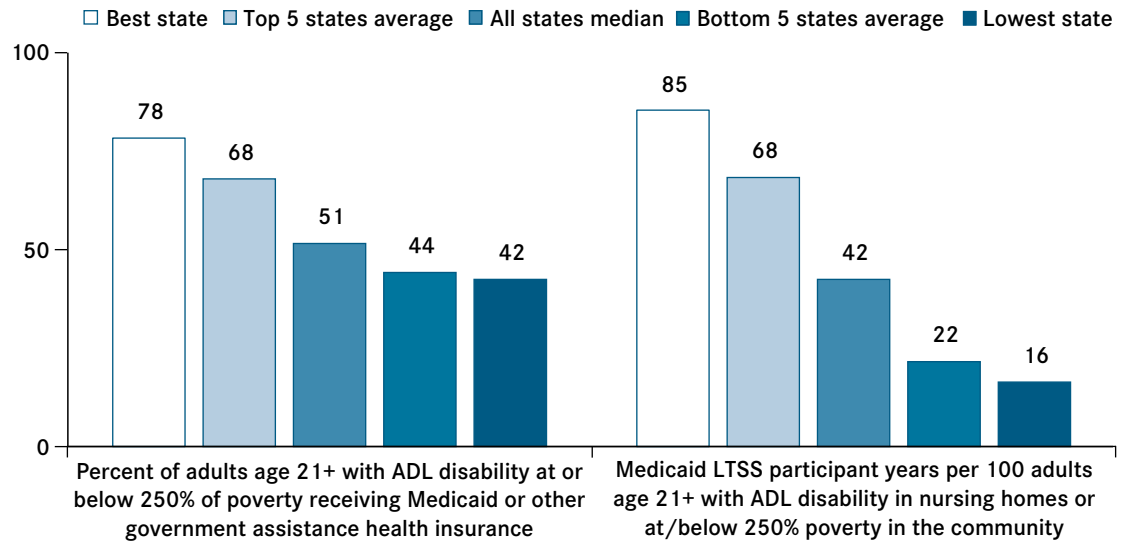
While the previous indicator measures basic Medicaid coverage, this indicator looks specifically at the receipt of Medicaid LTSS for

adults with ADL disabilities and low to moderate incomes. Not only do states have substantial leeway in establishing financial eligibility criteria, but they also have considerable latitude in determining the functional criteria needed to gain access to LTSS. If the state has restrictive functional eligibility criteria, people with disabilities might qualify for Medicaid health services but fail to qualify for LTSS.

Although this indicator is a critical measure of access to the LTSS safety net in a state, it does not measure whether the state offers a comprehensive or limited array of services or the number of hours per week that personal care services may be delivered. That said, 33 states improved the reach of their Medicaid LTSS programs. Despite this improvement, there was a large range in state Medicaid LTSS coverage, from 85 participants per 100 people in the target population (those with low to moderate incomes and a disability) in California to just 16 participants per 100 in Utah—less than one-fifth the level of the top state. Other top states were Minnesota, Washington, Connecticut, and Illinois. The average rate of coverage in the top five states (68 per 100 adults) was more than three times the average in the bottom five states (22 per 100 adults). The national average was 44 participants per 100. Exhibit 9 illustrates the

AFFORDABILITY AND ACCESS Exhibit 9

State Variation: Reach of Medicaid Safety Net



Top 5 states

1	District of Columbia	1	California
2	Massachusetts	2	Minnesota
3	New York	3	Washington
4	Alaska	4	Connecticut
5	Maine	5	Illinois

Note: ADL = Activities of Daily Living.
Data: Percentage on Medicaid - AARP Public Policy Institute analysis of 2012 American Community Survey Public Use Microdata Sample. Percentage on Medicaid LTSS - Mathematica Policy Research analysis of 2008/2009 Medicaid Analytical Extract (MAX); AARP Public Policy Institute analysis of 2009 American Community Survey Public Use Microdata Sample; and AARP Public Policy Institute, *Across the States 2012: Profiles of Long-Term Services and Supports*.
Source: State Long-Term Services and Supports Scorecard, 2014.

range of performance on the reach of the states' Medicaid safety net.

Aging and Disability Resource Center Functions

The last indicator in this dimension addresses LTSS accessibility. In a high-performing state system, consumers of all incomes—including people with disabilities and their families—can readily find information about a broad array of services and how to access them, and there is a coordinated approach to determining eligibility for public programs. As states began to improve their LTSS systems in the 1980s and 1990s, many established single points of entry, so that people with disabilities could get all their questions about available services answered in one place. Other states took a "no wrong door" approach that directed consumers to the correct agency, regardless of which public office they initially contacted. These approaches were folded into the concept of Aging and Disability Resource Centers (ADRCs), initially funded by grants to states from the Centers for Medicaid & Medicaid Services (CMS) and the Administration on Aging, now part of the Administration for Community Living (ACL). (See the Glossary for a description of ADRCs.)

The top-ranking states were New Hampshire, Florida, Minnesota, Indiana, and Wisconsin. More detail on this constructed indicator can be found in Appendix A8.

Dimension 2: Choice of Setting and Provider

Passed in 1990, the landmark Americans with Disabilities Act (ADA)[20] established the civil rights of people with disabilities to participate fully in all aspects of society. It set enforceable standards for preventing employment discrimination and ensuring access to public accommodations and transportation. These fundamental rights of people with disabilities emphasize the importance of the next dimension of a high-performing LTSS system: the ability of people to choose the setting in which they receive services and who provides them.

Using the ADA as its basis, the Supreme Court's Olmstead decision in 1999 addressed the right of people with disabilities to receive services in the least restrictive setting.[21] This decision represented a pivotal moment in the states' LTSS delivery systems because it addressed the Medicaid program's inadequate supply of home- and community-based alternatives to nursing homes. Calling for states to develop reasonable and appropriate community-based options sent a warning to states that long waiting lists and inadequate options must be addressed.

Defining what constitutes "community living" when it comes to Medicaid-funded HCBS has been a focus of CMS efforts over the past several years. After a lengthy comment period, new rules released in 2014 noted "we are moving away from defining HCB settings by what they are not, and towards defining them by the nature and quality of beneficiaries' experiences."[22]

The rule establishes qualities associated with community living by people with disabilities, such as the integration of the setting, the informed choice of individuals among settings and service options, the recognition of individual rights to privacy, and the facilitation of individual choice in services and supports.

Provider-owned or -controlled settings have additional obligations to ensure privacy, choice of roommates in shared rooms, lockable units with the right to decorate them, rights of visitation, and control of schedules and access to food. A person-centered care plan will drive services, with the ability to modify some of the setting requirements if the need is documented and the consumer or designated representative agrees. For example, lockable units may not be appropriate for some people with dementia.

Public policy plays a direct role in many aspects of this *Scorecard* dimension. Medicaid's central role in delivering LTSS makes it a key area of inquiry in determining how well states offer consumers the choice of setting that is so important to them. Federal law requires states participating in Medicaid to provide nursing home services to all who qualify, but HCBS alternatives remain optional services. While most states have begun to shift the balance of service delivery to offer more HCBS, the pace of change varies widely across the states. There is still much room for improvement, even among the top states. A person-centered approach recognizes individual preferences for where services are delivered, who delivers them, how they are arranged, and what community options are available.

Another area of great variability is the extent of the states' options that allow consumers to direct the services they receive, instead of using a traditional home care agency. Many consumers prefer the flexibility of choosing their service providers, often hiring a family member as their caregiver. This flexibility will be increasingly important as demand for personal care and home health aides continues to grow. The Bureau of Labor Statistics lists these occupations among the top three fastest-growing job categories from 2012 to 2022.[27] An adequate workforce is important to ensuring choice. Thus, the *Scorecard* measures the number of home care aides per 1,000 population aged 65 and older in the state.

Appendix B2 contains full descriptions and definitions of each indicator. Data tables are available in Appendices A9 and A10. Exhibit 10 illustrates the states' rankings by quartile.

FEDERAL INCENTIVES TO HELP STATES EXPAND MEDICAID HCBS

As the 2011 *Scorecard* was launched, states were beginning to explore options authorized by the ACA to improve their LTSS systems, including ways to better balance their Medicaid spending through the Community First Choice (CFC) option and the Balancing Incentive Program (BIP).[23] Adoption of the CFC option has been slow, with only two states (California and Oregon) approved as of January 2014.[24] CFC requires states to ensure that all qualifying beneficiaries have the option to receive HCBS. More popular has been the BIP program, which had 17 states participating as of January 2014.[25] States that adopt BIP must commit to implementing other measures that will enhance consumer choice, such as a single point of entry and use of a uniform assessment instrument. States receive higher federal matching for both these options. The ACA also provided $450 million per year from fiscal year 2012 to 2016 for Money Follows the Person (MFP) programs,[26] clearly a factor in the finding that nearly every state now has such a program.

Balance in Medicaid and State-Funded LTSS

For many years, Medicaid balancing has been the primary measure of state progress in LTSS reform. While the *Scorecard* takes a multidimensional approach to overall system performance, state progress in shifting Medicaid spending away from nursing homes and toward

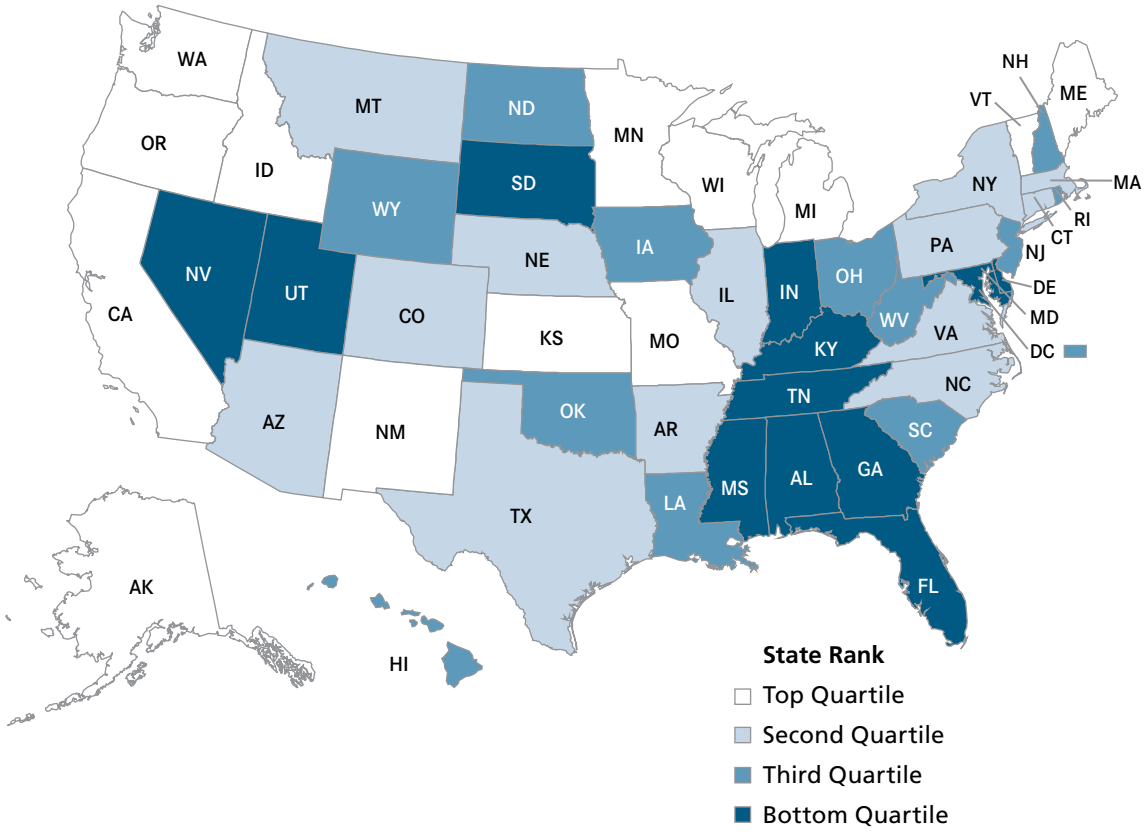
HCBS alternatives remains of paramount importance.

This analysis considers the spending balance among older people and adults with physical disabilities—the target populations for the *Scorecard*. However, serious disparities by population continue to plague state Medicaid programs. **Nationally, among all younger people with disabilities, 63 percent of Medicaid LTSS spending goes to HCBS, compared to just 28 percent for people over 65.**[28] While some older people and their families choose nursing homes as their setting of choice, too often outdated and ageist prejudices assume that older people can only be safely cared for in an institution. Some states that are leaders in serving all of their younger populations in the community are far behind in doing the same for their older residents. The tremendous variation in state LTSS systems clearly indicates that some states are embracing a new model that allows for greater choice for people of all ages. Federal initiatives have supported this trend, and many states have deliberately pursued a direction toward HCBS as a cost-effective means to give consumers the choices they want.[29]

The *Scorecard* contains two measures of Medicaid balance (described below), which are highly correlated with each other. Indicators of Medicaid balance also correlate with the reach of the states' Medicaid safety net (described in the affordability dimension). In addition, states

CHOICE Exhibit 10

State Ranking on Choice of Setting and Provider Dimension



Source: State Long-Term Services and Supports Scorecard, 2014.

that are more balanced toward HCBS have, in general, lower nursing home use.

Percent of Medicaid and State-Funded LTSS Spending Going to HCBS

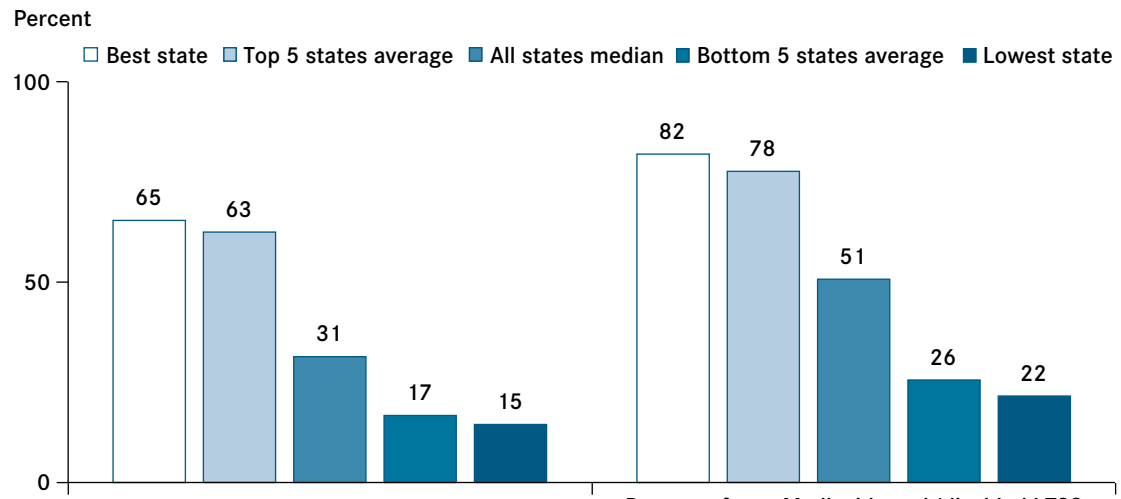
Change in Medicaid balancing is slowly improving. While 24 states improved their Medicaid balancing (and only 3 showed a decline), the rate of improvement was generally modest. Also, in 24 states there was little to no change on this measure; however, given the intense pressure on state Medicaid budgets, even holding on to program gains is a significant accomplishment. The largest *rates* of improvement were seen in Maryland, North Dakota, Delaware, Hawaii, and Ohio, all of which improved by more than 25 percent. These states still had less than the average percentage of Medicaid LTSS dollars going to HCBS, demonstrating that it is easier to show a large increase from a small baseline.

New Mexico and Minnesota were national leaders, spending more than 65 percent of their Medicaid LTSS dollars for older people and adults with physical disabilities on HCBS, followed closely by Washington, Alaska, and Oregon. North Dakota had the lowest level of balance, spending only 14.5 percent of Medicaid LTSS dollars on HCBS. The top five states allocated on average 62.5 percent of LTSS dollars for HCBS, compared to the bottom five states, which allocated on average just 16.7 percent—about one-fourth the level. The national average was 39.3 percent. Exhibit 11

CHOICE

Exhibit 11

State Variation: Measures of Medicaid LTSS Balance



Top 5 states

1	New Mexico	1	Alaska
2	Minnesota	2	Minnesota
3	Washington	3	New Mexico
4	Alaska	4	District of Columbia
5	Oregon	5	Idaho

Data: LTSS Spending - AARP Public Policy Institute analysis of Truven Health Analytics, Medicaid Expenditures for Long Term Services and Supports in 2011 (Revised October 2013); AARP Public Policy Institute Survey (2012); New Medicaid Users - Mathematica Policy Research analysis of 2008/2009 Medicaid Analytical Extract (MAX).
Source: State Long-Term Services and Supports Scorecard, 2014.

illustrates the range of state performance on two measures of Medicaid balancing.

Percent of New Medicaid LTSS Users First Receiving Services in the Community

Nearly 90 percent of people aged 65 and older want to remain in their own homes as long as possible.[30] Those who enter a nursing home may find it difficult to return home. Therefore, this indicator measures whether a new Medicaid LTSS user receives HCBS or is admitted to a nursing home. In the top five states, 77.6 percent of new LTSS users were served in HCBS settings—more than three times the performance of the bottom five states, in which only 25.6 percent of new LTSS users were served in HCBS.

Participant Direction

Many users of LTSS value the flexibility and control of directly hiring the person who provides services. Variously called consumer direction, self-direction, or participant direction, this model allows individuals to hire and fire their service providers, set their hours, and in some cases determine their rate of pay. People who pay out-of-pocket for services have been doing this for years, but Medicaid and other publicly funded programs are beginning to catch up.

The *Scorecard* finds California continues to lead the nation by far in the proportion of people with disabilities who self-direct their services, followed by Vermont, Alaska, Washington, and Michigan. Many states have almost no participant direction. In the top five states, 75 per 1,000 people aged 18-plus with disabilities self-direct their services, compared to less than 1 per 1,000 in the bottom five states. Yet in most states, relatively few consumers have the option of directing their own services. The range of performance is illustrated in Exhibit 12.

Home Health and Personal Care Aides

The Bureau of Labor Statistics projects the demand for personal care and home health aides to increase by nearly 50 percent by 2022.[31] Without an adequate workforce, consumers will find it difficult to remain in their homes and communities—regardless of their payment source. Many states allow participants to hire family members to provide services, a practice that can both mitigate workforce shortages and compensate individuals who may have left paid employment to care for a family member.

The *Scorecard* finds that most states (36) improved on this indicator and only 3 declined. The sluggish economy during this period may have accounted for this finding, but the variation is notable. The leading state was New York, with a significantly higher supply of home care workers than most states, followed by New Mexico, California, Texas, and Alaska. The state with the lowest supply was South Dakota (see Exhibit 13).

Assisted Living and Residential Care

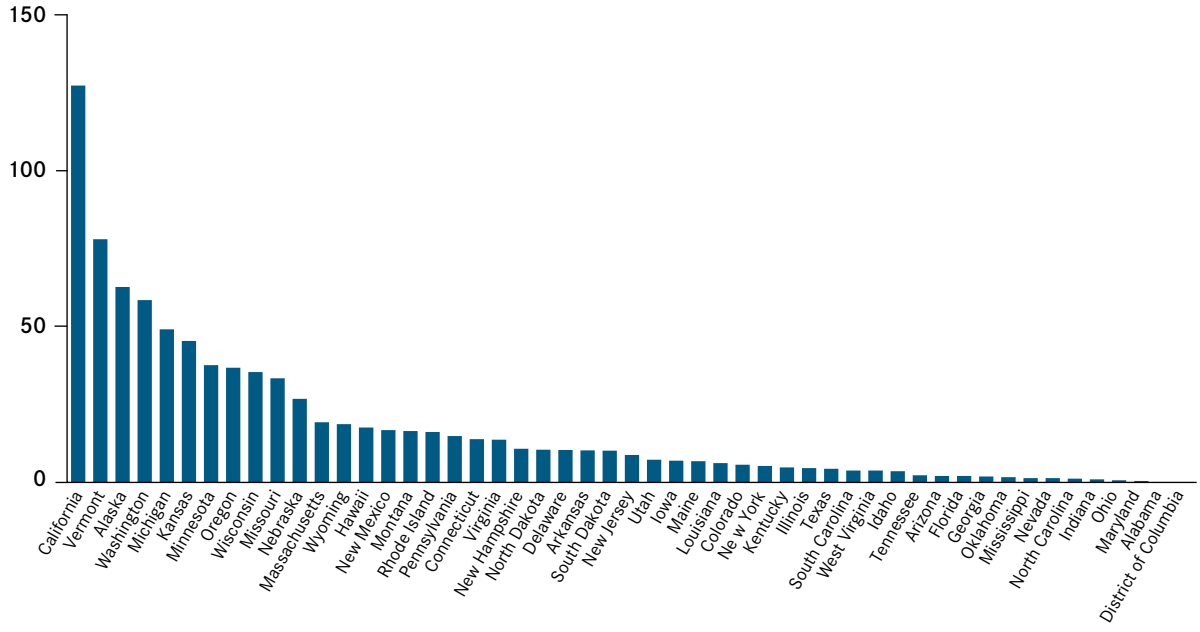
Many people choose a residential alternative such as assisted living or adult foster care when living in their own home is no longer viable. With a less institutional feel than nursing homes, these settings have grown in popularity, particularly among the older population. The availability of these residential alternatives is reported as the number of assisted living and residential care units per 1,000 people aged 65 and older. Although most assisted living residents pay for services out-of-pocket, some

CHOICE

Exhibit 12

State Rates of Participant Directed Services for Adults with Disabilities

Number of people participant-directing services per 1,000 adults age 18+ with disabilities



Data: National Resource Center for Participant-Directed Services, Boston College National Inventory of Participant -Directed Supports and Services, WAVE TWO, 2013 survey data; 2012 American Community Survey.
Source: State Long-Term Services and Supports Scorecard, 2014.

Medicaid and state-funded programs pay for services in these settings. States can influence the availability of these alternative residential environments to a broader range of consumers by expanding public subsidization and enacting appropriate licensure laws. In accordance with the new CMS regulations on community living, assisted living facilities will need to meet the CMS standards in order for Medicaid to pay for services in this setting.

The range of performance was substantial, with Minnesota the far leader (125 units per 1,000 population), followed by Wisconsin, Idaho, Oregon, and Washington. In the top five states there were on average 69 units per 1,000 people aged 65-plus, compared to the bottom five states, which averaged just 13 units. The national average was 31.

Dimension 3: Quality of Life and Quality of Care

This dimension includes three measures of quality of life in the community and three measures of quality of care in nursing homes. In general, states that ranked in the top quartile of performance tended to score high across all indicators in the dimension. Appendix B2 contains full descriptions and definitions of each indicator. Data tables are available in Appendices A11 and A12. Exhibit 14 illustrates the states' rankings by quartile.

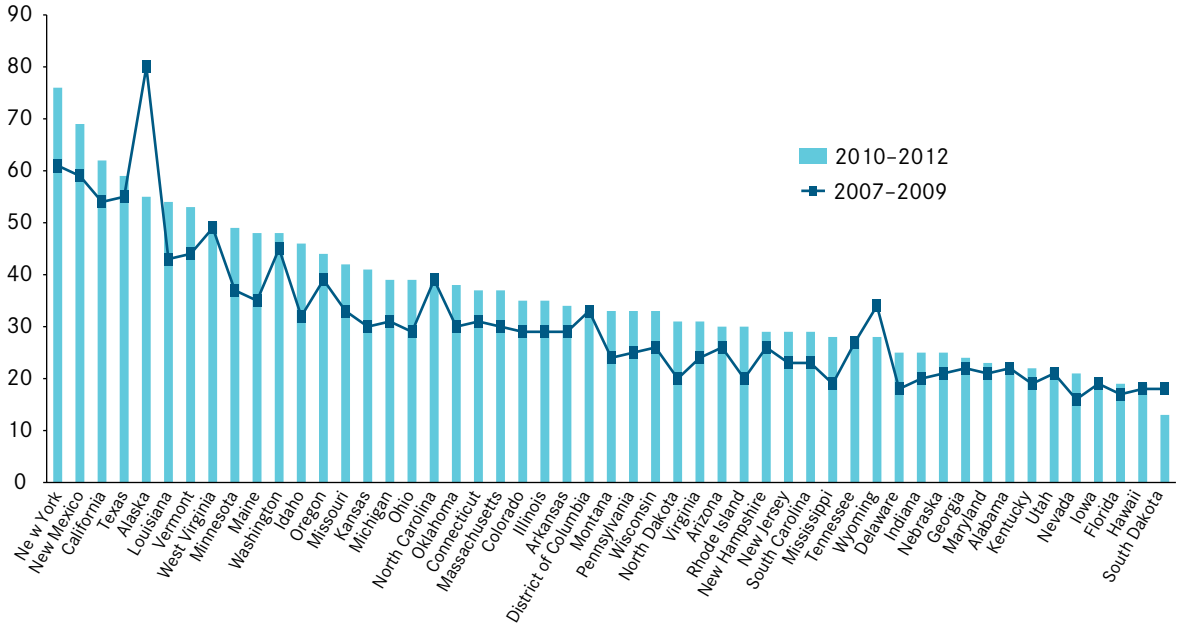
Quality encompasses a diverse range of factors, some of which are difficult or impossible to quantify and measure. The quality of HCBS was an area we were not able to measure in either the 2011 *Scorecard* or this one. A consistent, reliable source of data across all the

CHOICE

Exhibit 13

State Performance: Home Health Aide Supply, 2010-2012 Compared to 2007–2009

Number of personal care, psychiatric, and home health aide direct care workers per 1,000 population age 65 or older



Data: 2007–2012 American Community Survey Public Use Microdata, 2007-2012 U.S. Census Bureau Population Estimates.
Source: State Long-Term Services and Supports Scorecard, 2014.

states is simply not available. Even in Medicaid, the largest source of public payment for LTSS, no federal agency requires that states report on consumer and family experience with services received; adequacy of care plans; timely delivery of services; coordination of HCBS with housing, transportation, and health services; or the cultural competency of service providers. These and other aspects of the HCBS system are important in understanding how well states are doing to ensure both quality of life and quality of care for beneficiaries. While some states measure these or other aspects of HCBS quality, and managed care organizations may be required to report on some of these aspects, it currently is impossible to find a uniform source of data for all states.

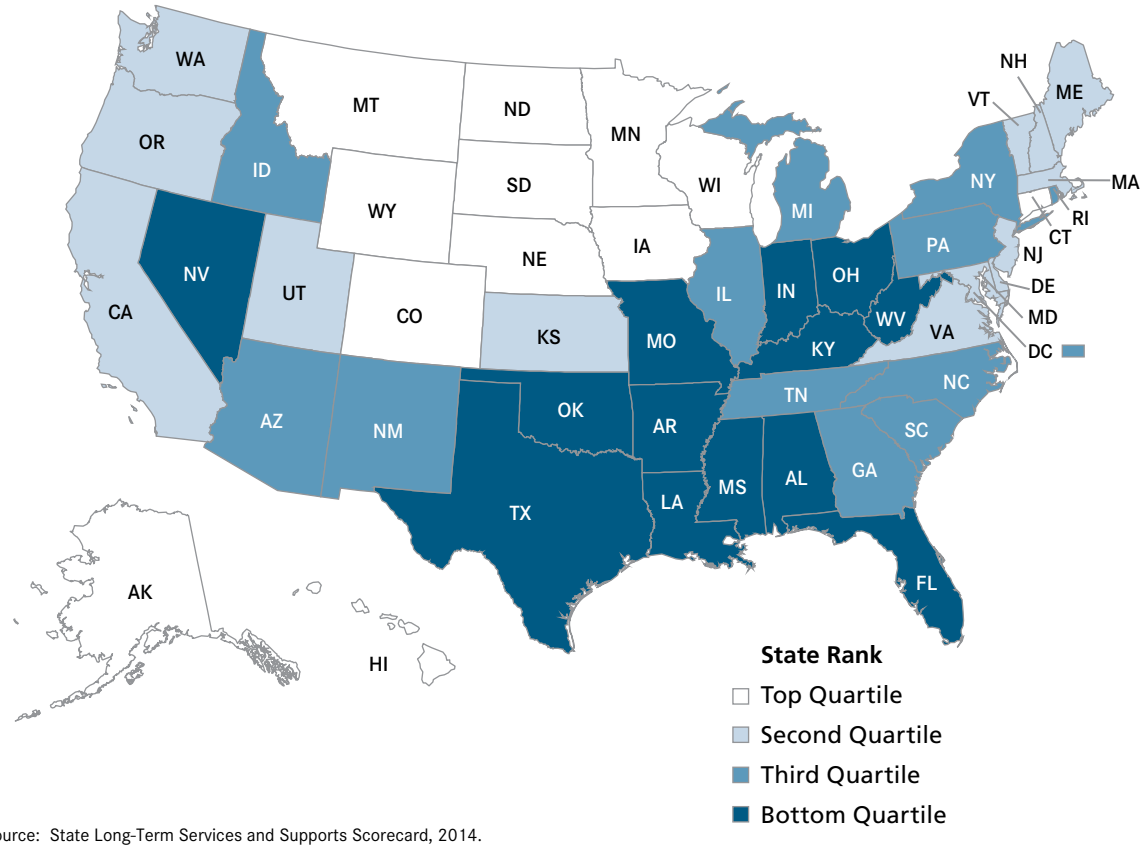
Quality of Life in the Community

Most people of all ages and disabilities want to remain in their homes. Social connections built over a lifetime, favorite restaurants and shops, friendly neighbors, places of worship, the local library—these have value and meaning for people and enhance the social engagement that is critical to successful aging and quality of life. Yet people need appropriate services and supports if they are to successfully remain in their communities. Among working-age adults, the ability to find employment is a critical component of life quality. Although states cannot directly control the life satisfaction and perceived support experienced by people with disabilities, these broad public health measures provide a meaningful reflector of the effectiveness of public- and private-sector policies.

QUALITY

Exhibit 14

State Ranking on Quality of Life and Quality of Care Dimension



Source: State Long-Term Services and Supports Scorecard, 2014.

Social and Emotional Support

In two-thirds of the states (33), the percentage of people with disabilities who reported getting needed support improved, although gains were modest. The range of performance was from 79.1 percent in the top state (Minnesota) to 66.6 percent in Mississippi. Other top-performing states were Delaware, Oregon, Nebraska, and Washington. Although this measure of support is not directly influenced by public policy, feeling supported was highest in the nation's top-ranked state and was lowest in one of the lowest-ranked states.

Life Satisfaction

Life satisfaction among people with disabilities can depend on many factors, some of which are unrelated to their experience with their state's LTSS system. The range of state performance was fairly narrow on this indicator, from a low of 82.5 percent in Florida to a high of 92.1 percent in South Dakota. Other top-ranked states were Alaska, Nebraska, Kansas, Iowa, and North Dakota.

Rate of Employment

Adults with disabilities are much less likely to be employed than are people without a disability.[32] This is a major issue for advocates, not only because jobs bring income but also because being able to work is part of an adult's identity and ability to connect with others.

Twice as many states (20) declined on this indicator as improved (10). Given the nation's

slow economy, it may not be surprising that employment by people with disabilities declined in many states. The top performers were South Dakota, Colorado, Minnesota, Connecticut, and Alaska, where the relative rate of employment among people with disabilities was 32.2 percent. By contrast, in the bottom five states, employment averaged just half this level: 16 percent.

Nursing Home Quality

Nursing home residents are a vulnerable population. As alternatives to nursing homes have expanded, those who remain in institutional settings generally have the most severe disabilities, complex medical conditions, or advanced dementia. States have an oversight responsibility, but providers are ultimately responsible for the quality of services provided in nursing homes.

Pressure Sores

Pressure sores—areas of damaged skin that result from staying in one position too long—are a key measure of nursing home quality. They are preventable with good care, but once they develop, they can lead to serious medical complications, including life-threatening infections. Thus, nursing homes that have low rates of pressure sores among their residents are generally providing higher-quality care. Changes in the data methodology for this indicator prevent this *Scorecard* from measuring change in performance over time.

The range in performance on this indicator is significant. The top-performing state (Hawaii) reported 3 percent of nursing home residents with pressure sores, compared to the lowest-ranked state (Louisiana), which reported 9 percent. While these percentages may sound low, they translate to tens of thousands of people who suffer from a dangerous and preventable condition.

Other top states were New Hampshire, Minnesota, Idaho, Nebraska, North Dakota, and Wisconsin. In the top five states, the incidence of pressure sores was 4.0 percent, less than half the average in the bottom five states (8.3 percent).

Staff Turnover

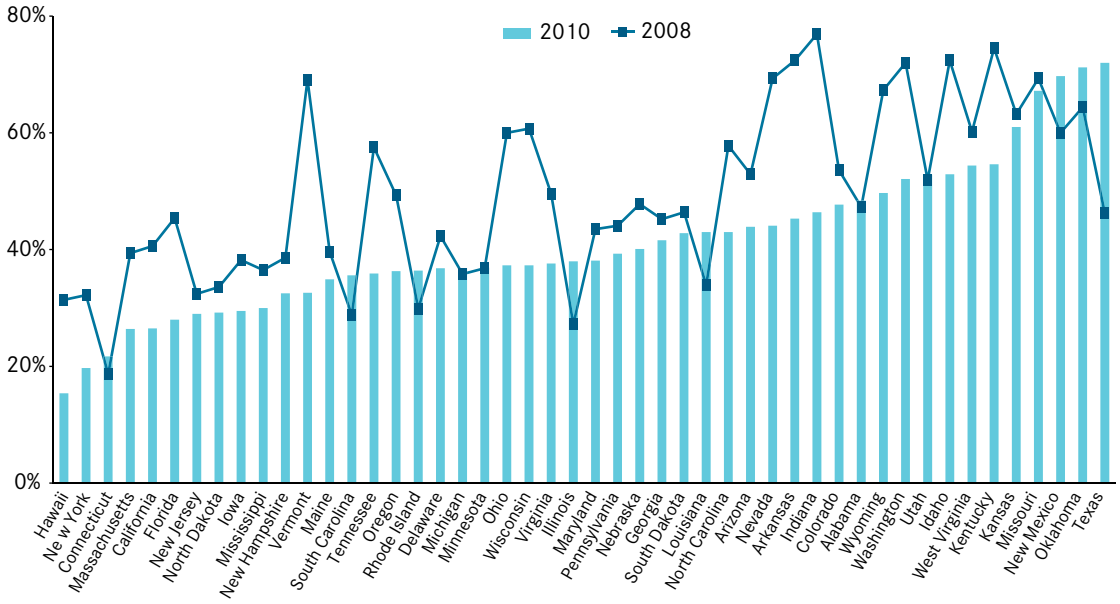
Turnover among frontline workers in nursing homes traditionally is high. Excessive turnover can be disorienting to residents, especially those with dementia, and can result in disruptive, inconsistent care leading to adverse health outcomes. On this indicator, nearly four times as many states (31) showed improvement over decline (8). This indicator is likely sensitive to the weak economy and lack of jobs, as workers are less likely to leave employment when opportunities for other work are scarce. Despite some improvement, the turnover rates remain very high in multiple states, with half exceeding 40 percent a year. As Exhibit 15 illustrates, although some rates have declined, substantial differences across states remain. In states with very high turnover rates, residents are at risk for poorer quality of care and lack of continuity of care.

The range of performance on this indicator was large, and turnover was high, even in the top states. In the top five states (Hawaii, New York, Connecticut, the District of Columbia, and Massachusetts), turnover averaged 21.3 percent, compared to 68.2 percent in the five lowest-performing states—more than three times higher.

QUALITY Exhibit 15

State Performance: Nursing Home Staff Turnover, 2010 Compared to 2008

Ratio of employee terminations that occurred during the year, regardless of cause, to the average number of active employees during the same time period



Note: Data not available for Alaska (2008 - 2010) and District of Columbia and Montana (2008), therefore, change in state performance cannot be shown.
Data: American Health Care Association, *Report of Findings: 2010 Nursing Facility Staffing Survey;* American Health Care Association, *Report of Findings: 2008 Nursing Facility Staff Vacancy, Retention and Turnover Survey*.
Source: State Long-Term Services and Supports Scorecard, 2014.

Use of Antipsychotic Medications

Concern over excessive and inappropriate use of antipsychotic medications in nursing homes has become an area of focus in recent years. In 2011, testimony by the Department of Health and Human Services Inspector General found that nearly a quarter (22 percent) of antipsychotic medications prescribed in nursing homes failed to meet CMS standards for avoiding unnecessary drugs. Of even greater concern, the Inspector General found that 83 percent of Medicare claims for antipsychotic drugs in nursing homes were prescribed "off label"—a potentially dangerous use specifically warned against for patients with dementia.

Among the risks of this off-label prescribing, the testimony noted:

- *use for staff convenience rather than providing appropriate nonpharmacological interventions;*
- *use without first determining the causal and contributing factors of the behavior;*
- *lack of specific and individualized care plans;*
- *lack of continued monitoring of the need for or the amount of the medication; and*
- *inappropriate admission of residents with mental health diagnoses that the facility is not prepared to treat.*[33]

New data available from Medicare's Nursing Home Compare website enabled us to report on

this measure for the first time. Nursing home residents with a diagnosis of bipolar disorder, schizophrenia, Tourette's syndrome, and Huntington's disease were excluded from the sample. Moreover, our data focused on long-stay nursing home residents, as the negative impact of inappropriate prescribing is most evident over several months' duration. Because prior data do not exist, we were unable to show change over time for this indicator.

Hawaii, Alaska, Michigan, New Jersey, and North Carolina had the lowest use of inappropriate antipsychotic medications (averaging 14.5 percent), far below the level of the five bottom-ranked states, which averaged 26.1 percent use.

Dimension 4: Support for Family Caregivers

Family caregivers are the backbone of our nation's LTSS system—a fact that has received growing recognition over the past several years. The *Scorecard* defines "family caregiver" broadly as any relative, partner, friend, or neighbor who has a significant personal relationship with and provides a broad range of assistance for an older person or other adult with a chronic or disabling condition.

More than 90 percent of older people receiving care in the community rely on unpaid family care, either alone or in combination with paid help.[34] Two-thirds of them get *all* their help from family caregivers, generally wives and adult daughters.[35] In 2009, more than 42 million caregivers provided help to an adult with limitations in daily activities at any point in time.[36] The economic value of this help was approximately $450 billion in 2009—nearly four times the amount that the Medicaid program spent on all LTSS that year ($119 billion).[37]

Family caregivers traditionally have helped with tasks like bathing and dressing, shopping and meal preparation, transportation, and financial management. But research now shows that nearly half (46 percent) of family caregivers are engaged in complex medical/nursing tasks for people with multiple chronic physical and cognitive conditions.[38] Many caregivers, who often receive little or no training, expressed considerable stress over tasks like administering multiple medications (including injections), providing wound care, preparing special diets, and managing tube feedings and specialized equipment, among others.[39]

If our nation expects family caregivers to continue providing this critical assistance, it must provide help and support to prevent caregiver burnout or the need to quit jobs, jeopardizing the health and economic security of caregivers themselves. One step is to provide instruction and guidance to family caregivers to help them perform health monitoring and maintenance tasks. Another is to permit direct care workers to help with these tasks. Also, in a high-performing LTSS system, caregivers' needs—physical, emotional, financial, and work-related—are assessed and addressed. Their strengths are valued, and supports are tailored to their individual values and preferences. The 2013 federal Commission on Long-Term Care developed bipartisan recommendations for improving the nation's LTSS system. A key recommendation in their final report was to develop a national strategy for supporting family caregivers and assessing their needs.[40]

The recent CMS rule on community living addressed the need for Medicaid HCBS programs to conduct an assessment of caregivers' needs when their assistance is part of the care plan for the person with a disability.[41] This is an important part of the person- and family-centered care process. Medicaid HCBS programs often reduce the hours of care authorized when the beneficiary has a family caregiver. If family caregivers are expected to continue providing support, it is important that their needs are both assessed and addressed with appropriate information, training, respite, and other services tailored to their individual needs and preferences.

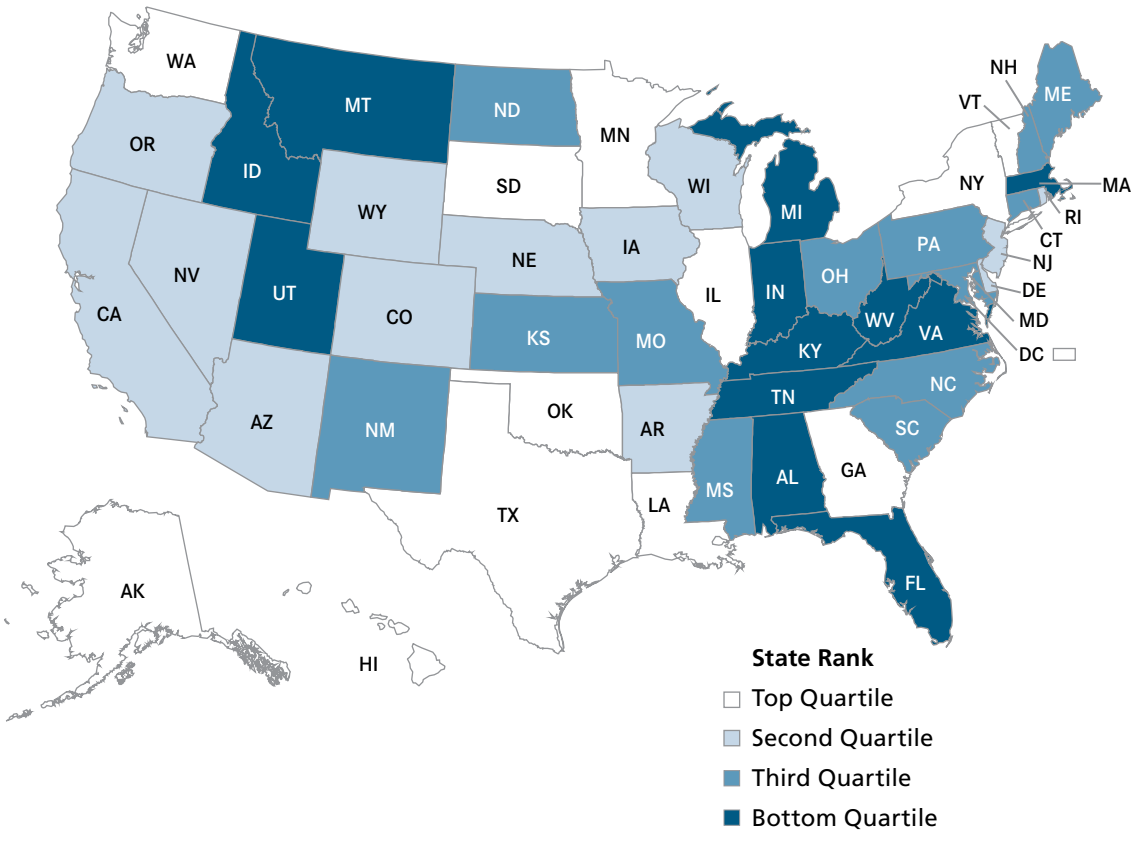
Appendix B2 contains full descriptions and definitions of each indicator. Data tables are available in Appendices A13 to A17. Exhibit 16 contains the states' rankings by quartile.

Legal and System Supports

Support for family caregivers is an area of great public policy interest, given the critical role that caregivers play in support for people with LTSS needs. Twenty-nine states showed improvement, although 22 saw little to no change. The top states were the District of Columbia, Washington, California, Hawaii, and Connecticut. It appears that increased advocacy on the need to change laws to support family caregivers has begun to bear fruit. We used the

SUPPORT FOR FAMILY CAREGIVERS Exhibit 16

State Ranking on Support for Family Caregivers Dimension



Source: State Long-Term Services and Supports Scorecard, 2014.

most current nationally comparable sources of data to populate this indicator. It is possible that more recent policy changes are not captured here. Appendix A15 presents state scores on the composite indicator and each component.

Most family caregivers either are employed (58 percent) or were employed at some time while they were providing care (74 percent).[42] Balancing work and family caregiving can be stressful, and caregivers who leave the workforce can suffer serious negative economic impacts. One study found that caregivers aged 50 and older who quit their jobs to care for a parent lose, on average, more than $300,000 in lifetime wages and benefits.[43]

The stresses on working caregivers are compounded when they lack the supports and protections that could help them manage their dual responsibilities, including the ability to take family medical leave, access to paid sick days, and protection from discrimination on the basis of their caregiver status. The Family and Medical Leave Act (FMLA) covers about 60 percent of workers, but even those who are covered by this protection may provide care to family members whose relationship is outside the scope of the federal law.[44] For example, care for a grandparent, in-law, or sibling is not covered unless a state chooses to broaden the scope of the FMLA. Moreover, leave protected by the FMLA is unpaid. Many workers cannot afford to miss a paycheck and do not have access to paid sick days.

Reliance on family caregivers is extensive across the globe. But most Western countries do more than the United States currently does to support them. A report by the Organisation for Economic Co-operation and Development (OECD) found that many of their member nations provide paid leave, flexible work schedules, respite services, and financial compensation for family caregivers.[45]

It also is critical to understand what it means to assess the needs of family caregivers. A survey of state Medicaid programs revealed that the concept of caregiver assessment is not well understood, and relatively few states directly ask caregivers about their health and well-being or the supports they might need to continue in their role.[46]

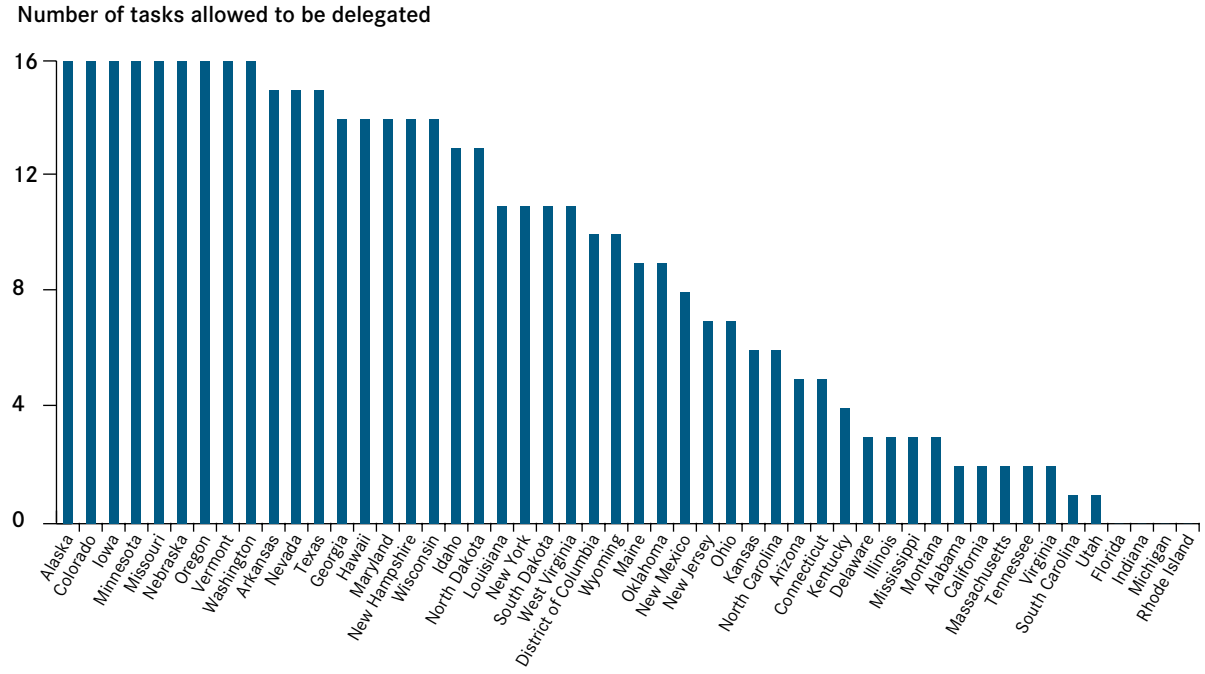
Nurse Delegation

State Nurse Practice Acts generally determine the extent to which direct care workers can provide assistance with a broad range of health maintenance tasks—a practice known as "nurse delegation." Nurses are allowed to train a family member to perform these tasks, but in many states they cannot be delegated to a paid direct care worker assisting in home settings. Because many family caregivers are employed, they often hire a paid caregiver to help while they are at work. If the aide cannot perform these health maintenance tasks, the family caregiver may have to leave work during the day to give a medication, a tube feeding, or even administer eye or ear drops. The caregiver's alternative would be to hire a nurse to perform these routine tasks, at a significantly higher cost. Exhibit 17 illustrates the range of state performance on this indicator.

Thirteen states improved on this indicator and nine now allow nurses to delegate all 16 tasks: Alaska, Colorado, Iowa, Minnesota, Missouri, Nebraska, Oregon, Vermont, and Washington. This practice benefits family caregivers and can also conserve public funds if the individual's paid care is reimbursed by

SUPPORT FOR FAMILY CAREGIVERS Exhibit 17

State Policies on Delegation of 16 Health Maintenance Tasks



Note: Data not available for Pennsylvania. No tasks are allowed to be delegated in Florida, Indiana, Michigan, and Rhode Island.
Data: AARP Public Policy Institute, Survey on Nurse Delegation in Home Settings, 2013.
Source: State Long-Term Services and Supports Scorecard, 2014.

a public program, such as Medicaid. Yet four states do not allow nurse delegation of any of the 16 tasks measured. In a period of fiscal austerity, this indicator represents a low-hanging fruit for states that want to improve their performance without increasing public expenditures. Appendix A16 is a complete list of the tasks that can be delegated in each state.

Elements of Caregiver Well-Being

Our nation depends on the voluntary contributions of family caregivers, yet it provides little to them in the way of support. Thus it is not surprising that caregivers report higher levels of stress than the general population.[47] In a survey on stress in America, more than half (55 percent) of caregivers said they felt overwhelmed by their care responsibilities. On a scale of 1 to 10 (with 1 representing little or no stress), caregivers ranked themselves at 6.5, compared to 5.2 in the general public. The American Psychological Association's Stress in America study notes that caregivers are less likely to engage in preventive health behaviors than non-caregivers due to the demands on their time. And 60 percent of caregivers in this study reported lying awake at night, compared to 44 percent among the general public.[48]

The states with the highest percent of caregivers expressing the measured elements of well-being were Hawaii, the District of Columbia, Rhode Island, Illinois, and South Dakota. Nationally, 59.9 percent of caregivers reported that they did not experience of a lot of worry in the past day, 51.8 percent did not experience a lot of stress, 64.8 percent felt well rested, and 68.8 percent said that they had

enough time to get everything they needed done—an average of 61.3 percent. State scores on each element of well-being as well as the indicator average can be found in Appendix A17. The average of the top five states across these four measures was 66.5 percent; the average of the bottom five states was 55.8 percent.

Dimension 5: Effective Transitions

This dimension is a new addition to the *LTSS Scorecard*. In the 2011 report, we lacked sufficient data to construct a robust view of state performance in effective transitions. With growing interest in this area and the availability of new data sources, we were able to fulfill our original vision of demonstrating state performance on all five aspects of a high-performing LTSS system. To populate the dimension, three new indicators were combined with three repeated indicators that appeared in the choice (1) and quality (2) dimensions of the first *Scorecard*. The dimension has strong internal consistency and aligns well with both the choice of setting and provider and quality of life and quality of care dimensions.

People who need LTSS often also have complex chronic health conditions. Yet fragmentation in the health and social service systems—Medicare, Medicaid, private health insurance, and programs such as the Older Americans Act—can result in uncoordinated care that is costly and yields poor outcomes. A movement toward person- and family-centered care is a start. The concept of person- and family-centered care is designed to look at the whole person and his or her needs and preferences, including meaningfully involving the individual's family caregivers, as appropriate.

One area in which efforts to improve integration have begun focuses on people who are eligible for both Medicare and Medicaid. These individuals, often referred to as "dual eligibles," are among the sickest, poorest, and costliest beneficiaries. While they compose just 18 percent of all Medicare beneficiaries, they account for some 31 percent of Medicare costs.[49] Similarly, they accounted for 15 percent of Medicaid enrollees in 2007 but 39 percent of Medicaid expenditures, largely because of the high cost of LTSS.[50] One analysis found that, regardless of the number of chronic health conditions, people with functional limitations had dramatically higher Medicare spending.[51] A recent report found that two-thirds of the states are in the process of launching initiatives to better coordinate care for dual eligibles.[52]

An additional area of reform is to improve care transitions when patients move between one care setting or provider and another. Smooth care transitions are at the core of person- and family-centered care.[53] Better care transitions can prevent costly hospital admissions and readmissions, particularly for people who are at high risk and often have multiple chronic conditions. The health care system is beginning to recognize that improved care transitions should include nonmedical services such as family caregiver supports and transportation.[54] Appropriate caregiver guidance and instruction also are critical.

Another area of growing importance is the states' movement toward managed care for their Medicaid LTSS populations. Sixteen states adopted managed Medicaid LTSS as of 2012, and 26 are expected to do so by 2014.[55] It is too

early for the *Scorecard* to measure the impact of managed LTSS on state performance, but it is a developing area to monitor.

A framework developed by The SCAN Foundation calls for five important activities to guide states toward more integrated, person-centered care: administrative reorganization, global budgeting, uniform assessment, integrated information systems, and quality measurement and monitoring.[56] Not all are currently measurable with consistent state-level data. Therefore, for this edition of the *Scorecard*, we defined the fifth dimension as "effective transitions." This was the area for which we were best able to obtain consistent state data.

The dimension looks at two types of transitions. One type focuses on minimizing the disruptive transitions between care settings; the other type measures the relative success of states to transition people from nursing homes back to the community.

Hospitalizations are common among nursing home residents, and often are inappropriate, avoidable, or related to conditions that could be treated outside the hospital setting. Research finds that avoidable hospitalizations cost more than $4 billion per year.[57] These hospitalizations can lead to medical complications that can have serious consequences for a vulnerable LTSS population.[58]

Scores in this dimension were correlated with scores on both the quality and choice dimensions. Appendix B2 contains full descriptions and definitions of each indicator. Data tables are available in Appendices A18 and A19. Exhibit 18 illustrates the states' rankings by quartile.

Nursing Home Residents with Low Care Needs

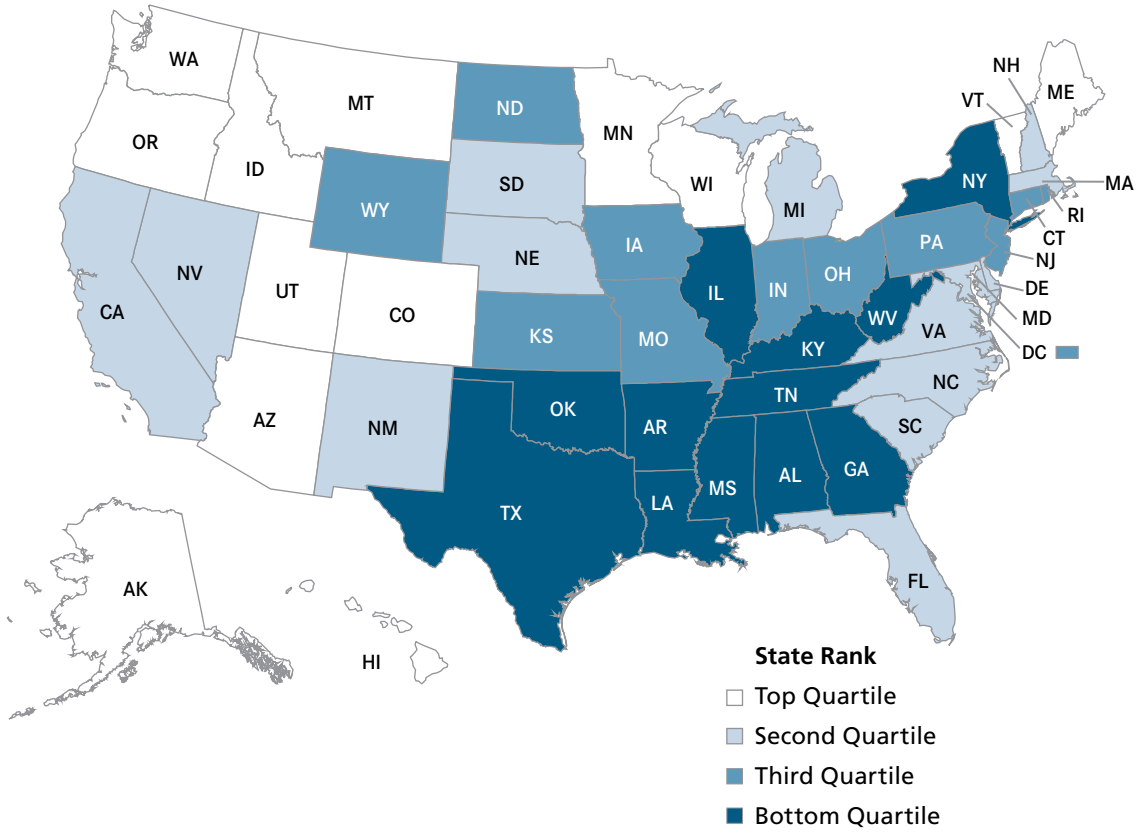
As the private sector develops alternatives to nursing homes, people who can manage their daily needs in less restrictive environments generally prefer these other options. States that have a relatively high proportion of nursing home residents who have low care needs may not be taking appropriate steps to transition these residents to these alternatives. While this indicator also may reflect inadequate choices of setting (the dimension in which it was included in the 2011 *Scorecard*), we believe that, included with the other indicators in this dimension, it can help states to assess their efforts to support the ability of those with low care needs to transition to other options. Of course, if a state has not balanced its LTSS system to provide an array of HCBS options, it may be difficult to transition even people with low care needs back to the community.

There was a wide range of performance on this indicator. The top states were Maine, Hawaii, Utah, South Carolina, and Pennsylvania, which averaged just 4.6 percent of nursing home residents with low care needs, compared to the bottom five states, in which 23 percent of residents had low care needs—or five times as many.

Percent of New Nursing Home Stays Lasting 100 Days or More

Many people enter a nursing home for a relatively short duration, often to receive post-acute or rehabilitative care after a joint replacement or a stroke. But people who enter a nursing home and remain there for 100 or more days are far less likely to return to the community than are those who have shorter

State Ranking on Effective Transitions Dimension



Source: State Long-Term Services and Supports Scorecard, 2014.

stays. This new indicator was developed for the *Scorecard* and represents the first attempt to analyze state variation in the proportion of nursing home residents who appear to be unlikely to leave that setting.

There was great state variation in performance on this indicator. In the top five states, 12.9 percent of nursing home residents remained for 100 or more days, less than half the average in the bottom five states (27.9 percent). People entering nursing homes in the lowest-performing state, Louisiana, were more than three times as likely (35 percent) to stay for 100 or more days as were residents in the top state (Oregon at 10.3 percent). The top states on this indicator were Oregon, Arizona, Utah, Maine, and Minnesota.

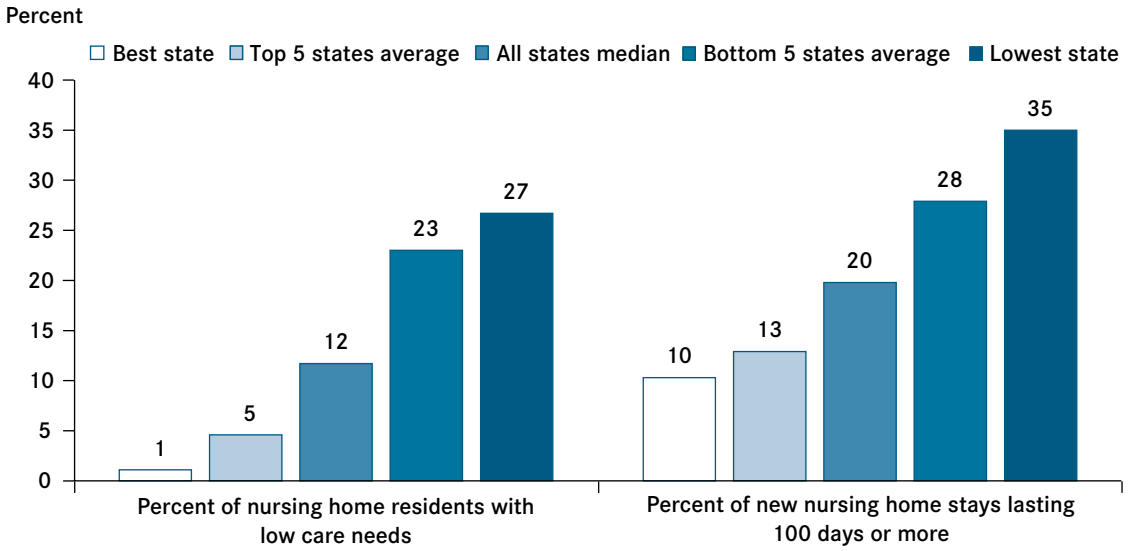
Of the measures in this dimension that involve transitions to or from nursing homes (five of the six indicators), such a wide range of performance is typical, with a twofold to fivefold difference between top and bottom states (see Exhibit 19 for the range of performance on residents with low care needs and new nursing home stays lasting 100 days or more).

Hospital Admissions

Another key way to measure effective transitions is to evaluate the relative number of hospitalizations among nursing home residents and patients receiving home health services.

EFFECTIVE TRANSITIONS Exhibit 19

State Variation: Effective Transitions



Top 5 states

	Percent of nursing home residents with low care needs	Percent of new nursing home stays lasting 100 days or more
1	Maine	Oregon
2	Hawaii	Arizona
3	Utah	Utah
4	South Carolina	Maine
5	Pennsylvania	Minnesota

Data: Analysis of 2010 MDS data by V. Mor and J. Teno at Brown University; Analysis of 2009 Chronic Conditions Warehouse Timeline file by Mathematica Policy Research.
Source: State Long-Term Services and Supports Scorecard, 2014.

These indicators were included in the 2011 *Scorecard* as measures of quality, because a lower rate of hospitalizations would generally be expected in a high-quality setting. However, with the development of this dimension, both indicators are now included as measures of effective transitions. Preventive services, early treatment of acute illnesses, and good management of chronic conditions can all help to prevent unnecessary hospitalizations among nursing home residents. Likewise, home health agencies should ensure timely care transitions for patients who are leaving a hospital or nursing home. Once home care begins, home health agencies should monitor patients for their overall health status and provide training to family caregivers to minimize rehospitalizations.

The ACA contained several initiatives to improve transitions and reduce unnecessary hospitalizations. These include the Community-based Care Transitions Program (CCTP), the Hospital Readmissions Reduction Program (HRRP), and accountable care organizations (ACOs). CCTP tests models for improving care transitions and reducing hospital readmissions among high-risk Medicare beneficiaries. HRRP penalizes and reduces payments to hospitals for excessive readmissions. ACOs are doctors, hospitals, and other providers who join voluntarily to give coordinated care to their Medicare patients. Their goal is to ensure that patients, especially those with chronic conditions, receive high-quality care while avoiding unnecessary services and preventing medical errors. Successful ACOs retain some

of the savings achieved from the Medicare program.

Hospitalizations for Home Health

The top-performing states (Utah, Oregon, Idaho, Montana, and Maine) averaged 21.1 percent of patients with hospitalizations, compared to the lowest five states that averaged 31 percent, a rate nearly 50 percent higher.

Hospitalizations from Nursing Homes

The range of performance on this indicator is substantial. The top states (Minnesota, Oregon, Arizona, Rhode Island, and Utah) had a hospitalization rate that averaged just 10.3 percent, compared to the bottom five states that averaged 27.9 percent—nearly three times higher. Moving back and forth between nursing homes and hospitals can be very stressful to patients and their families and costly to the system. Promoting evidenced-based practices to minimize these transitions can reduce these personal and system costs.

Burdensome Hospital Transitions at End of Life

Unnecessary transitions among settings are disruptive, especially to people with dementia, and can increase the risk of medical errors. Moreover, when they occur at the end of life, they can indicate poor management of care or overly aggressive treatment. A research team at Brown University defined transitions to a hospital as "potentially burdensome" when they (a) occurred in the last 3 days of life, (b) discharged an individual to a different nursing home than the one in which he or she resided prior to the hospitalization, (c) involved two or more hospitalizations for urinary tract infection, dehydration, or septicemia in the last 120 days of life, or (d) included three or more hospitalizations for any reason in the last 90 days of life. Research showed that black and Hispanic residents were at increased risk of experiencing burdensome transitions at the end of life, as were those without an advance directive.[59]

This new *Scorecard* indicator measures state performance in minimizing burdensome hospital transitions by looking at the transitions experienced by people who die in a nursing home. End-of-life care and care for people with advanced and serious illnesses are part of the overall LTSS system. People at the end of life should not be subjected to excessive hospitalizations. They should retain choice and control over where they die.

There was substantial variation in state performance. In the top states (Wyoming, Alaska, Idaho, Montana, and Vermont), an average of 9.3 percent of nursing home residents with moderate to severe dementia experienced a potentially burdensome transition, while the bottom five states averaged 34.8 percent, almost four times as high.

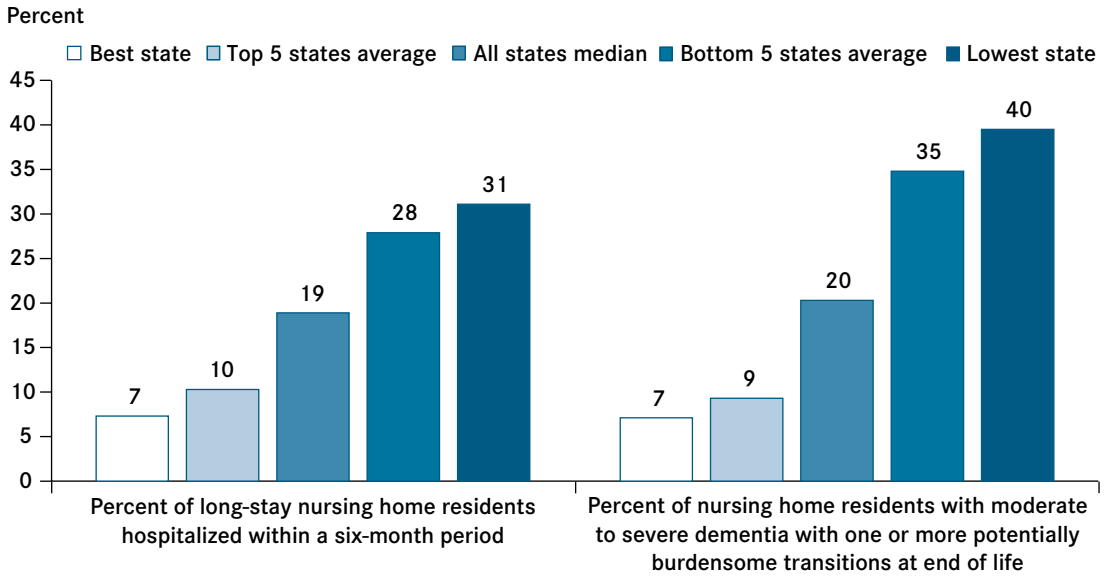
Exhibit 20 illustrates variation in state performance on this indicator and the broader measure of hospitalization rates among long-stay nursing home residents. Scores on the two measures are closely related and the amount of state to state variation is similar.

Transitions Back to the Community

While the 2011 *Scorecard* evaluated whether states adopted MFP programs, it did not compare states on the actual number of people who left nursing homes after residing there for an extended duration. A new indicator—the

EFFECTIVE TRANSITIONS Exhibit 20

State Variation: Nursing Home Transitions



Top 5 states

1	Minnesota	1	Wyoming
2	Oregon	2	Alaska
3	Arizona	3	Idaho
3	Rhode Island	4	Montana
3	Utah	5	Vermont

Data: Analysis of 2009 MDS and Medicare enrollment data and 2010 MEDPAR file by V. Mor and J. Teno at Brown University.
Source: State Long-Term Services and Supports Scorecard, 2014.

percentage of people with 90-plus-day nursing home stays who transitioned back to the community—was developed for inclusion in the *Scorecard*. The population includes both long-stay residents as well as extended rehab patients who are at high risk of not being able to return home after such a long time in the nursing facility.

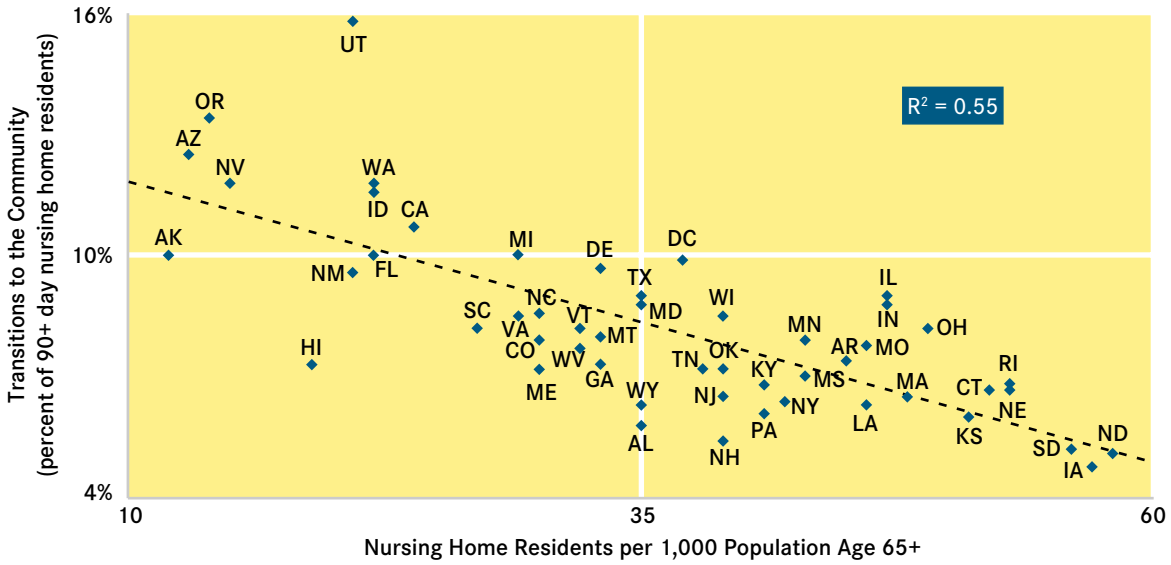
A high-performing LTSS system will not only prevent excessive use of institutional settings, but also will continue to improve by helping nursing home residents who would prefer to reside in the community to make this transition. The top states were Utah, Oregon, Arizona, Nevada, and Washington. On average, these states transitioned 13.1 percent of long-stay nursing home residents to community settings. By contrast, the rate of transitions was just 5.3 percent in the bottom five states.

This measure showed a strong correlation with the rate of nursing home use in the state (see Exhibit 21). The number of people transitioning is much smaller than the total nursing home population, so this correlation is quite notable and suggests that some common factor underlies both a high rate of institutional use and difficulty in transitioning people into the community. States with high nursing home use (see Appendix A22) were also more likely to have nursing home residents with low care needs, high hospitalizations from home health, and new nursing home stays lasting 100 or more days, as well as low performance on the effective transitions overall dimension rank.

EFFECTIVE TRANSITIONS

Exhibit 21

Nursing Home Utilization and Transitions Back to the Community



Data: Transitions to the Community: 2009 Chronic Conditions Warehouse Timeline File; Nursing Home Utilization: 2010 *Across the States, 2012.*
Source: State Long-Term Services and Supports Scorecard, 2014.

MAJOR FINDINGS

The cost of LTSS continues to outpace affordability for middle-income families, and private long-term care insurance is not filling the gap.

Nursing homes are not the setting of choice for most people with disabilities. Ideally, states offer affordable alternatives to nursing homes that also are more desirable for consumers. But when they don't, people with disabilities may find themselves both impoverished and residing in a place they don't want to be.

As we found in the 2011 *Scorecard,* middle-income families cannot afford LTSS in any state. The situation is even worse now. Home care generally is more affordable than nursing home care, and consumers can stretch out their ability to pay for services before spending all their savings and turning to Medicaid. But too many families become impoverished with no other choice than a nursing home. Despite efforts to promote private long-term care insurance, very few people purchase it and coverage remains low in all states. Thus, Medicaid remains a critical safety net.

Public policy makes a difference.

Several key indicators of system performance are directly influenced by public policy. While the private sector can do much to improve LTSS system performance, measures that are directly affected by public policy have a clearer road map toward improved performance. These include:

- The reach of the state's Medicaid program for people with disabilities who have low incomes.
- The reach of the state's Medicaid LTSS for people with disabilities who have low incomes.
- The functions of the state's ADRCs to help people find and access services.

- The proportion of Medicaid and state LTSS funds that support HCBS.
- The proportion of new Medicaid LTSS beneficiaries who use HCBS.
- The proportion of participants in publicly funded LTSS programs who direct their own services.
- Limiting the inappropriate use of antipsychotic medications in nursing homes.
- Legal and system supports for family caregivers.
- Nurse delegation practices for consumers to get help with health maintenance tasks like medications.
- Policies to improve transitions, including providing instruction to family caregivers.

Critically, several of these measures appear to be drivers of overall system performance. Two Medicaid measures had the strongest correlation to overall system performance: the reach of the Medicaid LTSS safety net to low- to moderate-income adults with disabilities, and the percentage of Medicaid LTSS spending going to HCBS. While it is beyond the scope of this *Scorecard* to distinguish between correlation and causation, states that have developed robust and balanced Medicaid LTSS systems clearly tend to have higher-performing systems across the board.

This finding demonstrates the importance of state leadership and vision. Without concerted effort, policies will languish and system performance will stagnate. But policymakers who take up the reins of leadership and drive toward improvement can make a difference.

In the absence of a broad public program to ensure access to affordable LTSS for all Americans, Medicaid remains the program of last resort for middle-income families. States have great control over Medicaid policies that determine the types of LTSS services offered and the settings in which they are provided. They establish both functional and financial eligibility standards for Medicaid coverage. Their decisions can directly affect access to HCBS and choice of services and providers. Clearly, public policy to modernize and improve the Medicaid program is making a difference in many states across the nation. But performance is uneven. Lagging states can learn from the public policy decisions made in the states that are leading or showing marked improvement.

Another area of enormous importance is the legal and system supports for family caregivers. Most older adults with LTSS needs will rely exclusively on family caregivers, never turning to Medicaid or other public programs for help. Public policies that provide legal protection to working caregivers and expand access to family and medical leave and paid sick days can make a tremendous difference in the lives of caregivers.

Although the private sector is largely responsible for measures of employment, states can do more to invest in initiatives that help working-age people with disabilities find and retain employment. Some states have developed model employer programs,[60] and an initiative by the National Governors Association in 2012–2013 addressed ways that states can improve the employment of people with disabilities.[61]

Finally, federal initiatives can provide an important mechanism to encourage positive change in the states. Federal initiatives were instrumental in bringing attention to the

inappropriate use of antipsychotic medications in nursing homes. Also, federal efforts to reduce unnecessary hospitalizations provide an incentive for states to ensure that providers improve the quality of care they provide in all settings and take steps that make transitions among settings less disruptive. Steps to guide and instruct family caregivers, especially when family members are being released from the hospital, should be part of these efforts. Improving transitions and providing care more effectively will benefit all; such care will be less costly for users and payers, of higher quality, and less disruptive for consumers and their family members.

States with more effective transitions have lower use of nursing homes and generally score better on both choice and quality.

A notable finding is that top states (including each of the top eight states) generally are ranked in the top quartile of performance on the effective transitions dimension. These states tend to minimize disruptive transitions among care settings and focus more on helping nursing home residents return to their homes and communities. Managing transitions across care settings is an important component of state LTSS systems. Populating the dimension on effective transitions was an important step forward for the *Scorecard*. The dimension of effective transitions aligns well with both the choice of setting and provider and quality of life and quality of care dimensions.

In addition, four of six indicators in this dimension are related to the rate of nursing home use in the states. In other words, states with high rates of nursing home use do not perform as well on most measures of effective transitions.

When there are excessive transitions between hospitals, nursing homes, and home- and community-based settings, quality of care suffers, as does quality of life. Overuse of hospitals raises costs for consumers, insurers, and public payers. It creates stress for family caregivers and often violates the preferences of people at the end of life who would prefer to die at home. Yet states also must take active steps to facilitate the transitions that people want—movement from nursing homes back to the home- and community-based settings that most people prefer.

Some states have made progress on important indicators, but there are persistent wide differences in state performance.

There is great disparity across the states in access, choice, quality, and provision of well-coordinated care to older people and adults with disabilities and in providing support to family caregivers. A few states have made progress, and these states are distinctly different from most other states. Moreover, the highest-performing states are continuing to improve further, raising national expectations as to what constitutes high performance. By contrast, other states do poorly on multiple measures of LTSS system performance included in the *Scorecard*. Even when these states improve on some aspects of system performance, they continue to rank low overall because they started so far behind higher-performing states.

The states that ranked highest across all five dimensions were Minnesota, Washington, Oregon, Colorado, Alaska, Hawaii, Vermont, Wisconsin, California, Maine, the District of Columbia, and Connecticut. Minnesota was the

only state to rank in the top quartile across all dimensions—a major achievement.

Even top-performing states have room to improve their LTSS systems. Despite the strong performance of top-quartile states, no state performed in the top quartile across all 26 indicators. Nearly every state that performed in the lowest quartile overall had at least 1 indicator in the top quartile; however, the performance of the lowest-ranked states was almost universally low.

As for changes across time, most states demonstrated little to no change between the first edition of the *Scorecard* and this one. For any given indicator, when states demonstrated a substantial change of more than 10 percent, they more often improved, rather than declined, but most improvements were modest (see Appendix A4 for the count of indicators improving, declining, and staying about the same for every state). Two important changes stand out: improvements in the Medicaid safety net for low-income people with disabilities on Medicaid and expansions in the functions of Aging and Disability Resource Centers.

Most striking is the continued tremendous variation among states on most indicators. High-performing states had indicator scores that doubled or tripled (or more) the rates attained by lower-performing states. Improvement of 10 percent is a notable achievement, but not enough to cross the gap between low- and high-performing states, where differences often exceed 200 percent.

Some national successes are worth noting. It is a notable success that several indicators were excluded from this *Scorecard* because most states had improved to a nearly uniform level of performance. These were the use of physical restraints in nursing homes and the inclusion of treatment plans to prevent pressure sores in high-risk home health patients. While continued improvement in these measures is still possible, the variation between most states is small, and large differences in rank may not correspond to meaningful differences in performance.

Use of physical restraints in nursing homes was a harmful and demeaning practice associated with poor-quality care. However, as nursing homes eliminate the use of these restraints, it is important to ensure that they do not simply substitute the inappropriate use of sedating antipsychotic medications for physical restraints, an area that the *Scorecard* is now monitoring.

Prevention of pressure sores also is a critical quality measure. If home health agencies ensure that patients never develop pressure sores, they stand a better chance of avoiding serious infections and hospitalizations.

In addition, two components that were included in the composite indicator "tools and programs to support consumer choice" in the first *Scorecard* no longer showed an adequate range of performance for us to meaningfully rank the states. These were the state adoption of "options counseling" to inform consumers about alternatives to nursing homes (adopted by 45 states) and participation in the MFP program (adopted by 46 states), which helps long-stay nursing home residents transition back to the community. As a result, there was no longer adequate state variation on the full composite to distinguish state performance, and the indicator was not included in this *Scorecard*. However, the *Scorecard* includes a new indicator

that measures the frequency of people with a 90-plus-day nursing home stay to successfully transition back to the community. This indicator may include those transitioning through MFP or other programs, as well as those returning to the community without specific intervention.

As the LTSS system changes, both nationally and in the states, the *Scorecard* must continue to evolve to capture new trends for which data are available.

The gradual pace of improvement must accelerate to be ready for the aging of baby boomers.

The pace of change has been slow at a time when we need to prepare for baby boomers entering their 80s in the next 12 years. This is particularly important because the availability of family caregivers is already declining. In 2010, there were seven potential caregivers for every potential care recipient, but this ratio is projected to decline to four caregivers to every recipient by 2030 and to fewer than three caregivers to every recipient by 2050.[62] As the ratio of potential family caregivers declines, we will need a larger paid workforce and mechanisms for people to afford paid care. As people live longer, often with chronic health conditions and limits on performing daily activities, the need for an adequate workforce will intensify.

IMPACT OF IMPROVED PERFORMANCE

A dramatic range of performance exists among the states on many indicators. If all states raised their level of performance to match the top-performing state, it would have a tremendous impact on the people who need services. Exhibit 22 illustrates the potential for improvement on selected indicators.

Exhibit 22

National Cumulative Impact if All States Achieved Top State Rates

Indicator	If all states improved their performance to the level of the best-performing state for this indicator:	
Home Health Aide Supply	1,501,919	more personal care, home care, and home health aides would be available to provide LTSS in the community.
Low-Income PWD with Medicaid	1,378,228	more low or moderate-income (<250% poverty) adults age 21+ with ADL disabilities would be covered by Medicaid.
Medicaid LTSS Balance: New Users	200,323	more people would first receive services in home and community settings, instead of a nursing home.
Nursing Home Low Care Needs	157,101	nursing home residents with low care needs would instead be served in home and community settings.
Transitions Back to Community	105,919	more people with 90+ day nursing home stays would be able to leave a nursing home for a more home-like setting.
Long Nursing Home Stays	77,817	more people entering nursing homes would be able to return to the community within 100 days.

Notes: PWD = People with Disabilities.
Source: State Long-Term Services and Supports Scorecard, 2014.

RAISING EXPECTATIONS: THE NEED FOR ACTION TO IMPROVE PERFORMANCE

> *Where people live affects the opportunities available to them and, ultimately, their quality of life. … State-specific factors, including state leadership and vision, state responses to federal policy, consumer demand and advocacy, and provider supply and political strength, among other things, affect programs and services.*[63] (National Health Policy Forum, "State Variation in Long-Term Services and Supports: Location, Location, Location")

The *Scorecard* clearly shows that where one lives has a tremendous impact on the experience that people and their families are likely to have when the need for LTSS arises. We have a long tradition in this country of valuing the diversity of state traditions and values. But while our country gives states ample leeway in establishing their own laws, we also hold dear universal values that guide our entire nation. Equitable treatment of older adults, people with disabilities, and their family caregivers should be among them.

This second edition *Scorecard* shows that most states have seen only modest improvement since the first *Scorecard*, with the pace of change on many indicators slow and uneven. The wide disparities across states and gaps in support observed in the 2011 *Scorecard* continue, affecting millions of people who encounter a fragmented, expensive LTSS system, often with little choice of setting or care. We still have very far to go to meet the needs of an aging population, adults with disabilities, and family caregivers.

Two things are clear. First, *we need a rational approach at the federal level to guide the states and to establish standards for LTSS system performance below which no state should fall*. When the first *Scorecard* was published in 2011, there was hope that a new federally administered comprehensive public insurance program, the CLASS Act, would move the nation forward. This program would have improved LTSS affordability for program participants, but the legislation was repealed before it was implemented, a public policy setback. With the repeal, however, Congress authorized a federal Commission on Long-Term Care to study the issue of LTSS financing and delivery. While consensus on how to establish a national system of LTSS did not emerge, the commission spurred interest in this issue and examined new options for both public and private financing. Until this stumbling block is overcome, middle-income families will continue to struggle with how to pay for LTSS, often impoverishing themselves—at great personal and family distress—to get the services they and their family caregivers need.

Second, despite the lack of strong federal solutions, *state leadership and vision make a difference*. Willingness to experiment, innovate, and challenge the status quo are the hallmarks of successful states. Leading states combine these characteristics with a commitment to the rights of people with disabilities and older people to live with dignity in the setting of their choice, supported by the services they need to maximize their independence. Many states have been pushed in the direction of change by advocacy at the state level by organizations representing the interests of older people and

people with disabilities. Legal challenges, often based on the Supreme Court's Olmstead decision, have helped to spur some states toward better Medicaid balancing. But major system changes cannot be accomplished overnight. It's time to pick up the pace.

An area of considerable change in state Medicaid programs is their move toward adopting managed care in their delivery of LTSS. By the end of this year, more than half the states will have managed Medicaid LTSS programs. It will be critical for states to monitor access to and delivery of services to ensure that consumers receive the services they need and have an adequate choice of providers. States need to take an active role in monitoring the terms and conditions of their contracts with managed care organizations to ensure that there are adequate provider networks, appropriate training of care coordinators, and continuing oversight.[64]

One goal of the *Scorecard* is to shed light on high-performing states so that other states can learn from their successes. An area of substantial change between the 2011 *Scorecard* and this report was in the legal and system supports for family caregivers. Several jurisdictions enacted laws requiring employers to provide paid sick days—an important protection for working caregivers who need to use sick days to take family members to medical appointments or to maintain their own health. Jersey City, New Jersey; New York City; Portland, Oregon; and Seattle, Washington, have enacted such laws.

Connecticut enacted major legislation to support family caregivers statewide. The state now requires employers to provide paid sick days, and its employment antidiscrimination provisions prohibit employers from asking workers about their familial responsibilities.[65] In addition to these changes, Connecticut expanded the number of health maintenance tasks that nurses may delegate. Of note, however, is that Connecticut's law allows sick days to be used for the worker's own illness, or to care for a child or spouse; it does not cover workers who care for a parent or other relative. Rhode Island enacted legislation that requires employers to provide paid family and medical leave, an enormous benefit to family caregivers.

States that take action to change such laws as these benefit a broad scope of people who are affected by the LTSS system, not just people with limited incomes who turn to the Medicaid program for help. Legislation to help family caregivers, including the many caregivers who also hold down paid employment, is an important area of state policy action. Such legislation places some of the responsibility on the private sector to treat family caregivers fairly. Caregivers remain the backbone of our nation's LTSS system, and even those who have adequate incomes need help and support to sustain their important roles.

But given the high cost of LTSS, many people continue to rely on Medicaid as the program of last resort. The *Scorecard* shows that the top states generally scored very high on measures of Medicaid performance. For example, looking at the four indicators of Medicaid performance, the top 12 states scored in the top quartile on these measures more than three-quarters of the time.

California and Oregon, both strong performers on measures of Medicaid balancing, were the first two states approved for the Community First Choice option—a federal initiative that helps move states toward leveling the playing field between institutional services and

HCBS. Arizona and Maryland have submitted applications to implement this program, and several other states (Arkansas, Minnesota, Montana, and New York) have indicated their intention to do so.[66]

Mississippi has been a low performer on many *Scorecard* indicators. However, it showed substantial improvement in serving new Medicaid LTSS users first in HCBS settings, going from 32.5 percent in the first *Scorecard* to 48.1 percent in the current report—the largest rate of improvement in any state on this measure. While still ranking 24th on the indicator, Mississippi is making efforts to improve its historically low level of Medicaid balancing.

Although many quality measures reflect actions controlled by private-sector providers of services, states can play an important oversight role. For example, Colorado instituted a "pay for performance" (P4P) program that provides higher Medicaid reimbursement to nursing facilities that achieve designated benchmark measures.[67] Demonstrating its commitment to quality, it added a measure on the use of antipsychotic medications in nursing homes to its P4P program,[68] a measure reflected in this *Scorecard*.

The *Scorecard* can only be as good as the data available to measure state performance. While this project compiled a wealth of data, there remain important areas in which we are unable to measure performance. For example, there is no uniform source of data to measure HCBS quality, an indicator that would improve the *Scorecard*. Appropriate measures of home health quality also are not available. Those that exist are more reflective of the health care system than of LTSS system performance. As resources continue to be strained at both federal and state levels, it often is easier to cut back on data collection rather than make cuts in important services. Yet data are essential to measuring and evaluating whether programs are meeting their objectives.

CONCLUSION

When the first *LTSS Scorecard* was released in 2011, we were heartened by the immediate positive response from states across the nation. State officials reached out to us to better understand their performance and think about ways to improve. We conducted case studies of states at different levels of performance (Minnesota, Idaho, and Georgia)[69] to shed additional light on what factors led to high performance or impeded it. State advocates used the *Scorecard* as the centerpiece of their efforts to push change.

It was notable that Minnesota, the top state in both *Scorecards*, was one of the first states to reach out to the *Scorecard* team to discuss ways to improve their performance in the few areas where they ranked low. This commitment to excellence demonstrates why they lead the nation, with an impressive showing in the *Scorecard*. Of the 26 indicators, Minnesota ranked in the first quartile on 18, with only 1 indicator in the bottom quartile.

Building a high-performing LTSS system is not a simple task, and the diverse indicators measured in the *Scorecard* interact with one another, creating a complex picture. While a small number of state systems are generally high- or low-performing, most state systems have a constellation of relative strengths and weaknesses.

Many aspects of performance measured by the 26 indicators are related. When costs are high for people who pay privately, they will rapidly spend down to Medicaid as they spend all of their life savings on LTSS. If that Medicaid safety net is inadequate, they may have to lean so heavily on family caregivers that those individuals need to leave their jobs, jeopardizing financial security for themselves and their families. If they have not developed a strong base of alternatives to nursing homes, states will strain their budgets. If they do not focus on transitions between settings, they will rely too heavily on nursing homes. And across all settings, poor quality of care will lead to poor health, contributing to higher system costs.

Some states have tackled these thorny issues and found ways to improve their LTSS systems. Most states still must rise to meet the challenge. One reason states are struggling is because there is no comprehensive national system for states to build on and little political consensus as to how to create one. Many policymakers see LTSS as a looming disaster on the horizon, both because of the aging of the Baby Boom Generation into the years of highest LTSS needs and because we lack a national solution to protect against the unpredictable cost of services. We need to do better at both national and state levels.

The private insurance market for long-term care generally has stalled and failed to spread in any state, with only about a dozen companies continuing to offer products. There is no national system of social insurance yet, and little political consensus as to how to solve this dilemma. Until a more adequate national solution is achieved, states will continue to be the major laboratories of experimentation.

National policy direction should help guide the states. As the report of the federal Commission on Long-Term Care noted, public policy "must encourage and enable individuals to prepare adequately to finance their own needs while providing a strong safety net for those who simply cannot do so." It also noted, "Medicaid must be improved to better provide needed LTSS to enable people to have more choice of person- and family-centered services that meet their needs, and promote opportunities for persons with disabilities to engage in meaningful work."[70]

Our hope is that this *Scorecard* will help keep the states moving in the right direction toward higher performance and an accelerated pace of change. But success depends on states taking the initiative and making a commitment to do better. In partnership with federal initiatives and private-sector actions, the states have the capacity to improve the delivery of LTSS, thereby improving the lives of older adults, people with disabilities, and their family caregivers.

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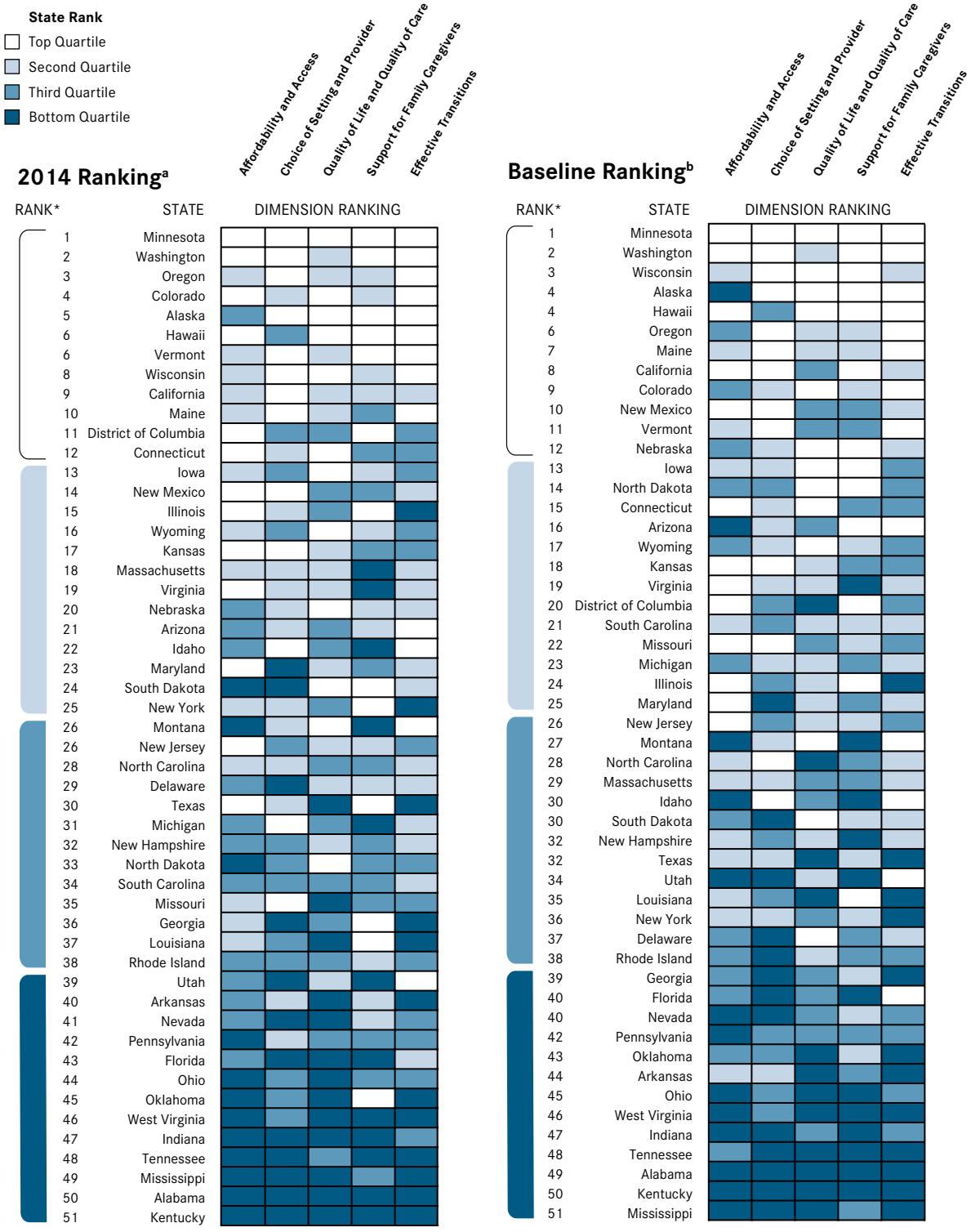
LIST OF APPENDICES

Appendix A

Appendix B

Exhibit A1

State Scorecard Summary of Current and Baseline LTSS System Performance Across Dimensions



How to use these two tables: Between the release of the 2011 and 2014 Scorecards, a total of 5 new indicators were added giving a more detailed look at performance across the five dimensions. To better understand the current results in relationship to the original 2011 *Scorecard,* a historical baseline was created that includes this broader group of indicators. The baseline is not a replacement for the original 2011 *Scorecard;* it simply serves as a more complete comparison given the large number of new indicators. Small changes in ranking up or down are not necessarily significant while substantial movement is likely reflective of actions taken by a state to reshape its LTSS program. It is very important to look at the individual indicators that make up each dimension to understand what activities in the state may have caused its ranking to change.

*Ties in rank are adjusted as per methodology description on page 21.

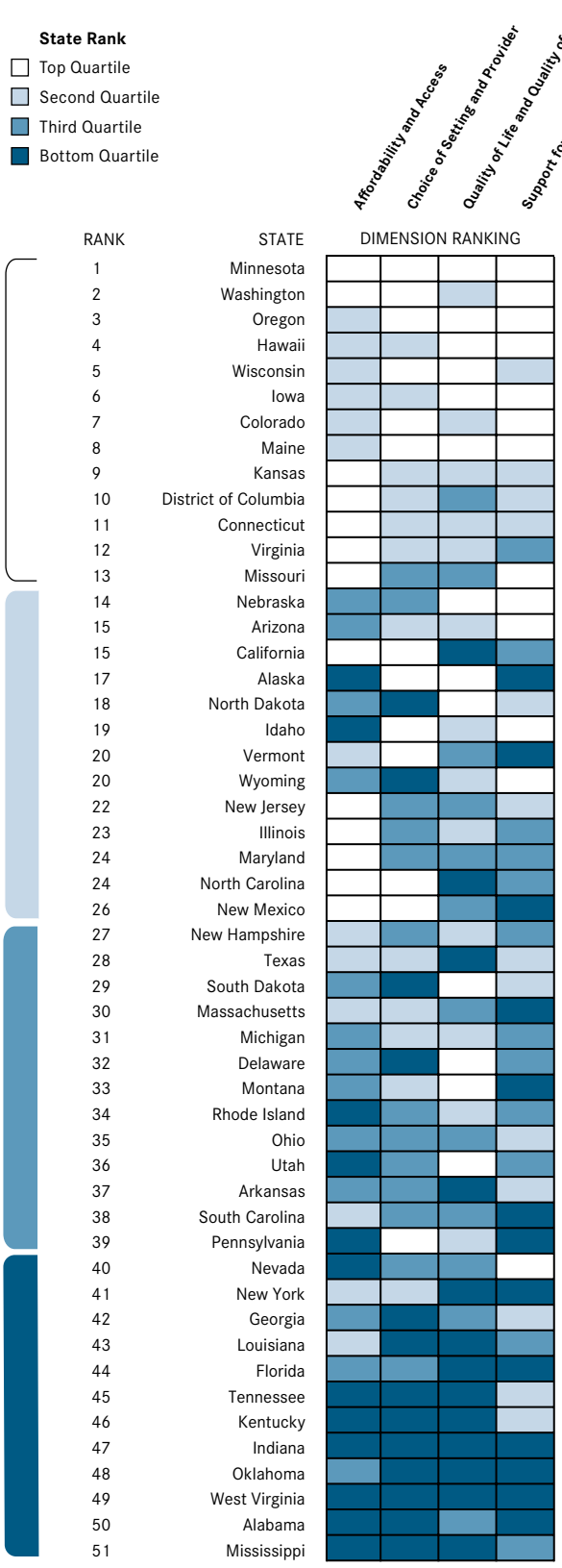
[a]We do not encourage comparison of ranks from baseline to the most current data; this is because an increase in rank does not necessarily correspond to an increase in level of performance, as the rank could improve even as performance declines (or vice versa), depending on other states. Comparison of data at the indicator level is the best way to understand changes in system performance.

[b]Baseline data are calculated solely to be a statistically valid reference for the current data and should not be interpreted as "prior level of performance" or as a replacement for the 2011 *State LTSS Scorecard*.

Source: State Long-Term Services and Supports Scorecard, 2014.

Exhibit A2

2011 *State Scorecard* Summary of LTSS System Performance Across Dimensions



Note: Because of changes in the indicator set, rankings from the 2011 *Scorecard* are not entirely comparable to the current *Scorecard* rankings. Changes in rank may not reflect changes in performance, and should not be interpreted as such.
Source: State Long-Term Services and Supports Scorecard, 2011

Exhibit A3

Summary of Indicator Rankings by State

Overall Rank*	State	Number of indicators with data	Number of Indicators for which the State is in the Top 5 States	Top Quartile	2nd Quartile	3rd Quartile	Bottom Quartile	Bottom 5 States
50	Alabama	26	0	1	3	5	17	5
5	Alaska	23	10	12	7	1	3	2
21	Arizona	24	3	4	10	7	3	1
40	Arkansas	26	0	3	7	7	9	4
9	California	26	4	12	6	4	4	2
4	Colorado	26	2	8	14	4	0	0
12	Connecticut	25	4	9	5	8	3	2
29	Delaware	26	1	5	10	5	6	1
11	District of Columbia	24	8	12	3	3	6	5
43	Florida	26	1	6	3	7	10	4
36	Georgia	26	1	3	6	9	8	2
6	Hawaii	23	8	11	5	5	2	2
22	Idaho	26	5	10	6	5	5	3
15	Illinois	26	2	7	7	7	5	3
47	Indiana	26	1	2	3	9	12	3
13	Iowa	26	2	9	6	7	4	2
17	Kansas	26	2	6	9	5	6	1
51	Kentucky	26	0	1	0	11	14	4
37	Louisiana	26	0	5	3	7	11	8
10	Maine	24	5	10	4	7	3	0
23	Maryland	26	1	6	8	9	3	1
18	Massachusetts	26	2	5	12	4	5	2
31	Michigan	26	2	4	7	12	3	1
1	Minnesota	26	11	18	5	2	1	1
49	Mississippi	26	0	3	1	7	15	6
35	Missouri	26	2	4	6	8	8	3
26	Montana	26	2	9	7	4	6	2
20	Nebraska	26	5	8	5	8	5	1
41	Nevada	26	1	5	4	7	10	4
32	New Hampshire	26	2	6	6	8	6	2
26	New Jersey	26	1	6	8	6	6	2
14	New Mexico	25	3	5	9	9	2	1
25	New York	26	3	6	6	5	9	6
28	North Carolina	26	1	3	10	9	4	0
33	North Dakota	26	3	7	7	5	7	4
44	Ohio	26	0	0	9	11	6	2
45	Oklahoma	26	1	2	5	6	13	6
3	Oregon	26	8	13	7	5	1	0
42	Pennsylvania	25	1	1	8	11	5	0
38	Rhode Island	26	2	4	8	7	7	5
34	South Carolina	26	1	2	11	8	5	1
24	South Dakota	26	4	8	7	4	7	5
48	Tennessee	26	0	0	7	9	10	5
30	Texas	24	1	6	3	7	8	3
39	Utah	26	6	9	2	5	10	4
6	Vermont	26	3	13	8	3	2	1
19	Virginia	24	1	3	11	7	3	2
2	Washington	26	8	16	5	4	1	0
46	West Virginia	26	0	1	4	8	13	5
8	Wisconsin	24	3	10	9	3	2	0
16	Wyoming	26	1	6	11	6	3	1

* Final rank for overall LTSS system performance across five dimensions.
Source: State Long-Term Services and Supports Scorecard, 2014.

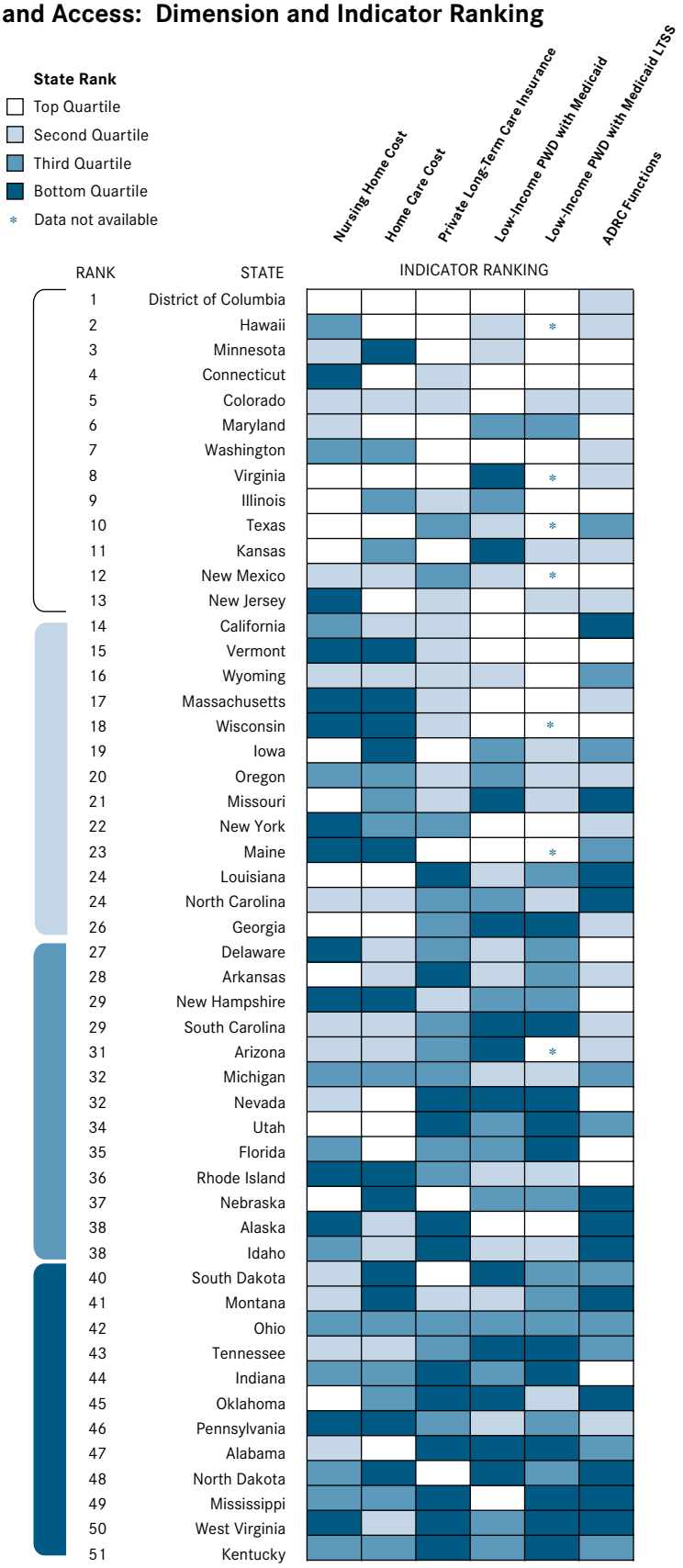
Exhibit A4

Summary of Change in Performance by State

State	Across All Dimensions, Number of Indicators That Showed:			
	Improvement	Decline	Little/No Change	No Trend*
United States	**8**	**1**	**10**	**7**
Alabama	4	2	13	7
Alaska	7	2	7	10
Arizona	6	0	10	10
Arkansas	8	3	8	7
California	8	1	10	7
Colorado	11	0	8	7
Connecticut	7	1	10	8
Delaware	10	2	7	7
District of Columbia	10	1	5	10
Florida	6	1	12	7
Georgia	6	1	11	8
Hawaii	7	2	7	10
Idaho	8	0	11	7
Illinois	10	1	8	7
Indiana	7	1	10	8
Iowa	7	2	10	7
Kansas	5	2	12	7
Kentucky	5	3	9	9
Louisiana	7	1	11	7
Maine	9	1	7	9
Maryland	10	0	9	7
Massachusetts	12	0	7	7
Michigan	4	1	12	9
Minnesota	9	3	7	7
Mississippi	11	1	7	7
Missouri	4	1	14	7
Montana	9	2	7	8
Nebraska	6	2	11	7
Nevada	7	4	8	7
New Hampshire	8	2	9	7
New Jersey	9	1	9	7
New Mexico	4	4	9	9
New York	7	1	11	7
North Carolina	5	0	14	7
North Dakota	7	4	8	7
Ohio	8	1	10	7
Oklahoma	7	2	10	7
Oregon	10	2	7	7
Pennsylvania	12	0	6	8
Rhode Island	8	2	9	7
South Carolina	5	3	11	7
South Dakota	6	2	11	7
Tennessee	6	0	13	7
Texas	7	2	8	9
Utah	4	4	11	7
Vermont	7	4	8	7
Virginia	5	1	11	9
Washington	9	2	8	7
West Virginia	6	2	11	7
Wisconsin	8	1	8	9
Wyoming	6	4	9	7

* No trend means that there are missing data for one or both years (current year and/or baseline year) and therefore a year to year trend cannot be calculated to determine whether a state's indicator performance has improved, declined, or stayed about the same. To calculate a trend, data from both curent and baseline years must be available. For this *Scorecard*, there are 7 indicators with no baseline year data (see Exhibit 2). In addition, there are serveral states that have missing indicator data for current year (refer to the data tables in Appendix A for current year state data in each indicator). Some states will have 8, 9, or 10 indicators with no data to calculate a year to year trend. Overall, this *Scorecard* is unable to show year to year trend data for 7 indicators in 35 states; 8 indicators in 5 states; 9 indicators in 7 states; and 10 indicators in 4 states.
Source: State Long-Term Services and Supports Scorecard, 2014.

Affordability and Access: Dimension and Indicator Ranking



PWD = People with Disabilities; ADRC = Aging and Disability Resource Center
Source: State Long-Term Services and Supports Scorecard, 2014.

Indicator Performance, Ranking, and Change

State	Median Annual Nursing Home Private Pay Cost as a Percentage of Median Household Income Age 65+				Median Annual Home Care Private Pay Cost as a Percentage of Median Household Income Age 65+				Private Long-Term Care Insurance Policies in Effect per 1,000 Population Age 40+			
	2010	2013	Rank	Change in Performance	2010	2013	Rank	Change in Performance	2009	2011	Rank	Change in Performance
United States	**241%**	**246%**		↔	**88%**	**84%**		↔	**44**	**46**		↔
Alabama	215%	214%	17	↔	79%	79%	13	↔	33	33	43	↔
Alaska	444%	456%	51	↔	95%	82%	17		29	29	49	↔
Arizona	224%	224%	24	↔	89%	80%	14	✓	35	37	37	↔
Arkansas	201%	195%	10	↔	91%	84%	25	↔	29	30	48	↔
California	224%	241%	28	↔	82%	82%	17	↔	43	45	24	↔
Colorado	216%	211%	14	↔	89%	81%	15	↔	52	56	13	↔
Connecticut	345%	359%	49	↔	83%	77%	9	↔	52	53	16	↔
Delaware	277%	277%	39	↔	87%	84%	25	↔	40	40	30	↔
District of Columbia	166%	169%	2	↔	55%	47%	1	✓	114	130	1	✓
Florida	254%	272%	38	↔	82%	78%	11	↔	34	36	38	↔
Georgia	188%	181%	6	↔	86%	75%	5	✓	34	36	38	↔
Hawaii	236%	263%	36	X	73%	71%	4	↔	121	109	3	↔
Idaho	231%	238%	27	↔	87%	82%	17	↔	36	35	40	↔
Illinois	203%	198%	11	↔	93%	88%	34	↔	45	50	20	✓
Indiana	230%	241%	28	↔	94%	87%	32	↔	31	34	42	↔
Iowa	179%	185%	8	↔	109%	95%	42	✓	87	87	7	↔
Kansas	177%	175%	4	↔	87%	85%	27	↔	73	73	8	↔
Kentucky	250%	269%	37	↔	94%	92%	37	↔	32	33	43	↔
Louisiana	180%	189%	9	↔	84%	76%	6	↔	28	31	46	✓
Maine	339%	303%	44	✓	120%	96%	46	✓	300	107	4	X
Maryland	207%	223%	22	↔	70%	65%	2	↔	56	63	12	✓
Massachusetts	329%	346%	47	↔	108%	97%	47	✓	47	53	16	✓
Michigan	249%	262%	35	↔	89%	86%	28	↔	36	38	33	↔
Minnesota	219%	211%	14	↔	110%	100%	49	↔	71	73	8	↔
Mississippi	267%	250%	34	↔	96%	89%	36	↔	31	31	46	↔
Missouri	167%	175%	4	↔	87%	86%	28	↔	54	56	13	↔
Montana	226%	234%	26	↔	98%	94%	41	↔	55	55	15	↔
Nebraska	217%	198%	11	↔	96%	95%	42	↔	103	102	5	↔
Nevada	215%	218%	19	↔	85%	76%	6	✓	29	26	51	X
New Hampshire	297%	302%	43	↔	107%	93%	39	✓	46	48	21	↔
New Jersey	300%	303%	44	↔	81%	76%	6	↔	41	46	23	✓
New Mexico	219%	223%	22	↔	77%	82%	17	↔	37	38	33	↔
New York	393%	396%	50	↔	96%	92%	37	↔	35	38	33	↔
North Carolina	221%	231%	25	↔	88%	82%	17	↔	41	42	28	↔
North Dakota	233%	249%	33	↔	113%	103%	50	↔	107	102	5	↔
Ohio	237%	246%	31	↔	88%	87%	32	↔	36	39	32	↔
Oklahoma	181%	168%	1	↔	93%	86%	28	↔	35	35	40	↔
Oregon	252%	244%	30	↔	95%	86%	28	↔	44	48	21	↔
Pennsylvania	299%	311%	46	↔	97%	93%	39	↔	37	41	29	✓
Rhode Island	350%	352%	48	↔	125%	111%	51	✓	38	40	30	↔
South Carolina	211%	221%	20	↔	84%	81%	15	↔	42	43	27	↔
South Dakota	223%	215%	18	↔	100%	95%	42	↔	110	112	2	↔
Tennessee	212%	221%	20	↔	90%	82%	17	↔	41	44	26	↔
Texas	205%	181%	6	✓	81%	77%	9	↔	36	38	33	↔
Utah	166%	170%	3	↔	84%	78%	11	↔	36	33	43	↔
Vermont	270%	300%	42	X	97%	99%	48	↔	50	51	19	↔
Virginia	196%	198%	11	↔	70%	65%	2	↔	63	68	10	↔
Washington	221%	246%	31	X	93%	88%	34	↔	48	66	11	✓
West Virginia	306%	290%	41	↔	87%	83%	23	↔	28	28	50	↔
Wisconsin	258%	279%	40	↔	101%	95%	42	↔	52	53	16	↔
Wyoming	203%	212%	16	↔	75%	83%	23	X	46	45	24	↔

* Data not available; for change over time, data from both current and baseline years must be available.
** Change over time data are based on a partial baseline (not shown); see Exhibit A8 for additional detail.
✓ Represents an improvement in performance.
↔ Represents little or no change in performance.
X Represents a decline in performance.
Data: See Appendix B2 for a full description of each indicator.
Source: State Long-Term Services and Supports Scorecard, 2014.

Exhibit A6 (continued)

Indicator Performance, Ranking, and Change

State	Percent of Adults Age 21+ with ADL Disability at or Below 250% of Poverty Receiving Medicaid or Other Government Assistance Health Insurance				Medicaid LTSS Participant Years per 100 Adults Age 21+ with ADL Disability in Nursing Homes or At/Below 250% Poverty in the Community				Aging and Disability Resource Center Functions (Composite Indicator, scale 0–70)		
	2008-09	2011-12	Rank	Change in Performance	2007	2009	Rank	Change in Performance	2012	Rank	Change in Performance**
United States	**51.6%**	**53.7%**		↔	**36.9**	**43.8**		✓	**52**		✓
Alabama	47.3%	46.4%	46	↔	21.9	23.2	42	↔	45	38	✓
Alaska	61.5%	64.5%	4	✓	46.8	57.7	8	✓	42	42	↔
Arizona	45.6%	48.4%	40	✓	*	*	*	*	54	23	✓
Arkansas	49.2%	52.1%	23	✓	30	36.2	29	✓	54	23	X
California	58.4%	62.8%	6	✓	69.9	85.2	1	✓	34	49	✓
Colorado	48.1%	58.2%	10	✓	37.2	46.6	20	✓	54	23	✓
Connecticut	57.0%	60.7%	8	✓	54.9	60.7	4	✓	60	10	✓
Delaware	47.0%	53.2%	18	✓	31.6	32.3	33	↔	59	13	✓
District of Columbia	60.8%	78.1%	1	✓	48.2	59.4	6	✓	54	23	↔
Florida	44.6%	48.8%	39	✓	24.1	25.4	39	↔	66	2	✓
Georgia	48.0%	47.1%	45	↔	20.5	24.2	41	✓	57	17	↔
Hawaii	51.8%	54.4%	17	✓	29.5	*	*	*	58	14	✓
Idaho	44.3%	51.8%	24	✓	40.3	47.7	17	✓	38	47	✓
Illinois	48.3%	49.9%	33	↔	51.2	60.1	5	✓	61	7	✓
Indiana	48.8%	49.1%	38	↔	22.4	27.5	37	✓	64	4	✓
Iowa	49.8%	49.7%	35	↔	38.3	52.2	14	✓	45	38	✓
Kansas	46.9%	48.4%	40	↔	43.1	45.2	21	↔	57	17	✓
Kentucky	50.2%	50.2%	32	↔	*	25	40	*	49	34	↔
Louisiana	54.2%	53.0%	19	↔	25.3	32.4	32	✓	43	41	↔
Maine	63.6%	63.2%	5	↔	*	*	*	*	51	32	↔
Maryland	51.1%	51.0%	28	↔	31.9	40.7	24	✓	60	10	✓
Massachusetts	61.8%	67.4%	2	✓	38.7	57.7	8	✓	58	14	↔
Michigan	51.7%	55.6%	14	✓	*	46.7	19	*	49	34	↔
Minnesota	53.9%	54.5%	16	↔	74.6	71.6	2	X	65	3	↔
Mississippi	54.6%	58.5%	9	✓	24.8	31.9	34	✓	14	51	X
Missouri	51.7%	47.3%	43	X	45.9	53.4	13	✓	39	46	↔
Montana	41.5%	52.9%	20	✓	30.2	34	30	✓	40	45	↔
Nebraska	48.5%	49.5%	36	↔	31.2	39.1	27	✓	30	50	↔
Nevada	39.9%	47.3%	43	✓	26.7	26.1	38	↔	61	7	✓
New Hampshire	52.3%	49.4%	37	X	40.5	41	23	↔	67	1	↔
New Jersey	52.6%	56.1%	13	✓	43.2	51.1	15	✓	54	23	↔
New Mexico	50.4%	51.4%	26	↔	37	*	*	*	62	6	↔
New York	63.1%	65.8%	3	✓	51.8	56	10	✓	57	17	↔
North Carolina	49.4%	50.7%	30	↔	45.7	53.6	12	✓	44	40	↔
North Dakota	53.6%	46.1%	48	X	34.1	40.4	25	✓	42	42	✓
Ohio	51.2%	51.1%	27	↔	36.1	39.4	26	✓	52	30	✓
Oklahoma	46.7%	43.2%	49	X	39.3	43.5	22	✓	36	48	✓
Oregon	46.0%	49.9%	33	✓	42.1	48.7	16	✓	57	17	✓
Pennsylvania	48.5%	51.6%	25	✓	26.8	33	31	✓	54	23	✓
Rhode Island	56.8%	55.3%	15	↔	39.1	46.9	18	✓	60	10	✓
South Carolina	49.3%	46.3%	47	X	23.6	27.6	36	✓	57	17	↔
South Dakota	45.7%	42.3%	51	X	28.1	36.5	28	✓	50	33	✓
Tennessee	48.2%	48.1%	42	↔	15.9	18.6	43	✓	53	29	✓
Texas	49.3%	52.9%	20	✓	*	*	*	*	52	30	✓
Utah	38.7%	51.0%	28	✓	17.3	16.3	44	↔	46	36	✓
Vermont	58.2%	60.8%	7	✓	63.3	59.4	6	X	61	7	✓
Virginia	52.4%	42.5%	50	X	*	*	*	*	56	22	✓
Washington	52.1%	57.1%	11	✓	54.5	63	3	✓	58	14	↔
West Virginia	49.9%	50.6%	31	↔	24.2	30.7	35	✓	42	42	X
Wisconsin	52.9%	57.0%	12	✓	*	*	*	*	64	4	↔
Wyoming	40.7%	52.3%	22	✓	29.1	55	11	✓	46	36	✓

* Data not available; for change over time, data from both current and baseline years must be available.
** Change over time data are based on a partial baseline (not shown); see Exhibit A8 for additional detail.
✓ Represents an improvement in performance.
↔ Represents little or no change in performance.
X Represents a decline in performance.
Data: See Appendix B2 for a full description of each indicator.
Source: State Long-Term Services and Supports Scorecard, 2014.

Income, Private Pay Cost, and LTSS Affordability

State	Median Household Income Age 65+	Median Annual Cost of Care: Nursing Home Private Room	Median Annual Cost of Care: 30 Hours/Week of Home Care	Median Cost as a Percentage of Median Household Income*: Nursing Home Private Room	Median Cost as a Percentage of Median Household Income*: 30 Hours/Week of Home Care
United States	**$36,743**	**$83,950**	**$30,326**	**246%**	**84%**
Alabama	$32,287	$69,543	$24,960	214%	79%
Alaska	$46,666	$255,891	$38,220	456%	82%
Arizona	$39,083	$86,505	$31,200	224%	80%
Arkansas	$30,891	$60,225	$26,520	195%	84%
California	$42,406	$97,820	$35,802	241%	82%
Colorado	$41,985	$87,235	$33,727	211%	81%
Connecticut	$41,947	$151,658	$32,760	359%	77%
Delaware	$42,211	$107,310	$34,398	277%	84%
District of Columbia	$46,926	$105,120	$28,860	169%	47%
Florida	$36,415	$91,250	$28,860	272%	78%
Georgia	$35,371	$67,525	$27,300	181%	75%
Hawaii	$59,378	$145,270	$39,000	263%	71%
Idaho	$34,040	$86,505	$28,860	238%	82%
Illinois	$37,161	$70,445	$31,980	198%	88%
Indiana	$34,636	$85,775	$29,640	241%	87%
Iowa	$34,731	$64,058	$33,150	185%	95%
Kansas	$36,516	$62,780	$29,016	175%	85%
Kentucky	$30,023	$81,395	$27,300	269%	92%
Louisiana	$30,935	$58,345	$23,400	189%	76%
Maine	$33,358	$104,025	$34,320	303%	96%
Maryland	$47,949	$100,072	$31,200	223%	65%
Massachusetts	$38,233	$133,225	$37,752	346%	97%
Michigan	$35,504	$93,075	$30,420	262%	86%
Minnesota	$37,428	$79,935	$39,000	211%	100%
Mississippi	$28,388	$75,738	$26,520	250%	89%
Missouri	$33,906	$58,035	$28,080	175%	86%
Montana	$34,941	$79,388	$32,760	234%	94%
Nebraska	$35,655	$72,088	$34,164	198%	95%
Nevada	$40,181	$89,425	$32,744	218%	76%
New Hampshire	$41,445	$120,450	$37,050	302%	93%
New Jersey	$43,254	$121,180	$32,760	303%	76%
New Mexico	$34,727	$79,753	$31,013	223%	82%
New York	$37,246	$125,732	$34,320	396%	92%
North Carolina	$33,749	$77,471	$27,300	231%	82%
North Dakota	$34,462	$91,250	$36,348	249%	103%
Ohio	$33,901	$82,125	$29,640	246%	87%
Oklahoma	$33,397	$55,360	$29,562	168%	86%
Oregon	$38,428	$92,710	$32,760	244%	86%
Pennsylvania	$33,942	$104,390	$31,200	311%	93%
Rhode Island	$35,510	$111,325	$35,802	352%	111%
South Carolina	$34,541	$73,365	$28,080	221%	81%
South Dakota	$34,913	$74,132	$31,200	215%	95%
Tennessee	$32,963	$71,540	$27,253	221%	82%
Texas	$36,675	$61,320	$28,080	181%	77%
Utah	$42,491	$72,088	$32,760	170%	78%
Vermont	$36,848	$107,675	$37,440	300%	99%
Virginia	$41,982	$83,950	$28,080	198%	65%
Washington	$41,474	$95,995	$35,022	246%	88%
West Virginia	$29,897	$91,495	$24,960	290%	83%
Wisconsin	$34,652	$96,725	$33,540	279%	95%
Wyoming	$36,362	$75,920	$30,810	212%	83%

* These ratios are calculated at the market, not state level, and may not be exactly equal to the ratio of state median cost to state median income.
Data: Genworth 2013 Cost of Care Survey; 2012 American Community Survey Public Use Microdata Sample.
Source: State Long-Term Services and Supports Scorecard, 2014.

ADRC Functions: Composite Indicator Rank, Component Scores, and Change

	Most Current Year (2012)						
State	Information, Referral, and Awareness (5 criteria, 10 possible points)	Options Counseling (4 criteria, 8 possible points)	Streamlining Access (7 criteria, 14 possible points)	Care Transitions (2 criteria, 4 possible points)	Target Populations and Partnerships (6 criteria, 12 possible points)	Quality Assurance (6 criteria, 12 possible points)	Total Fully Functional Score (60 points possible)
Alabama	6	5	10	3	7	6	37
Alaska	7	5	7	3	7	7	36
Arizona	6	6	11	3	9	9	44
Arkansas	8	5	11	4	10	6	44
California	6	7	4	2	7	5	31
Colorado	7	8	12	2	7	9	45
Connecticut	8	8	12	2	11	9	50
Delaware	9	6	13	3	10	8	49
District of Columbia	8	7	8	3	9	9	44
Florida	10	5	14	4	12	11	56
Georgia	8	8	11	4	10	6	47
Hawaii	8	8	11	3	9	9	48
Idaho	3	2	11	1	5	6	28
Illinois	6	7	13	4	11	11	52
Indiana	8	8	14	3	11	10	54
Iowa	7	8	10	3	8	7	43
Kansas	7	8	13	3	9	7	47
Kentucky	8	3	11	3	7	7	39
Louisiana	7	5	8	0	9	4	33
Maine	6	8	6	4	9	8	41
Maryland	7	8	12	3	11	9	50
Massachusetts	8	6	10	4	11	9	48
Michigan	8	8	13	2	11	7	49
Minnesota	9	8	11	4	12	11	55
Mississippi	3	2	2	0	1	1	9
Missouri	8	8	5	2	9	6	38
Montana	4	2	9	2	8	8	33
Nebraska	2	1	9	3	7	6	28
Nevada	10	7	13	3	8	10	51
New Hampshire	8	8	14	4	11	12	57
New Jersey	7	6	9	3	9	10	44
New Mexico	8	8	13	3	11	9	52
New York	7	8	12	1	12	11	51
North Carolina	6	8	7	3	8	6	38
North Dakota	8	8	5	2	8	9	40
Ohio	5	5	11	4	9	8	42
Oklahoma	6	4	3	3	7	3	26
Oregon	9	8	14	4	10	9	54
Pennsylvania	5	5	14	3	9	8	44
Rhode Island	10	7	14	3	7	9	50
South Carolina	8	5	12	3	10	9	47
South Dakota	9	7	14	2	6	9	47
Tennessee	6	5	13	3	6	10	43
Texas	8	7	9	3	9	9	45
Utah	6	6	11	0	7	7	37
Vermont	8	8	13	2	11	9	51
Virginia	8	7	12	3	9	9	48
Washington	9	7	14	4	11	9	54
West Virginia	3	5	9	3	4	8	32
Wisconsin	9	8	12	3	12	10	54
Wyoming	7	7	4	3	7	8	36

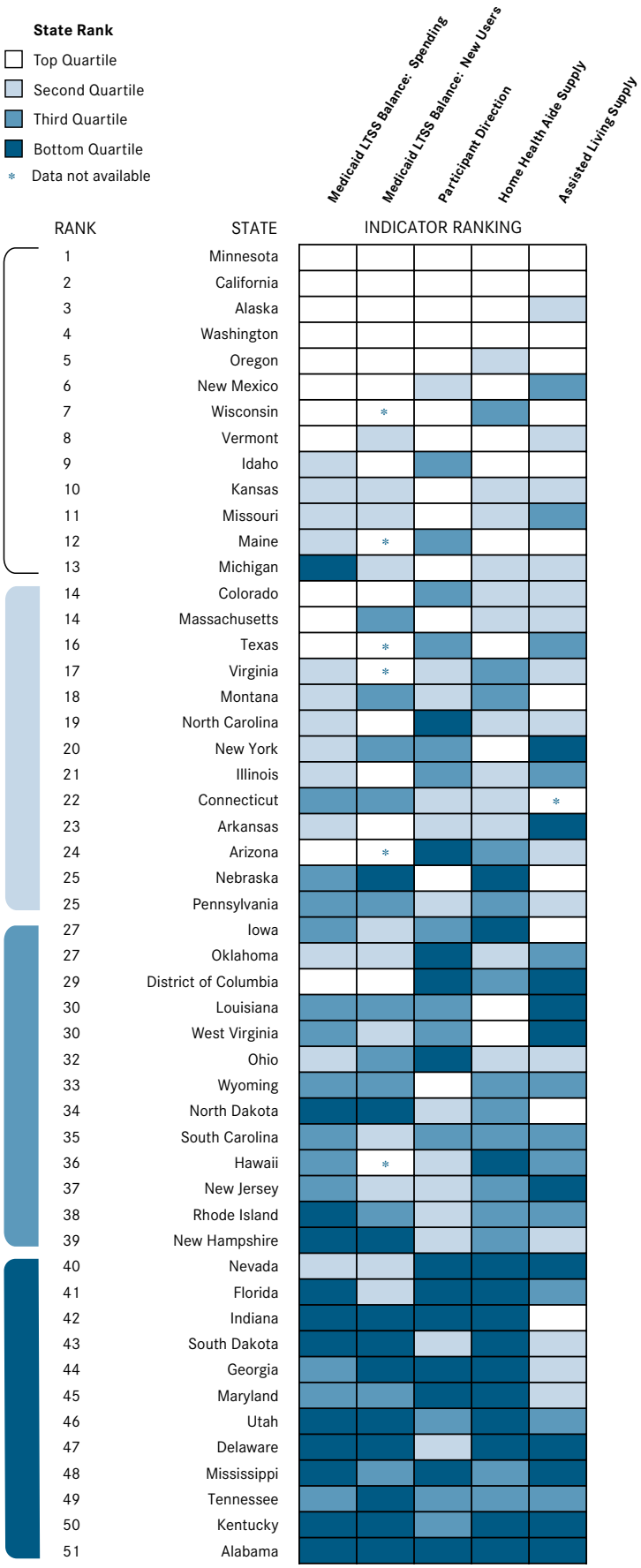
Note: ADRC Functions = Aging and Disability Resource Center Functions.
Data: The Lewin Group, Findings from 2010 Fully Functioning Assessment and 2012 State ADRC System Assessments Across Criteria of Fully Functioning Aging and Disability Resource Centers.
Source: State Long-Term Services and Supports Scorecard, 2014.

ADRC Functions: Composite Indicator Rank, Components Scores, and Change

	Most Current Year (2012)				Baseline Year (2010)			Components of Change		
	Fully Functional Score (out of 60)	Statewideness (out of 10)	Total Score (out of 70)	Rank	Fully Functional Score (out of 52)	Statewideness (out of 10)	Total Score (out of 62)	Improvement from Baseline		New Items (out of 8)
United States	**44**	**8**	**52**		**32**	**6**	**38**	**8**	✓	**6**
Alabama	37	8	45	38	23	3	26	13	✓	6
Alaska	36	6	42	42	25	8	33	5	↔	4
Arizona	44	10	54	23	35	9	44	6	✓	4
Arkansas	44	10	54	23	43	10	53	-7	X	8
California	31	3	34	49	4	3	7	23	✓	4
Colorado	45	9	54	23	28	4	32	16	✓	6
Connecticut	50	10	60	10	35	8	43	11	✓	6
Delaware	49	10	59	13	39	0	39	14	✓	6
District of Columbia	44	10	54	23	42	10	52	-3	↔	5
Florida	56	10	66	2	47	4	51	7	✓	8
Georgia	47	10	57	17	41	10	51	-1	↔	7
Hawaii	48	10	58	14	27	10	37	15	✓	6
Idaho	28	10	38	47	8	0	8	26	✓	4
Illinois	52	9	61	7	35	8	43	10	✓	8
Indiana	54	10	64	4	36	10	46	12	✓	6
Iowa	43	2	45	38	29	1	30	10	✓	5
Kansas	47	10	57	17	26	2	28	23	✓	6
Kentucky	39	10	49	34	32	10	42	1	↔	6
Louisiana	33	10	43	41	31	10	41	-4	↔	6
Maine	41	10	51	32	31	9	40	3	↔	8
Maryland	50	10	60	10	37	5	42	10	✓	8
Massachusetts	48	10	58	14	42	10	52	-2	↔	8
Michigan	49	0	49	34	37	0	37	4	↔	8
Minnesota	55	10	65	3	46	10	56	1	↔	8
Mississippi	9	5	14	51	29	2	31	-17	X	0
Missouri	38	1	39	46	33	0	33	4	↔	2
Montana	33	7	40	45	30	6	36	-1	↔	5
Nebraska	28	2	30	50	23	1	24	1	↔	5
Nevada	51	10	61	7	31	9	40	15	✓	6
New Hampshire	57	10	67	1	50	10	60	-1	↔	8
New Jersey	44	10	54	23	47	3	50	-3	↔	7
New Mexico	52	10	62	6	45	10	55	0	↔	7
New York	51	6	57	17	41	6	47	2	↔	8
North Carolina	38	6	44	40	35	4	39	1	↔	4
North Dakota	40	2	42	42	29	1	30	10	✓	2
Ohio	42	10	52	30	15	2	17	28	✓	7
Oklahoma	26	10	36	48	18	4	22	11	✓	3
Oregon	54	3	57	17	39	1	40	9	✓	8
Pennsylvania	44	10	54	23	29	3	32	16	✓	6
Rhode Island	50	10	60	10	38	10	48	6	✓	6
South Carolina	47	10	57	17	38	8	46	3	↔	8
South Dakota	47	3	50	33	33	0	33	11	✓	6
Tennessee	43	10	53	29	30	10	40	6	✓	7
Texas	45	7	52	30	31	6	37	8	✓	7
Utah	37	9	46	36	19	3	22	18	✓	6
Vermont	51	10	61	7	32	5	37	16	✓	8
Virginia	48	8	56	22	25	6	31	17	✓	8
Washington	54	4	58	14	43	3	46	4	✓	8
West Virginia	32	10	42	42	41	10	51	-13	X	4
Wisconsin	54	10	64	4	50	8	58	0	↔	6
Wyoming	36	10	46	36	2	0	2	40	✓	4

Note: ADRC Functions = Aging and Disability Resource Center Functions.
✓ Represents an improvement in performance.
↔ Represents little or no change in performance.
X Represents a decline in performance.
Data: The Lewin Group, Findings from 2010 Fully Functioning Assessment and 2012 State ADRC System Assessments Across Criteria of Fully Functioning Aging and Disability Resource Centers.
Source: State Long-Term Services and Supports Scorecard, 2014.

Choice of Setting and Provider: Dimension and Indicator Ranking



Source: State Long-Term Services and Supports Scorecard, 2014.

Indicator Performance, Ranking, and Change

State	Percent of Medicaid and State-Funded LTSS Spending Going to HCBS for Older People and Adults with Physical Disabilities				Percent of New Medicaid Aged/ Disabled LTSS Users First Receiving Services in the Community				Number of People Participant-Directing Services per 1,000 Adults Age 18+ with Disabilities		
	2009	2011	Rank	Change in Performance	2007	2009	Rank	Change in Performance	2013	Rank	Change in Performance
United States	**37.1%**	**39.3%**		↔	**57.2%**	**53.6%**		X	**23.4**		*
Alabama	14.9%	18.0%	47	✓	50.8%	34.1%	38	X	0.1	50	*
Alaska	56.3%	61.4%	4	✓	75.0%	81.9%	1	✓	62.7	3	*
Arizona	44.8%	45.5%	12	↔	*	*	*	*	2.1	40	*
Arkansas	29.8%	32.1%	24	✓	62.9%	64.1%	11	↔	10.3	24	*
California	55.8%	56.3%	6	↔	70.9%	67.6%	10	X	127.3	1	*
Colorado	44.6%	47.1%	9	✓	59.1%	62.0%	12	✓	5.7	31	*
Connecticut	27.5%	28.5%	29	↔	38.3%	39.9%	30	↔	13.9	19	*
Delaware	13.3%	17.9%	48	✓	28.8%	30.9%	40	✓	10.4	23	*
District of Columbia	45.8%	45.7%	11	↔	67.2%	74.2%	4	✓	0.03	51	*
Florida	22.6%	23.5%	40	↔	49.9%	59.0%	15	✓	2.1	40	*
Georgia	26.6%	28.2%	31	↔	32.7%	26.6%	43	X	1.9	42	*
Hawaii	20.5%	26.9%	33	✓	37.0%	*	*	*	17.6	14	*
Idaho	43.1%	40.8%	17	↔	67.5%	73.0%	5	✓	3.6	38	*
Illinois	33.8%	39.4%	19	✓	64.6%	69.6%	8	✓	4.6	34	*
Indiana	18.2%	22.7%	42	✓	21.8%	32.0%	39	✓	1.0	47	*
Iowa	30.1%	27.3%	32	X	58.7%	57.1%	17	↔	7.0	28	*
Kansas	40.7%	36.6%	22	X	55.6%	51.9%	20	X	45.4	6	*
Kentucky	22.0%	22.1%	44	↔	*	28.4%	41	*	4.8	33	*
Louisiana	32.4%	30.2%	28	↔	40.5%	45.0%	27	✓	6.2	30	*
Maine	28.1%	35.0%	23	✓	*	*	*	*	6.8	29	*
Maryland	16.5%	25.1%	36	✓	37.2%	39.5%	32	✓	0.5	49	*
Massachusetts	38.0%	47.4%	8	✓	31.0%	39.9%	30	✓	19.3	12	*
Michigan	21.8%	23.1%	41	↔	*	52.6%	19	*	49.1	5	*
Minnesota	60.3%	65.2%	2	✓	83.3%	80.3%	2	X	37.6	7	*
Mississippi	15.8%	19.1%	45	✓	32.5%	48.1%	24	✓	1.4	44	*
Missouri	34.3%	38.4%	20	✓	54.2%	60.1%	13	✓	33.4	10	*
Montana	34.0%	37.4%	21	✓	39.9%	43.3%	28	✓	16.5	16	*
Nebraska	25.5%	25.8%	35	↔	31.6%	37.1%	35	✓	26.8	11	*
Nevada	40.8%	42.2%	15	↔	55.5%	59.0%	15	✓	1.4	44	*
New Hampshire	17.9%	18.9%	46	↔	36.3%	35.0%	37	↔	10.8	21	*
New Jersey	22.1%	24.6%	39	✓	49.4%	51.4%	22	↔	8.8	26	*
New Mexico	64.6%	65.4%	1	↔	73.7%	78.8%	3	✓	16.8	15	*
New York	41.5%	43.4%	14	↔	48.8%	45.9%	26	X	5.3	32	*
North Carolina	42.7%	40.2%	18	↔	67.3%	68.7%	9	↔	1.2	46	*
North Dakota	10.7%	14.5%	51	✓	31.1%	35.7%	36	✓	10.5	22	*
Ohio	24.7%	31.4%	26	✓	37.1%	40.2%	29	✓	0.7	48	*
Oklahoma	32.7%	32.0%	25	↔	60.1%	59.6%	14	↔	1.7	43	*
Oregon	59.1%	57.9%	5	↔	69.7%	71.2%	6	↔	36.8	8	*
Pennsylvania	21.5%	24.9%	37	✓	31.0%	39.1%	33	✓	14.9	18	*
Rhode Island	14.4%	16.3%	50	✓	36.5%	37.6%	34	↔	16.2	17	*
South Carolina	27.9%	28.5%	29	↔	50.6%	50.7%	23	↔	3.8	36	*
South Dakota	14.0%	17.0%	49	✓	24.9%	26.8%	42	✓	10.2	25	*
Tennessee	24.2%	24.9%	37	↔	22.8%	21.6%	45	↔	2.3	39	*
Texas	50.0%	53.5%	7	✓	*	*	*	*	4.4	35	*
Utah	29.0%	22.3%	43	X	29.5%	24.5%	44	X	7.3	27	*
Vermont	42.2%	44.5%	13	↔	65.1%	54.9%	18	X	78.0	2	*
Virginia	36.3%	41.1%	16	✓	*	*	*	*	13.7	20	*
Washington	62.6%	62.5%	3	↔	66.5%	70.4%	7	✓	58.5	4	*
West Virginia	27.0%	30.4%	27	✓	52.5%	51.8%	21	↔	3.8	36	*
Wisconsin	44.3%	46.2%	10	↔	*	*	*	*	35.4	9	*
Wyoming	25.8%	26.3%	34	↔	49.7%	47.7%	25	↔	18.7	13	*

* Data not available; for change over time, data from both current and baseline years must be available.
✓ Represents an improvement in performance.
↔ Represents little or no change in performance.
X Represents a decline in performance.
Data: See Appendix B2 for a full description of each indicator.
Source: State Long-Term Services and Supports Scorecard, 2014.

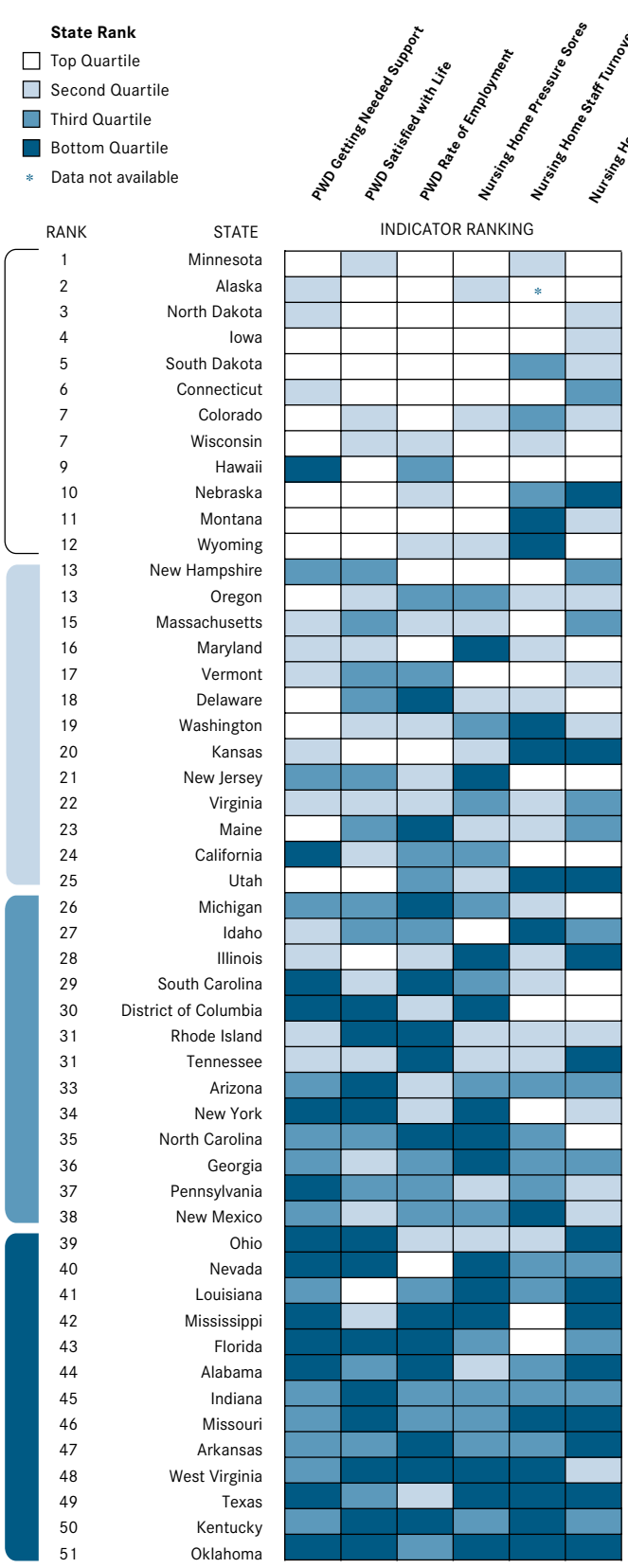
Exhibit A10 (continued)

Indicator Performance, Ranking, and Change

State	Home Health and Personal Care Aides per 1,000 Population Age 65+				Assisted Living and Residential Care Units per 1,000 Population Age 65+			
	2007–09	2010–12	Rank	Change in Performance	2010	2012–13	Rank	Change in Performance
United States	**34**	**40**		✓	**31**	**31**		↔
Alabama	22	22	44	↔	15	15	45	↔
Alaska	80	55	5	X	34	33	16	↔
Arizona	26	30	31	✓	32	31	18	↔
Arkansas	29	34	24	✓	18	16	42	X
California	54	62	3	✓	49	46	6	↔
Colorado	29	35	22	✓	30	30	22	↔
Connecticut	31	37	20	✓	*	*	*	*
Delaware	18	25	39	✓	18	16	42	X
District of Columbia	33	33	25	↔	7	14	47	✓
Florida	17	19	49	✓	26	25	28	↔
Georgia	22	24	42	↔	29	27	24	↔
Hawaii	18	19	49	↔	25	23	34	↔
Idaho	32	46	12	✓	60	57	3	↔
Illinois	29	35	22	✓	18	19	38	↔
Indiana	20	25	39	✓	39	36	11	↔
Iowa	19	20	48	↔	47	45	7	↔
Kansas	30	41	15	✓	22	31	18	✓
Kentucky	19	22	44	✓	19	17	40	X
Louisiana	43	54	6	✓	10	11	49	✓
Maine	35	48	10	✓	42	41	10	↔
Maryland	21	23	43	↔	28	27	24	↔
Massachusetts	30	37	20	✓	28	27	24	↔
Michigan	31	39	16	✓	29	34	13	✓
Minnesota	37	49	9	✓	78	125	1	✓
Mississippi	19	28	36	✓	13	15	45	✓
Missouri	33	42	14	✓	25	25	28	↔
Montana	24	33	25	✓	34	35	12	↔
Nebraska	21	25	39	✓	46	45	7	↔
Nevada	16	21	47	✓	13	11	49	X
New Hampshire	26	29	33	✓	27	27	24	↔
New Jersey	23	29	33	✓	17	17	40	↔
New Mexico	59	69	2	✓	28	23	34	X
New York	61	76	1	✓	15	16	42	↔
North Carolina	39	38	18	↔	34	32	17	↔
North Dakota	20	31	29	✓	37	45	7	✓
Ohio	29	39	16	✓	30	28	23	↔
Oklahoma	30	38	18	✓	25	24	32	↔
Oregon	39	44	13	✓	62	55	4	X
Pennsylvania	25	33	25	✓	36	34	13	↔
Rhode Island	20	30	31	✓	25	25	28	↔
South Carolina	23	29	33	✓	27	24	32	X
South Dakota	18	13	51	X	34	34	13	↔
Tennessee	27	28	36	↔	18	19	38	↔
Texas	55	59	4	↔	19	20	37	↔
Utah	21	22	44	↔	24	25	28	↔
Vermont	44	53	7	✓	30	31	18	↔
Virginia	24	31	29	✓	34	31	18	↔
Washington	45	48	10	↔	54	49	5	↔
West Virginia	49	50	8	↔	12	13	48	↔
Wisconsin	26	33	25	✓	57	58	2	↔
Wyoming	34	28	36	X	20	22	36	✓

* Data not available; for change over time, data from both current and baseline years must be available.
✓ Represents an improvement in performance.
↔ Represents little or no change in performance.
X Represents a decline in performance.
Data: See Appendix B2 for a full description of each indicator.
Source: State Long-Term Services and Supports Scorecard, 2014.

Quality of Life and Quality of Care: Dimension and Indicator Ranking



PWD = People with Disabilities
Source: State Long-Term Services and Supports Scorecard, 2014.

Indicator Performance, Ranking, and Change

State	Percent of Adults Age 18+ with Disabilities in the Community Usually or Always Getting Needed Support				Percent of Adults Age 18+ with Disabilities in the Community Satisfied or Very Satisfied with Life				Rate of Employment for Adults with ADL Disability Ages 18-64 Relative to Rate of Employment for Adults without ADL Disability Ages 18–64			
	2009	2010	Rank	Change in Performance	2009	2010	Rank	Change in Performance	2009–10	2011–12	Rank	Change in Performance
United States	**68.0%**	**71.1%**		✓	**84.4%**	**85.9%**		✓	**23.9%**	**22.8%**		↔
Alabama	65.8%	69.8%	39	✓	85.0%	85.8%	35	↔	18.6%	17.8%	47	↔
Alaska	78.2%	74.3%	14	X	91.5%	91.7%	2	↔	31.7%	30.5%	5	↔
Arizona	71.3%	71.6%	27	↔	83.7%	83.0%	49	↔	20.9%	24.5%	18	✓
Arkansas	66.4%	71.3%	31	✓	87.6%	85.8%	35	X	19.8%	21.0%	41	↔
California	67.1%	69.7%	40	✓	83.2%	86.7%	25	✓	23.2%	22.6%	33	↔
Colorado	72.3%	75.3%	8	✓	84.9%	87.8%	15	✓	27.8%	31.5%	2	✓
Connecticut	70.9%	72.5%	25	↔	85.4%	88.4%	13	✓	30.7%	30.7%	4	↔
Delaware	72.3%	77.4%	2	✓	87.2%	86.4%	28	↔	24.6%	21.1%	40	X
District of Columbia	62.3%	69.7%	40	✓	86.3%	83.0%	49	X	17.5%	24.0%	23	✓
Florida	67.7%	67.8%	49	↔	83.2%	82.5%	51	↔	23.9%	19.5%	43	X
Georgia	66.7%	70.0%	37	✓	87.4%	87.5%	18	↔	20.9%	22.8%	31	✓
Hawaii	68.1%	68.2%	47	↔	90.4%	88.7%	11	X	22.1%	22.9%	30	↔
Idaho	70.2%	73.6%	18	✓	85.4%	86.0%	33	↔	23.0%	23.4%	26	↔
Illinois	68.5%	74.2%	15	✓	87.0%	88.7%	11	✓	26.0%	24.4%	20	↔
Indiana	68.4%	70.0%	37	↔	87.2%	84.7%	42	X	20.8%	22.3%	36	↔
Iowa	72.5%	76.2%	7	✓	87.4%	89.5%	5	✓	31.7%	27.8%	10	X
Kansas	73.8%	73.8%	17	↔	88.3%	90.4%	4	✓	28.4%	29.2%	9	↔
Kentucky	65.6%	70.8%	34	✓	82.2%	84.3%	46	✓	17.6%	16.1%	49	X
Louisiana	68.4%	70.4%	35	↔	84.0%	88.9%	7	✓	20.4%	22.7%	32	✓
Maine	69.8%	75.1%	12	✓	86.8%	85.7%	37	↔	23.2%	21.5%	39	↔
Maryland	68.5%	73.9%	16	✓	82.9%	86.8%	24	✓	27.4%	30.3%	6	✓
Massachusetts	68.4%	73.3%	20	✓	83.5%	86.4%	28	✓	21.9%	26.8%	14	✓
Michigan	71.9%	71.6%	27	↔	83.5%	86.2%	32	✓	19.4%	19.3%	44	↔
Minnesota	73.9%	79.1%	1	✓	86.3%	87.5%	18	✓	34.9%	31.0%	3	X
Mississippi	61.3%	66.6%	51	✓	84.4%	87.6%	16	✓	16.7%	19.2%	46	✓
Missouri	70.4%	71.8%	26	↔	85.0%	84.9%	40	↔	23.2%	22.5%	35	↔
Montana	70.3%	75.2%	10	✓	84.7%	88.8%	9	✓	37.6%	30.2%	7	X
Nebraska	71.7%	76.7%	4	✓	89.1%	90.7%	3	✓	30.8%	26.9%	13	X
Nevada	70.4%	68.1%	48	X	82.8%	84.5%	45	✓	32.0%	27.8%	10	X
New Hampshire	66.9%	71.3%	31	✓	85.0%	86.5%	27	✓	22.1%	27.3%	12	✓
New Jersey	67.2%	71.4%	29	✓	83.4%	86.3%	31	✓	28.3%	24.9%	16	X
New Mexico	68.7%	70.4%	35	↔	84.6%	87.0%	23	✓	26.4%	22.3%	36	X
New York	62.2%	67.6%	50	✓	83.6%	83.2%	48	↔	24.1%	24.5%	18	↔
North Carolina	65.4%	70.9%	33	✓	84.7%	85.9%	34	✓	21.4%	20.7%	42	↔
North Dakota	71.9%	72.9%	23	↔	91.0%	89.5%	5	X	44.4%	30.2%	7	X
Ohio	67.5%	69.2%	44	↔	82.5%	84.6%	44	✓	26.0%	23.6%	25	X
Oklahoma	67.1%	69.5%	42	✓	83.3%	84.7%	42	✓	24.2%	23.0%	29	↔
Oregon	73.9%	77.3%	3	✓	86.1%	87.9%	14	✓	25.9%	22.6%	33	X
Pennsylvania	66.0%	68.9%	45	✓	83.4%	85.1%	38	✓	23.6%	21.9%	38	↔
Rhode Island	64.4%	72.7%	24	✓	80.2%	84.9%	40	✓	32.6%	13.8%	51	X
South Carolina	66.9%	69.3%	43	✓	86.9%	87.3%	21	↔	19.2%	19.3%	44	↔
South Dakota	76.2%	75.3%	8	↔	92.4%	92.1%	1	↔	31.5%	37.2%	1	✓
Tennessee	64.0%	73.2%	21	✓	80.4%	86.7%	25	✓	18.5%	17.5%	48	↔
Texas	66.1%	68.9%	45	✓	84.6%	85.0%	39	↔	26.3%	24.1%	22	X
Utah	74.4%	75.2%	10	↔	88.6%	88.9%	7	↔	29.1%	23.4%	26	X
Vermont	65.9%	73.0%	22	✓	86.4%	86.4%	28	↔	22.4%	23.4%	26	↔
Virginia	72.8%	73.5%	19	↔	84.8%	87.4%	20	✓	26.5%	24.8%	17	↔
Washington	72.9%	76.7%	4	✓	85.9%	87.6%	16	✓	28.1%	24.2%	21	X
West Virginia	68.3%	71.4%	29	✓	81.5%	84.1%	47	✓	17.1%	15.0%	50	X
Wisconsin	71.8%	76.4%	6	✓	85.6%	87.1%	22	✓	26.9%	23.8%	24	X
Wyoming	74.8%	74.8%	13	↔	87.2%	88.8%	9	✓	37.0%	25.0%	15	X

* Data not available; for change over time, data from both current and baseline years must be available.
✓ Represents an improvement in performance.
↔ Represents little or no change in performance.
X Represents a decline in performance.
Data: See Appendix B2 for a full description of each indicator.
Source: State Long-Term Services and Supports Scorecard, 2014.

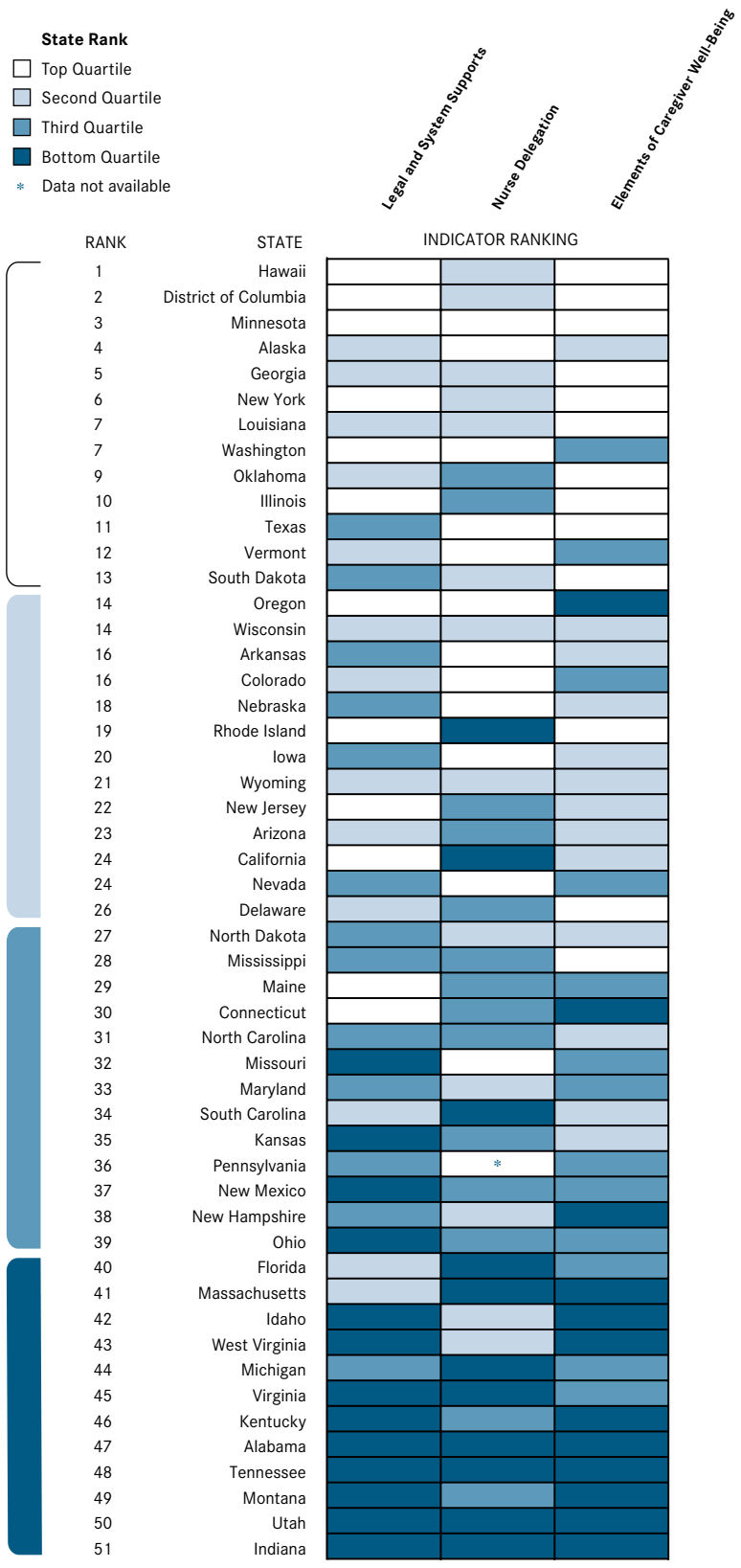
Indicator Performance, Ranking, and Change

State	Percent of High-Risk Nursing Home Residents with Pressure Sores			Nursing Home Staff Turnover: Ratio of Employee Terminations to the Average Number of Active Employees				Percent of Long-Stay Nursing Home Residents Who are Receiving an Anti-Psychotic Medication		
	2013	Rank	Change in Performance	2008	2010	Rank	Change in Performance	2013	Rank	Change in Performance
United States	**6.2%**		*	**48.7%**	**39.5%**		✓	**21.3%**		*
Alabama	5.5%	20	*	47.3%	48.4%	38	↔	22.7%	39	*
Alaska	5.8%	24	*	*	*	*	*	13.1%	2	*
Arizona	6.1%	27	*	52.9%	43.9%	33	✓	20.5%	27	*
Arkansas	6.8%	36	*	72.4%	45.3%	35	✓	24.6%	45	*
California	6.4%	30	*	40.6%	26.5%	6	✓	17.4%	11	*
Colorado	4.9%	13	*	53.6%	47.7%	37	✓	17.6%	14	*
Connecticut	4.7%	9	*	18.7%	21.7%	3	X	21.9%	33	*
Delaware	5.8%	24	*	42.3%	36.8%	19	✓	17.4%	11	*
District of Columbia	8.9%	50	*	*	23.5%	4	*	17.0%	7	*
Florida	6.4%	30	*	45.4%	28.0%	7	✓	22.2%	36	*
Georgia	6.9%	39	*	45.2%	41.6%	29	↔	22.1%	35	*
Hawaii	3.0%	1	*	31.4%	15.4%	1	✓	11.9%	1	*
Idaho	4.4%	4	*	72.4%	52.9%	43	✓	21.2%	29	*
Illinois	7.0%	43	*	27.2%	38.0%	25	X	25.1%	48	*
Indiana	6.8%	36	*	76.9%	46.4%	36	✓	21.3%	30	*
Iowa	4.8%	10	*	38.2%	29.5%	10	✓	19.9%	22	*
Kansas	5.4%	18	*	63.2%	61.0%	46	↔	22.7%	39	*
Kentucky	6.8%	36	*	74.5%	54.6%	45	✓	22.4%	38	*
Louisiana	9.0%	51	*	33.9%	43.0%	31	X	27.6%	50	*
Maine	4.9%	13	*	39.6%	34.9%	14	✓	21.6%	32	*
Maryland	7.2%	44	*	43.5%	38.1%	26	✓	16.7%	6	*
Massachusetts	5.1%	15	*	39.4%	26.4%	5	✓	22.2%	36	*
Michigan	6.1%	27	*	35.8%	36.8%	19	↔	14.9%	3	*
Minnesota	4.2%	3	*	36.8%	36.9%	21	↔	17.0%	7	*
Mississippi	7.6%	46	*	36.5%	30.0%	11	✓	24.7%	46	*
Missouri	6.1%	27	*	69.3%	67.2%	47	↔	24.4%	44	*
Montana	4.8%	10	*	*	51.2%	40	*	18.9%	17	*
Nebraska	4.4%	4	*	47.8%	40.1%	28	✓	22.7%	39	*
Nevada	6.9%	39	*	69.3%	44.1%	34	✓	20.7%	28	*
New Hampshire	3.8%	2	*	38.6%	32.5%	12	✓	22.0%	34	*
New Jersey	8.1%	49	*	32.4%	29.0%	8	✓	16.1%	4	*
New Mexico	6.4%	30	*	60.0%	69.7%	48	X	19.9%	22	*
New York	7.8%	48	*	32.2%	19.7%	2	✓	19.1%	19	*
North Carolina	7.2%	44	*	57.8%	43.0%	31	✓	16.4%	5	*
North Dakota	4.4%	4	*	33.6%	29.2%	9	✓	18.6%	15	*
Ohio	5.7%	21	*	60.0%	37.3%	22	✓	23.5%	43	*
Oklahoma	7.7%	47	*	64.4%	71.2%	49	X	23.0%	42	*
Oregon	6.6%	35	*	49.3%	36.3%	17	✓	18.7%	16	*
Pennsylvania	5.7%	21	*	44.1%	39.3%	27	✓	19.9%	22	*
Rhode Island	5.7%	21	*	29.9%	36.4%	18	X	19.4%	20	*
South Carolina	6.5%	34	*	28.8%	35.6%	15	X	17.1%	9	*
South Dakota	4.8%	10	*	46.4%	42.8%	30	↔	19.0%	18	*
Tennessee	5.4%	18	*	57.5%	35.9%	16	✓	24.8%	47	*
Texas	6.9%	39	*	46.2%	72.0%	50	X	27.6%	50	*
Utah	5.3%	17	*	51.9%	52.8%	42	↔	25.5%	49	*
Vermont	4.6%	8	*	69.1%	32.6%	13	✓	20.2%	26	*
Virginia	6.4%	30	*	49.6%	37.6%	24	✓	21.3%	30	*
Washington	5.9%	26	*	72.0%	52.1%	41	✓	20.1%	25	*
West Virginia	6.9%	39	*	60.2%	54.4%	44	↔	19.4%	20	*
Wisconsin	4.4%	4	*	60.7%	37.3%	22	✓	17.2%	10	*
Wyoming	5.1%	15	*	67.3%	49.7%	39	✓	17.4%	11	*

* Data not available; for change over time, data from both current and baseline years must be available.
✓ Represents an improvement in performance.
↔ Represents little or no change in performance.
X Represents a decline in performance.
Data: See Appendix B2 for a full description of each indicator.
Source: State Long-Term Services and Supports Scorecard, 2014.

SUPPORT FOR FAMILY CAREGIVERS Exhibit A13

Support for Family Caregivers: Dimension and Indicator Ranking



RANK	STATE
1	Hawaii
2	District of Columbia
3	Minnesota
4	Alaska
5	Georgia
6	New York
7	Louisiana
7	Washington
9	Oklahoma
10	Illinois
11	Texas
12	Vermont
13	South Dakota
14	Oregon
14	Wisconsin
16	Arkansas
16	Colorado
18	Nebraska
19	Rhode Island
20	Iowa
21	Wyoming
22	New Jersey
23	Arizona
24	California
24	Nevada
26	Delaware
27	North Dakota
28	Mississippi
29	Maine
30	Connecticut
31	North Carolina
32	Missouri
33	Maryland
34	South Carolina
35	Kansas
36	Pennsylvania
37	New Mexico
38	New Hampshire
39	Ohio
40	Florida
41	Massachusetts
42	Idaho
43	West Virginia
44	Michigan
45	Virginia
46	Kentucky
47	Alabama
48	Tennessee
49	Montana
50	Utah
51	Indiana

Source: State Long-Term Services and Supports Scorecard, 2014.

Indicator Performance, Ranking, and Change

State	Legal and System Supports for Family Caregivers (Composite Indicator, scale 0–14.5) 2012–13	Rank	Change in Performance**	Number of Health Maintenance Tasks Able to be Delegated to LTSS Workers (out of 16 tasks) 2011	2013	Rank	Change in Performance	Family Caregivers Without Much Worry or Stress, with Enough Time, Well-Rested 2010	2011–12	Rank	Change in Performance
United States	**3.45**		✓	**7.6**	**8.8**		✓	**60.6%**	**61.3%**		↔
Alabama	1.52	43	✓	4	2	40	X	57.5%	58.9%	44	↔
Alaska	3.75	21	✓	8	16	1	✓	63.5%	62.5%	15	↔
Arizona	4.40	17	↔	*	5	33	*	61.6%	62.3%	16	↔
Arkansas	2.50	29	✓	15	15	10	↔	58.4%	62.6%	14	✓
California	6.80	3	✓	2	2	40	↔	62.0%	61.7%	24	↔
Colorado	4.05	19	✓	16	16	1	↔	59.4%	61.1%	31	↔
Connecticut	6.50	5	✓	1	5	33	✓	60.5%	59.4%	40	↔
Delaware	3.07	25	✓	3	3	36	↔	59.9%	64.1%	7	✓
District of Columbia	8.00	1	✓	8	10	24	✓	66.3%	66.0%	2	↔
Florida	3.10	24	✓	0	0	47	↔	59.5%	61.0%	33	↔
Georgia	3.10	23	↔	*	14	13	*	61.5%	64.3%	6	✓
Hawaii	6.65	4	✓	14	14	13	↔	66.6%	72.8%	1	✓
Idaho	1.50	44	↔	13	13	18	↔	53.3%	56.0%	49	✓
Illinois	6.35	6	✓	2	3	36	✓	63.4%	64.5%	4	↔
Indiana	1.50	44	↔	*	0	47	*	58.6%	59.0%	42	↔
Iowa	2.26	34	↔	16	16	1	↔	62.2%	61.9%	20	↔
Kansas	1.80	40	✓	6	6	31	↔	62.0%	62.0%	19	↔
Kentucky	1.80	40	✓	6	4	35	X	56.0%	54.3%	51	↔
Louisiana	4.55	15	↔	11	11	20	↔	64.2%	63.3%	9	↔
Maine	5.25	10	✓	9	9	26	↔	61.4%	60.0%	38	↔
Maryland	2.05	37	✓	14	14	13	↔	60.2%	61.2%	29	↔
Massachusetts	3.45	22	✓	2	2	40	↔	58.8%	58.9%	44	↔
Michigan	2.10	35	↔	0	0	47	↔	61.6%	60.7%	36	↔
Minnesota	5.24	11	✓	13	16	1	✓	62.0%	62.8%	12	↔
Mississippi	3.00	26	↔	3	3	36	↔	60.4%	63.0%	10	✓
Missouri	1.50	44	↔	16	16	1	↔	60.5%	61.3%	27	↔
Montana	1.50	44	↔	0	3	36	✓	61.0%	56.5%	48	X
Nebraska	2.50	29	↔	16	16	1	↔	65.7%	61.9%	20	X
Nevada	2.50	29	↔	15	15	10	↔	61.6%	61.3%	27	↔
New Hampshire	2.05	37	✓	8	14	13	✓	60.0%	55.4%	50	X
New Jersey	5.35	8	✓	7	7	29	↔	60.1%	61.6%	25	↔
New Mexico	1.84	39	✓	*	8	28	*	61.2%	61.0%	33	↔
New York	4.72	12	✓	11	11	20	↔	60.8%	62.9%	11	↔
North Carolina	2.50	29	↔	6	6	31	↔	60.4%	62.3%	16	↔
North Dakota	2.40	33	↔	13	13	18	↔	66.2%	61.9%	20	X
Ohio	1.50	44	↔	7	7	29	↔	59.0%	61.2%	29	↔
Oklahoma	4.62	13	✓	0	9	26	✓	63.3%	63.9%	8	↔
Oregon	5.35	8	✓	16	16	1	↔	58.6%	59.1%	41	↔
Pennsylvania	2.10	35	✓	*	*	*	*	61.0%	61.1%	31	↔
Rhode Island	6.00	7	✓	0	0	47	↔	62.6%	64.8%	3	↔
South Carolina	4.48	16	✓	1	1	45	↔	61.8%	61.6%	25	↔
South Dakota	2.70	28	↔	11	11	20	↔	60.6%	64.5%	4	✓
Tennessee	1.50	44	↔	1	2	40	✓	57.6%	59.0%	42	↔
Texas	3.00	26	↔	14	15	10	✓	61.4%	62.8%	12	↔
Utah	1.75	42	✓	1	1	45	↔	57.9%	57.0%	47	↔
Vermont	4.60	14	↔	1	16	1	✓	59.2%	61.0%	33	↔
Virginia	1.50	44	↔	2	2	40	↔	60.2%	60.4%	37	↔
Washington	6.89	2	✓	14	16	1	✓	60.6%	60.0%	38	↔
West Virginia	0.50	51	↔	0	11	20	✓	54.9%	58.4%	46	✓
Wisconsin	4.08	18	✓	14	14	13	↔	62.1%	61.9%	20	↔
Wyoming	4.00	20	↔	10	10	24	↔	60.9%	62.3%	16	↔

* Data not available; for change over time, data from both current and baseline years must be available.
** Change over time data are based on a partial baseline (not shown); see Exhibit A15 for additional detail.
✓ Represents an improvement in performance.
↔ Represents little or no change in performance.
X Represents a decline in performance.
Data: See Appendix B2 for a full description of each indicator.
Source: State Long-Term Services and Supports Scorecard, 2014.

Legal and System Supports: Composite Indicator Rank, Component Scores, and Change

	Most Current Year (2012–2013)							
State	Exceeding Federal Mininum FMLA	Having Mandatory Paid Family Leave and Sick Days	Having Unemployment Insurance for Family Caregivers	Protecting Caregivers from Employment Discrimination	Spousal Impoverishment Provisions for Medicaid HCBS	Having a Caregiver Assessment	Total Score (out of 14.5)	Rank
Alabama					1.52		1.52	43
Alaska			1		2.75		3.75	21
Arizona			1		1.50	1.9	4.40	17
Arkansas			1		1.50		2.50	29
California	0.50	2.3	1		3.00		6.80	3
Colorado	0.25		1	0.3	2.50		4.05	19
Connecticut	2.00	1.0	1	1.0	1.50		6.50	5
Delaware	0.25		1		1.52	0.3	3.07	25
District of Columbia	3.00	1.0	1	1.0	2.00		8.00	1
Florida				0.3	2.50	0.3	3.10	24
Georgia					2.50	0.6	3.10	23
Hawaii	2.00		1		2.65	1.0	6.65	4
Idaho					1.50		1.50	44
Illinois	1.25		1	0.3	2.50	1.3	6.35	6
Indiana					1.50		1.50	44
Iowa	0.25				2.01		2.26	34
Kansas				0.3	1.50		1.80	40
Kentucky				0.3	1.50		1.80	40
Louisiana	1.25				3.00	0.3	4.55	15
Maine	0.75		1		2.50	1.0	5.25	10
Maryland	0.25			0.3	1.50		2.05	37
Massachusetts	0.75			0.3	1.50	0.9	3.45	22
Michigan				0.3	1.50	0.3	2.10	35
Minnesota	0.75		1		1.59	1.9	5.24	11
Mississippi					3.00		3.00	26
Missouri					1.50		1.50	44
Montana					1.50		1.50	44
Nebraska			1		1.50		2.50	29
Nevada			1		1.50		2.50	29
New Hampshire	0.25		1		0.50	0.3	2.05	37
New Jersey	1.25	2.3		0.3	1.50		5.35	8
New Mexico	0.25				1.59		1.84	39
New York	0.25	0.3	1	0.3	2.57	0.3	4.72	12
North Carolina			1		1.50		2.50	29
North Dakota					1.40	1.0	2.40	33
Ohio					1.50		1.50	44
Oklahoma			1		2.02	1.6	4.62	13
Oregon	2.25	0.3	1	0.3	1.50		5.35	8
Pennsylvania				0.3	1.50	0.3	2.10	35
Rhode Island	1.50	2.0	1		1.50		6.00	7
South Carolina			1		2.48	1.0	4.48	16
South Dakota					1.50	1.2	2.70	28
Tennessee					1.50		1.50	44
Texas			1		2.00		3.00	26
Utah	0.25				1.50		1.75	42
Vermont	1.50				2.50	0.6	4.60	14
Virginia					1.50		1.50	44
Washington	2.00	0.3	1		1.79	1.8	6.89	2
West Virginia					0.50		0.50	51
Wisconsin	1.00		1		2.08		4.08	18
Wyoming					3.00	1.0	4.00	20

Note: FMLA = Family and Medical Leave Act.
Data: See Appendix B2 for a full description of this indicator.
Source: State Long-Term Services and Supports Scorecard, 2014.

Legal and System Supports: Composite Indicator Rank, Component Scores, and Change

	Baseline Year (2008-2010)						Components of Change	
State	Exceeding Federal Mininum FMLA	Having Mandatory Paid Family Leave and Sick Days	Having Unemployment Insurance for Family Caregivers	Protecting Caregivers from Employment Discrimination	Spousal Impoverishment Provisions for Medicaid HCBS	Total Score (out of 12.0)	Improvement from Baseline*	
Alabama					0.54	0.54	0.98	✓
Alaska					3.00	3.00	0.75	✓
Arizona			1		1.50	2.50	0.00	↔
Arkansas					1.50	1.50	1.00	✓
California		2.3	1		3.00	6.30	0.50	✓
Colorado				0.3	2.50	2.80	1.25	✓
Connecticut	2.00				1.50	3.50	3.00	✓
Delaware					1.54	1.54	1.23	✓
District of Columbia	3.00	1.0		1.0	2.00	7.00	1.00	✓
Florida					2.50	2.50	0.30	✓
Georgia					2.50	2.50	0.00	↔
Hawaii	2.00				2.58	4.58	1.07	✓
Idaho					1.50	1.50	0.00	↔
Illinois	1.00			0.3	3.00	4.30	0.75	✓
Indiana					1.50	1.50	0.00	↔
Iowa	0.25				2.02	2.27	-0.01	↔
Kansas					1.50	1.50	0.30	✓
Kentucky					1.50	1.50	0.30	✓
Louisiana	1.25				3.00	4.25	0.00	↔
Maine	0.75				2.50	3.25	1.00	✓
Maryland				0.3	1.50	1.80	0.25	✓
Massachusetts	0.75				1.50	2.25	0.30	✓
Michigan				0.3	1.50	1.80	0.00	↔
Minnesota	0.50				1.60	2.10	1.24	✓
Mississippi					3.00	3.00	0.00	↔
Missouri					1.50	1.50	0.00	↔
Montana					1.50	1.50	0.00	↔
Nebraska			1		1.50	2.50	0.00	↔
Nevada			1		1.50	2.50	0.00	↔
New Hampshire	0.25				0.50	0.75	1.00	✓
New Jersey	1.25	2.0			1.50	4.75	0.60	✓
New Mexico					1.61	1.61	0.23	✓
New York					1.60	1.60	2.82	✓
North Carolina			1		1.50	2.50	0.00	↔
North Dakota					1.49	1.49	-0.09	↔
Ohio					1.50	1.50	0.00	↔
Oklahoma					2.04	2.04	0.98	✓
Oregon	2.25		1	0.3	1.50	5.05	0.30	✓
Pennsylvania					1.50	1.50	0.30	✓
Rhode Island	1.00				1.50	2.50	3.50	✓
South Carolina					2.51	2.51	0.97	✓
South Dakota					1.50	1.50	0.00	↔
Tennessee					1.50	1.50	0.00	↔
Texas			1		2.00	3.00	0.00	↔
Utah					1.50	1.50	0.25	✓
Vermont	1.50				2.50	4.00	0.00	↔
Virginia					1.50	1.50	0.00	↔
Washington	1.50		1		1.80	4.30	0.79	✓
West Virginia					0.50	0.50	0.00	↔
Wisconsin	1.00				1.99	2.99	1.09	✓
Wyoming					3.00	3.00	0.00	↔

* Improvement from baseline is based on components where data is available for both current and baseline years.
Note: FMLA = Family and Medical Leave Act.
✓ Represents an improvement in performance.
↔ Represents little or no change in performance.
Data: See Appendix B2 for a full description of this indicator.
Source: State Long-Term Services and Supports Scorecard, 2014.

Exhibit A16

Health Maintenance Tasks Able to be Delegated to LTSS Workers

State	Administer Oral Medications	Administer Medication on an as Needed Basis	Administer Medication via Pre-Filled Insulin or Insulin Pen	Draw Up Insulin for Dosage Measurement	Administer Intramuscular Injection Medications	Administer Glucometer Test	Administer Medication through Tubes	Insert Suppository
Alabama						Y		
Alaska	Y	Y	Y	Y	Y	Y	Y	Y
Arizona						Y		
Arkansas	Y	Y	Y	Y		Y	Y	Y
California						Y		
Colorado	Y	Y	Y	Y	Y	Y	Y	Y
Connecticut	Y					Y		
Delaware						Y		
District of Columbia	Y	Y	Y			Y		Y
Florida								
Georgia	Y	Y	Y	Y		Y	Y	Y
Hawaii	Y	Y	Y			Y	Y	Y
Idaho	Y	Y				Y	Y	Y
Illinois						Y		
Indiana								
Iowa	Y	Y	Y	Y	Y	Y	Y	Y
Kansas						Y		Y
Kentucky						Y		
Louisiana	Y					Y	Y	
Maine	Y		Y			Y		Y
Maryland	Y	Y	Y	Y		Y	Y	Y
Massachusetts						Y		
Michigan								
Minnesota	Y	Y	Y	Y	Y	Y	Y	Y
Mississippi						Y		
Missouri	Y	Y	Y	Y	Y	Y	Y	Y
Montana								
Nebraska	Y	Y	Y	Y	Y	Y	Y	Y
Nevada	Y	Y	Y	Y	Y	Y	Y	Y
New Hampshire	Y	Y	Y	Y	Y	Y	Y	Y
New Jersey								
New Mexico	Y		Y			Y	Y	Y
New York	Y	Y	Y	Y	Y	Y	Y	
North Carolina						Y		
North Dakota	Y	Y	Y	Y	Y	Y	Y	Y
Ohio						Y		Y
Oklahoma	Y	Y				Y	Y	Y
Oregon	Y	Y	Y	Y	Y	Y	Y	Y
Pennsylvania	*	*	*	*	*	*	*	*
Rhode Island								
South Carolina								
South Dakota	Y	Y				Y		Y
Tennessee	Y	Y						
Texas	Y	Y	Y	Y	Y	Y	Y	Y
Utah								
Vermont	Y	Y	Y	Y	Y	Y	Y	Y
Virginia						Y		
Washington	Y	Y	Y	Y	Y	Y	Y	Y
West Virginia	Y	Y	Y			Y	Y	Y
Wisconsin	Y	Y	Y			Y	Y	Y
Wyoming	Y	Y				Y	Y	Y

* Indicates data not available for this state.
Note: A blank space indicates that the state does not permit delegation of this health maintenance task to LTSS workers.
Data: See Appendix B2 for a full description of this indicator.
Source: State Long-Term Services and Supports Scorecard, 2014.

Exhibit A16 (continued)

Health Maintenance Tasks Able to be Delegated to LTSS Workers

State	Administer Eye/Ear Drops	Gastrostomy Tube Feeding	Administer Enema	Perform Intermittent Catheterization	Perform Ostomy Care Including Skin Care and Changing Appliance	Perform Nebulizer Treatment	Administer Oxygen Therapy	Perform Ventilator Respiratory Care	Total Number of Tasks Able to be Delegated	Rank
Alabama					Y				2	40
Alaska	Y	Y	Y	Y	Y	Y	Y	Y	16	1
Arizona			Y	Y	Y		Y		5	33
Arkansas	Y	Y	Y	Y	Y	Y	Y	Y	15	10
California			Y						2	40
Colorado	Y	Y	Y	Y	Y	Y	Y	Y	16	1
Connecticut	Y	Y			Y				5	33
Delaware				Y	Y				3	36
District of Columbia	Y		Y		Y	Y	Y		10	24
Florida									0	47
Georgia	Y	Y	Y	Y	Y	Y	Y		14	13
Hawaii	Y	Y	Y	Y	Y	Y	Y	Y	14	13
Idaho	Y	Y	Y	Y	Y	Y	Y	Y	13	18
Illinois				Y	Y				3	36
Indiana									0	47
Iowa	Y	Y	Y	Y	Y	Y	Y	Y	16	1
Kansas	Y		Y	Y			Y		6	31
Kentucky		Y	Y		Y				4	35
Louisiana	Y	Y	Y	Y	Y	Y	Y	Y	11	20
Maine	Y	Y	Y	Y	Y				9	26
Maryland	Y	Y	Y	Y	Y	Y	Y		14	13
Massachusetts					Y				2	40
Michigan								N	0	47
Minnesota	Y	Y	Y	Y	Y	Y	Y	Y	16	1
Mississippi			Y	Y					3	36
Missouri	Y	Y	Y	Y	Y	Y	Y	Y	16	1
Montana		Y			Y		Y		3	36
Nebraska	Y	Y	Y	Y	Y	Y	Y	Y	16	1
Nevada	Y	Y	Y	Y	Y	Y	Y		15	10
New Hampshire	Y	Y	Y	Y	Y		Y		14	13
New Jersey		Y	Y	Y	Y	Y	Y	Y	7	29
New Mexico	Y	Y				Y			8	28
New York		Y	Y		Y		Y		11	20
North Carolina		Y	Y	Y	Y		Y		6	31
North Dakota	Y	Y	Y	Y	Y				13	18
Ohio	Y	Y	Y	Y	Y				7	29
Oklahoma	Y	Y			Y	Y			9	26
Oregon	Y	Y	Y	Y	Y	Y	Y	Y	16	1
Pennsylvania	*	*	*	*	*	*	*	*	*	*
Rhode Island									0	47
South Carolina			Y						1	45
South Dakota	Y	Y	Y	Y	Y	Y	Y		11	20
Tennessee									2	40
Texas	Y	Y	Y	Y	Y	Y	Y		15	10
Utah					Y				1	45
Vermont	Y	Y	Y	Y	Y	Y	Y	Y	16	1
Virginia					Y				2	40
Washington	Y	Y	Y	Y	Y	Y	Y	Y	16	1
West Virginia	Y	Y	Y		Y	Y			11	20
Wisconsin	Y	Y	Y	Y	Y	Y	Y	Y	14	13
Wyoming	Y	Y	Y		Y		Y		10	24

* Indicates data not available for this state.
Note: A blank space indicates that the state does not permit delegation of this health maintenance task to LTSS workers.
Data: See Appendix B2 for a full description of this indicator.
Source: State Long-Term Services and Supports Scorecard, 2014.

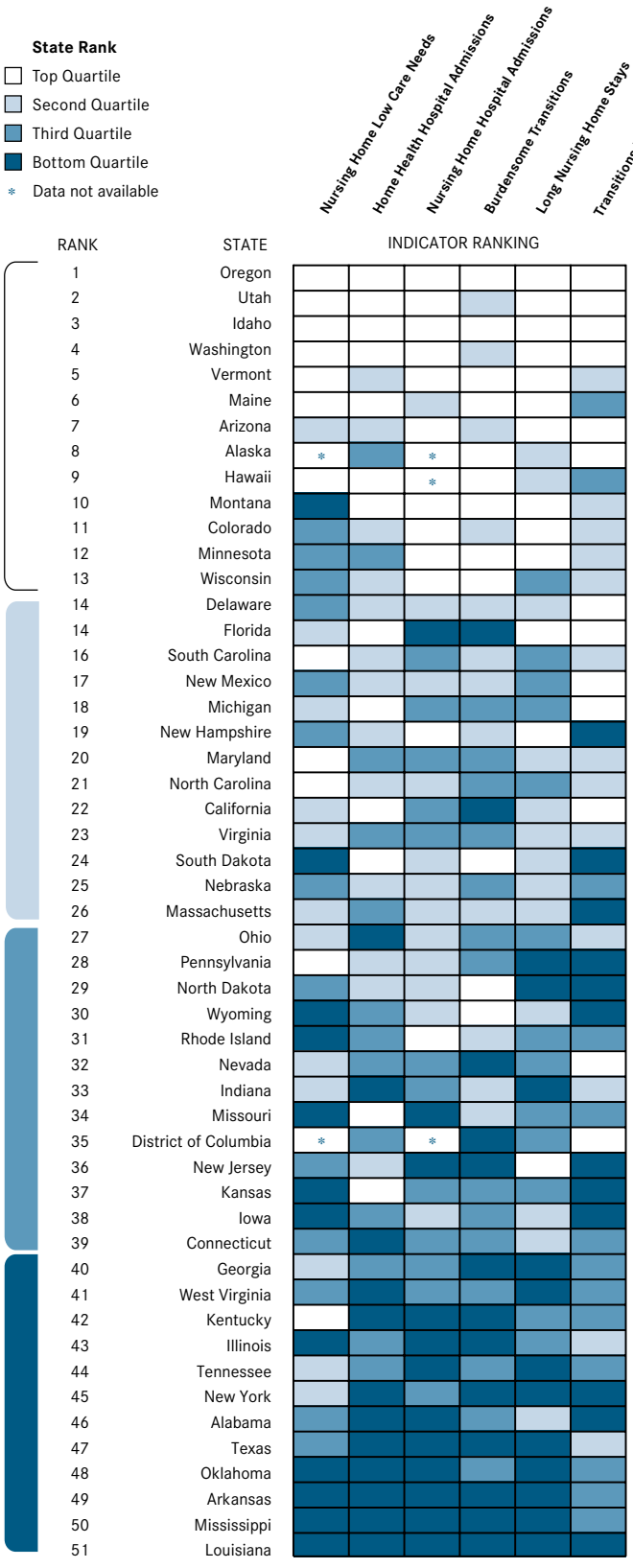
SUPPORT FOR FAMILY CAREGIVERS Exhibit A17

Elements of Caregiver Well-Being: Composite Indicator Rank and Component Scores

	In the Last Day, Family Caregivers:					
State	Did Not Experience Worry a Lot	Did Not Experience Stress a Lot	Felt Well-Rested	Had Enough Time to Get Things Done	Average Across Four Measures	Rank
United States	**59.9%**	**51.8%**	**64.8%**	**68.8%**	**61.3%**	
Alabama	57.7%	49.2%	61.1%	67.5%	58.9%	44
Alaska	64.3%	50.8%	73.8%	61.3%	62.5%	15
Arizona	61.2%	53.7%	65.1%	69.1%	62.3%	16
Arkansas	63.0%	53.6%	62.6%	71.1%	62.6%	14
California	56.4%	52.5%	65.6%	72.4%	61.7%	24
Colorado	61.0%	48.9%	66.7%	67.6%	61.1%	31
Connecticut	60.1%	46.5%	63.1%	68.0%	59.4%	40
Delaware	62.2%	55.2%	70.2%	68.8%	64.1%	7
District of Columbia	57.9%	58.6%	70.2%	77.4%	66.0%	2
Florida	58.2%	51.5%	64.4%	69.8%	61.0%	33
Georgia	64.1%	55.1%	66.9%	71.0%	64.3%	6
Hawaii	71.8%	66.6%	78.0%	75.0%	72.8%	1
Idaho	54.5%	44.6%	62.0%	62.9%	56.0%	49
Illinois	62.4%	53.7%	70.9%	71.1%	64.5%	4
Indiana	58.3%	49.2%	60.1%	68.6%	59.0%	42
Iowa	63.3%	52.6%	67.6%	64.1%	61.9%	20
Kansas	62.5%	49.7%	68.2%	67.6%	62.0%	19
Kentucky	53.2%	45.3%	56.3%	62.2%	54.3%	51
Louisiana	63.2%	54.4%	64.6%	70.9%	63.3%	9
Maine	59.4%	48.7%	65.4%	66.6%	60.0%	38
Maryland	61.7%	51.6%	63.4%	68.0%	61.2%	29
Massachusetts	57.3%	49.9%	62.7%	65.7%	58.9%	44
Michigan	59.6%	49.3%	65.9%	68.0%	60.7%	36
Minnesota	64.9%	52.9%	65.0%	68.4%	62.8%	12
Mississippi	61.0%	55.3%	63.4%	72.2%	63.0%	10
Missouri	60.1%	52.1%	65.1%	68.1%	61.3%	27
Montana	52.2%	44.9%	64.4%	64.4%	56.5%	48
Nebraska	60.5%	54.2%	67.3%	65.9%	61.9%	20
Nevada	57.3%	51.1%	66.4%	70.4%	61.3%	27
New Hampshire	58.9%	43.5%	57.3%	62.0%	55.4%	50
New Jersey	58.2%	52.9%	64.3%	70.8%	61.6%	25
New Mexico	59.8%	51.7%	66.4%	66.0%	61.0%	33
New York	60.5%	55.0%	65.6%	70.6%	62.9%	11
North Carolina	62.2%	53.0%	65.5%	68.4%	62.3%	16
North Dakota	63.3%	49.4%	63.1%	71.8%	61.9%	20
Ohio	62.3%	50.6%	64.5%	67.4%	61.2%	29
Oklahoma	62.1%	55.7%	65.5%	72.3%	63.9%	8
Oregon	58.3%	47.4%	64.3%	66.4%	59.1%	41
Pennsylvania	61.1%	51.3%	65.9%	66.1%	61.1%	31
Rhode Island	59.6%	54.5%	70.8%	74.2%	64.8%	3
South Carolina	61.1%	53.8%	64.8%	66.6%	61.6%	25
South Dakota	64.7%	57.3%	65.5%	70.7%	64.5%	4
Tennessee	57.2%	48.0%	62.2%	68.8%	59.0%	42
Texas	59.7%	54.8%	66.0%	70.9%	62.8%	12
Utah	56.9%	49.8%	60.8%	60.4%	57.0%	47
Vermont	59.6%	56.6%	63.3%	64.7%	61.0%	33
Virginia	60.4%	51.5%	62.7%	67.1%	60.4%	37
Washington	60.5%	48.5%	63.9%	67.0%	60.0%	38
West Virginia	56.1%	48.6%	62.4%	66.7%	58.4%	46
Wisconsin	59.5%	52.8%	67.1%	68.2%	61.9%	20
Wyoming	69.5%	50.7%	59.2%	69.8%	62.3%	16

Data are for the years 2011/2012. See Appendix B2 for a full description of this indicator.
Source: State Long-Term Services and Supports Scorecard, 2014.

Effective Transitions: Dimension and Indicator Ranking



Source: State Long-Term Services and Supports Scorecard, 2014.

Indicator Performance, Ranking, and Change

State	Percent of Nursing Home Residents with Low Care Needs				Percent of Home Health Patients with a Hospital Admission			Percent of Long-Stay Nursing Home Residents Hospitalized within a Six-Month Period			
	2007	2010	Rank	Change in Performance	2012	Rank	Change in Performance	2008	2010	Rank	Change in Performance
United States	**12.8%**	**12.3%**		↔	**26.2%**		*	**20.5%**	**18.9%**		↔
Alabama	14.9%	14.5%	34	↔	28.1%	42	*	22.9%	21.1%	37	↔
Alaska	*	*	*	*	25.6%	27	*	*	*	*	*
Arizona	11.2%	10.4%	21	↔	24.6%	18	*	10.8%	11.5%	3	↔
Arkansas	17.4%	17.3%	42	↔	28.4%	45	*	27.6%	26.9%	46	↔
California	10.8%	11.4%	24	↔	23.6%	10	*	20.4%	21.0%	36	↔
Colorado	12.9%	12.7%	28	↔	24.5%	16	*	12.1%	12.4%	8	↔
Connecticut	15.5%	15.1%	36	↔	32.3%	51	*	18.7%	18.9%	25	↔
Delaware	13.5%	14.5%	34	↔	24.8%	19	*	20.5%	18.8%	24	✓
District of Columbia	*	*	*	*	26.0%	32	*	*	*	*	*
Florida	8.1%	8.5%	13	↔	23.6%	10	*	24.4%	24.5%	43	↔
Georgia	12.7%	10.4%	21	✓	25.9%	31	*	20.8%	19.7%	28	↔
Hawaii	6.0%	4.7%	2	✓	23.2%	8	*	*	*	*	*
Idaho	7.8%	7.6%	11	↔	21.5%	3	*	12.7%	12.3%	7	↔
Illinois	25.1%	26.7%	49	↔	26.0%	32	*	25.3%	24.7%	44	↔
Indiana	11.7%	10.0%	17	✓	28.2%	43	*	20.4%	20.4%	32	↔
Iowa	17.5%	16.9%	41	↔	27.0%	36	*	17.2%	15.7%	18	✓
Kansas	18.6%	18.2%	44	↔	23.6%	10	*	21.6%	20.5%	35	↔
Kentucky	7.4%	7.1%	10	↔	27.9%	40	*	24.1%	23.6%	39	↔
Louisiana	22.6%	22.8%	47	↔	31.5%	49	*	31.6%	31.0%	47	↔
Maine	1.3%	1.1%	1	✓	22.2%	5	*	16.6%	13.8%	14	✓
Maryland	8.0%	8.2%	12	↔	25.8%	29	*	20.7%	20.0%	29	↔
Massachusetts	10.1%	10.3%	19	↔	26.7%	35	*	16.5%	16.7%	19	↔
Michigan	10.4%	10.3%	19	↔	23.0%	7	*	18.8%	20.4%	32	X
Minnesota	14.5%	12.9%	30	✓	27.6%	39	*	8.3%	7.3%	1	✓
Mississippi	17.5%	16.3%	39	↔	30.3%	48	*	32.5%	31.1%	48	↔
Missouri	20.0%	21.1%	46	↔	23.9%	13	*	22.3%	21.4%	38	↔
Montana	16.3%	15.3%	38	↔	21.5%	3	*	13.4%	12.0%	6	✓
Nebraska	13.6%	12.8%	29	↔	24.2%	15	*	17.8%	17.1%	21	↔
Nevada	10.9%	10.2%	18	↔	27.2%	37	*	19.2%	20.2%	30	↔
New Hampshire	11.6%	12.3%	27	↔	25.4%	25	*	13.6%	13.5%	12	↔
New Jersey	13.9%	13.0%	31	↔	24.8%	19	*	26.5%	25.9%	45	↔
New Mexico	13.3%	13.3%	32	↔	24.9%	22	*	14.1%	15.3%	16	X
New York	11.4%	8.9%	15	✓	29.5%	47	*	20.2%	18.9%	25	↔
North Carolina	8.1%	7.0%	9	✓	25.5%	26	*	18.9%	18.7%	23	↔
North Dakota	16.1%	15.1%	36	↔	24.1%	14	*	13.4%	13.6%	13	↔
Ohio	9.1%	9.2%	16	↔	27.9%	40	*	18.6%	16.8%	20	✓
Oklahoma	24.4%	25.0%	48	↔	31.5%	49	*	26.2%	24.4%	42	↔
Oregon	8.3%	6.5%	7	✓	21.4%	2	*	11.1%	9.9%	2	✓
Pennsylvania	6.7%	6.0%	5	✓	25.1%	23	*	17.9%	17.1%	21	↔
Rhode Island	17.7%	18.0%	43	↔	25.7%	28	*	11.6%	11.5%	3	↔
South Carolina	6.5%	5.7%	4	✓	24.8%	19	*	19.7%	19.5%	27	↔
South Dakota	17.0%	16.7%	40	↔	22.9%	6	*	15.8%	15.6%	17	↔
Tennessee	10.0%	10.6%	23	↔	27.3%	38	*	24.6%	23.6%	39	↔
Texas	16.4%	14.3%	33	✓	29.4%	46	*	25.0%	24.1%	41	↔
Utah	8.1%	5.6%	3	✓	18.9%	1	*	10.4%	11.5%	3	X
Vermont	7.9%	6.5%	7	✓	24.5%	16	*	11.8%	13.2%	10	X
Virginia	8.6%	8.6%	14	↔	25.8%	29	*	21.7%	20.4%	32	↔
Washington	6.7%	6.4%	6	↔	23.3%	9	*	14.4%	13.4%	11	↔
West Virginia	11.9%	11.7%	25	↔	28.2%	43	*	21.5%	20.2%	30	↔
Wisconsin	14.8%	11.8%	26	✓	25.1%	23	*	14.5%	13.1%	9	✓
Wyoming	17.0%	19.2%	45	X	26.3%	34	*	15.1%	13.9%	15	↔

* Data not available; for change over time, data from both current and baseline years must be available.
✓ Represents an improvement in performance.
↔ Represents little or no change in performance.
X Represents a decline in performance.
Data: See Appendix B2 for a full description of each indicator.
Source: State Long-Term Services and Supports Scorecard, 2014.

Exhibit A19 (continued)

Indicator Performance, Ranking, and Change

State	Percent of Nursing Home Residents with Moderate to Severe Dementia with One or More Potentially Burdensome Transitions at End of Life			Percent of New Nursing Home Stays Lasting 100 Days or More			Percent of People with 90+ Day Nursing Home Stays Successfully Transitioning Back to the Community		
	2009	Rank	Change in Performance	2009	Rank	Change in Performance	2009	Rank	Change in Performance
United States	**24.0%**		*	**20.6%**		*	**8.1%**		*
Alabama	23.5%	35	*	19.3%	24	*	5.8%	47	*
Alaska	8.8%	2	*	17.6%	14	*	10.0%	8	*
Arizona	20.0%	24	*	11.4%	2	*	12.5%	3	*
Arkansas	35.0%	49	*	27.2%	50	*	7.4%	29	*
California	29.3%	47	*	19.0%	20	*	10.7%	7	*
Colorado	17.0%	17	*	16.4%	7	*	7.9%	25	*
Connecticut	20.9%	29	*	18.2%	15	*	6.7%	38	*
Delaware	15.9%	15	*	18.9%	19	*	9.7%	12	*
District of Columbia	32.7%	48	*	22.2%	36	*	9.9%	11	*
Florida	25.8%	39	*	16.5%	9	*	10.0%	8	*
Georgia	26.9%	41	*	24.5%	46	*	7.3%	30	*
Hawaii	14.6%	11	*	19.1%	21	*	7.3%	30	*
Idaho	9.3%	3	*	16.7%	10	*	11.6%	6	*
Illinois	28.3%	44	*	20.4%	29	*	9.0%	14	*
Indiana	19.0%	21	*	24.4%	45	*	8.8%	16	*
Iowa	20.3%	25	*	19.2%	23	*	4.8%	51	*
Kansas	20.4%	27	*	20.6%	30	*	6.0%	46	*
Kentucky	25.8%	39	*	22.6%	38	*	6.8%	36	*
Louisiana	39.5%	51	*	35.0%	51	*	6.3%	43	*
Maine	14.9%	12	*	14.3%	4	*	7.2%	32	*
Maryland	25.0%	37	*	18.8%	17	*	8.8%	16	*
Massachusetts	17.8%	19	*	19.1%	21	*	6.5%	40	*
Michigan	23.5%	35	*	20.8%	32	*	10.0%	8	*
Minnesota	12.2%	6	*	16.2%	5	*	7.9%	25	*
Mississippi	37.4%	50	*	24.6%	47	*	7.0%	35	*
Missouri	19.6%	23	*	22.7%	39	*	7.8%	27	*
Montana	9.6%	4	*	17.5%	13	*	8.0%	24	*
Nebraska	21.8%	31	*	18.8%	17	*	6.7%	38	*
Nevada	27.6%	43	*	21.3%	33	*	11.8%	4	*
New Hampshire	15.8%	13	*	17.1%	12	*	5.4%	48	*
New Jersey	28.5%	45	*	16.4%	7	*	6.5%	40	*
New Mexico	17.1%	18	*	20.7%	31	*	9.6%	13	*
New York	27.3%	42	*	25.9%	48	*	6.4%	42	*
North Carolina	21.3%	30	*	22.3%	37	*	8.6%	18	*
North Dakota	12.9%	8	*	23.4%	41	*	5.1%	50	*
Ohio	21.8%	31	*	20.2%	28	*	8.2%	21	*
Oklahoma	20.8%	28	*	24.2%	44	*	7.2%	32	*
Oregon	12.8%	7	*	10.3%	1	*	13.4%	2	*
Pennsylvania	20.3%	25	*	23.1%	40	*	6.1%	45	*
Rhode Island	18.8%	20	*	21.3%	33	*	6.8%	36	*
South Carolina	19.5%	22	v	21.8%	35	*	8.2%	21	*
South Dakota	14.3%	10	*	19.5%	25	*	5.2%	49	*
Tennessee	25.0%	37	*	24.0%	43	*	7.2%	32	*
Texas	29.1%	46	*	26.9%	49	*	9.0%	14	*
Utah	15.8%	13	*	12.2%	3	*	15.8%	1	*
Vermont	11.8%	5	*	16.3%	6	*	8.2%	21	*
Virginia	22.1%	34	*	18.7%	16	*	8.5%	19	*
Washington	16.4%	16	*	16.9%	11	*	11.8%	4	*
West Virginia	21.9%	33	*	23.6%	42	*	7.7%	28	*
Wisconsin	14.2%	9	*	20.1%	27	*	8.5%	19	*
Wyoming	7.1%	1	*	19.8%	26	*	6.3%	43	*

* Data not available; for change over time, data from both current and baseline years must be available.
Data: See Appendix B2 for a full description of each indicator.
Source: State Long-Term Services and Supports Scorecard, 2014.

State Demographics: Age of Population (2012)

State	All Ages	Percent < Age 18	Percent Age 18–64	Percent Age 65+
United States	**313,914,040**	**23.5%**	**62.8%**	**13.7%**
Alabama	4,822,023	23.3%	62.1%	14.5%
Alaska	731,449	25.6%	65.9%	8.5%
Arizona	6,553,255	24.7%	60.5%	14.8%
Arkansas	2,949,131	24.1%	60.9%	15.0%
California	38,041,430	24.3%	63.6%	12.1%
Colorado	5,187,582	23.7%	64.5%	11.8%
Connecticut	3,590,347	22.1%	63.1%	14.8%
Delaware	917,092	22.3%	62.3%	15.4%
District of Columbia	632,323	17.3%	71.3%	11.4%
Florida	19,317,568	20.7%	61.1%	18.2%
Georgia	9,919,945	25.2%	63.4%	11.5%
Hawaii	1,392,313	21.8%	63.1%	15.1%
Idaho	1,595,728	26.6%	60.2%	13.2%
Illinois	12,875,255	23.8%	63.0%	13.2%
Indiana	6,537,334	24.3%	62.1%	13.6%
Iowa	3,074,186	23.5%	61.2%	15.3%
Kansas	2,885,905	25.0%	61.3%	13.7%
Kentucky	4,380,415	23.2%	62.8%	14.0%
Louisiana	4,601,893	24.3%	62.7%	13.0%
Maine	1,329,192	20.0%	63.0%	17.0%
Maryland	5,884,563	22.8%	64.2%	13.0%
Massachusetts	6,646,144	21.1%	64.5%	14.5%
Michigan	9,883,360	22.9%	62.5%	14.6%
Minnesota	5,379,139	23.8%	62.7%	13.6%
Mississippi	2,984,926	25.0%	61.5%	13.5%
Missouri	6,021,988	23.3%	62.0%	14.7%
Montana	1,005,141	21.9%	62.3%	15.8%
Nebraska	1,855,525	24.9%	61.2%	13.8%
Nevada	2,758,931	24.1%	62.9%	13.0%
New Hampshire	1,320,718	20.8%	64.5%	14.7%
New Jersey	8,864,590	22.9%	63.0%	14.1%
New Mexico	2,085,538	24.7%	61.2%	14.1%
New York	19,570,261	21.8%	64.1%	14.1%
North Carolina	9,752,073	23.4%	62.8%	13.8%
North Dakota	699,628	22.0%	63.5%	14.4%
Ohio	11,544,225	23.0%	62.2%	14.8%
Oklahoma	3,814,820	24.5%	61.4%	14.1%
Oregon	3,899,353	22.1%	63.0%	14.9%
Pennsylvania	12,763,536	21.4%	62.6%	16.0%
Rhode Island	1,050,292	20.7%	64.2%	15.1%
South Carolina	4,723,723	22.9%	62.4%	14.7%
South Dakota	833,354	24.5%	61.0%	14.5%
Tennessee	6,456,243	23.1%	62.6%	14.3%
Texas	26,059,203	26.8%	62.3%	10.9%
Utah	2,855,287	31.1%	59.4%	9.5%
Vermont	626,011	19.8%	64.5%	15.7%
Virginia	8,185,867	22.7%	64.4%	13.0%
Washington	6,897,012	23.0%	63.9%	13.2%
West Virginia	1,855,413	20.7%	62.5%	16.8%
Wisconsin	5,726,398	23.0%	62.6%	14.4%
Wyoming	576,412	23.7%	63.3%	13.0%

Data: U.S. Census Bureau, 2012 Population Estimates.
Source: State Long-Term Services and Supports Scorecard, 2014.

State Demographics: Median Household Income and Poverty (2012)

	Median Household Income		Percent Below Poverty Level			Percent At/Below 250% of Poverty Level		
State	All Ages	Householder Age 65+	All Ages	Age 18+	Age 65+	All Ages	Age 18+	Age 65+
United States	**$51,371**	**$36,743**	**15.9%**	**13.9%**	**9.5%**	**43.7%**	**40.5%**	**41.9%**
Alabama	$41,574	$32,287	19.0%	16.3%	11.1%	49.1%	46.1%	46.9%
Alaska	$67,712	$46,666	10.1%	8.8%	4.4%	34.2%	30.4%	32.8%
Arizona	$47,826	$39,083	18.7%	15.9%	8.3%	48.4%	44.4%	41.4%
Arkansas	$40,112	$30,891	19.8%	17.0%	10.9%	52.6%	49.0%	48.7%
California	$58,328	$42,406	17.0%	14.7%	10.4%	45.5%	42.0%	39.8%
Colorado	$56,765	$41,985	13.7%	12.2%	7.8%	38.8%	35.9%	35.2%
Connecticut	$67,276	$41,947	10.7%	9.5%	6.9%	30.5%	28.5%	33.2%
Delaware	$58,415	$42,211	12.0%	10.5%	7.4%	38.1%	34.8%	36.0%
District of Columbia	$66,583	$46,926	18.2%	16.3%	11.9%	37.5%	34.2%	33.8%
Florida	$45,040	$36,415	17.1%	14.9%	10.2%	48.7%	45.6%	43.6%
Georgia	$47,209	$35,371	19.2%	16.4%	11.2%	48.8%	45.2%	44.2%
Hawaii	$66,259	$59,378	11.6%	10.0%	6.9%	35.5%	32.9%	31.0%
Idaho	$45,489	$34,040	15.9%	14.1%	9.7%	49.6%	45.3%	44.0%
Illinois	$55,137	$37,161	14.7%	12.8%	8.8%	40.4%	37.5%	40.7%
Indiana	$46,974	$34,636	15.6%	13.4%	7.2%	45.2%	41.8%	43.4%
Iowa	$50,957	$34,731	12.7%	11.7%	7.8%	39.2%	37.1%	42.2%
Kansas	$50,241	$36,516	14.0%	12.3%	6.7%	42.4%	39.3%	41.4%
Kentucky	$41,724	$30,023	19.4%	17.2%	12.3%	49.5%	46.7%	50.3%
Louisiana	$42,944	$30,935	19.9%	17.3%	12.6%	49.8%	46.5%	49.5%
Maine	$46,709	$33,358	14.7%	13.1%	8.2%	44.5%	42.0%	44.1%
Maryland	$71,122	$47,949	10.3%	9.2%	7.6%	30.7%	28.3%	32.1%
Massachusetts	$65,339	$38,233	11.9%	10.9%	9.3%	32.6%	31.0%	38.2%
Michigan	$46,859	$35,504	17.4%	15.2%	8.3%	45.1%	42.0%	42.2%
Minnesota	$58,906	$37,428	11.4%	10.4%	7.9%	34.3%	32.2%	38.4%
Mississippi	$37,095	$28,388	24.2%	20.5%	15.1%	57.6%	53.5%	52.8%
Missouri	$45,321	$33,906	16.2%	14.3%	9.0%	46.1%	42.8%	44.7%
Montana	$45,076	$34,941	15.5%	14.2%	8.6%	47.2%	44.6%	43.1%
Nebraska	$50,723	$35,655	13.0%	11.4%	7.4%	40.8%	37.6%	42.8%
Nevada	$49,760	$40,181	16.4%	14.1%	8.1%	46.7%	42.6%	39.7%
New Hampshire	$63,280	$41,445	10.0%	8.6%	6.6%	31.4%	29.3%	36.5%
New Jersey	$69,667	$43,254	10.8%	9.3%	7.9%	31.6%	29.4%	33.8%
New Mexico	$42,558	$34,727	20.8%	18.0%	11.9%	52.3%	48.2%	45.5%
New York	$56,448	$37,246	15.9%	13.9%	11.4%	40.6%	37.7%	41.3%
North Carolina	$45,150	$33,749	18.0%	15.6%	10.0%	48.4%	45.1%	45.2%
North Dakota	$53,585	$34,462	11.2%	10.7%	10.6%	34.4%	33.2%	40.4%
Ohio	$46,829	$33,901	16.3%	14.0%	8.0%	43.9%	40.6%	43.3%
Oklahoma	$44,312	$33,397	17.2%	15.0%	9.9%	49.3%	45.6%	46.4%
Oregon	$49,161	$38,428	17.2%	15.5%	7.5%	46.6%	43.8%	40.4%
Pennsylvania	$51,230	$33,942	13.7%	12.0%	8.3%	40.0%	37.3%	43.8%
Rhode Island	$54,554	$35,510	13.7%	12.2%	9.7%	38.5%	36.2%	43.4%
South Carolina	$43,107	$34,541	18.3%	15.6%	10.1%	49.7%	46.2%	45.6%
South Dakota	$48,362	$34,913	13.4%	12.1%	10.0%	42.1%	39.3%	43.6%
Tennessee	$42,764	$32,963	17.9%	15.5%	10.0%	49.0%	45.7%	46.5%
Texas	$50,740	$36,675	17.9%	15.0%	11.6%	47.9%	43.7%	44.0%
Utah	$57,049	$42,491	12.8%	11.8%	6.8%	44.4%	40.2%	36.3%
Vermont	$52,977	$36,848	11.8%	10.9%	7.5%	40.5%	38.0%	41.8%
Virginia	$61,741	$41,982	11.7%	10.7%	7.9%	35.4%	32.9%	36.1%
Washington	$57,573	$41,474	13.5%	12.0%	7.8%	38.7%	35.8%	36.1%
West Virginia	$40,196	$29,897	17.8%	16.0%	8.8%	49.2%	47.3%	52.3%
Wisconsin	$51,059	$34,652	13.2%	11.7%	7.5%	39.4%	37.1%	42.5%
Wyoming	$54,901	$36,362	12.6%	11.3%	4.8%	40.2%	37.3%	40.3%

Data: U.S. Census Bureau, 2012 American Community Survey; AARP Public Policy Institute Analysis of 2012 ACS Public Use Microdata Sample.
Source: State Long-Term Services and Supports Scorecard, 2014.

DEMOGRAPHIC CONTEXT Exhibit A22

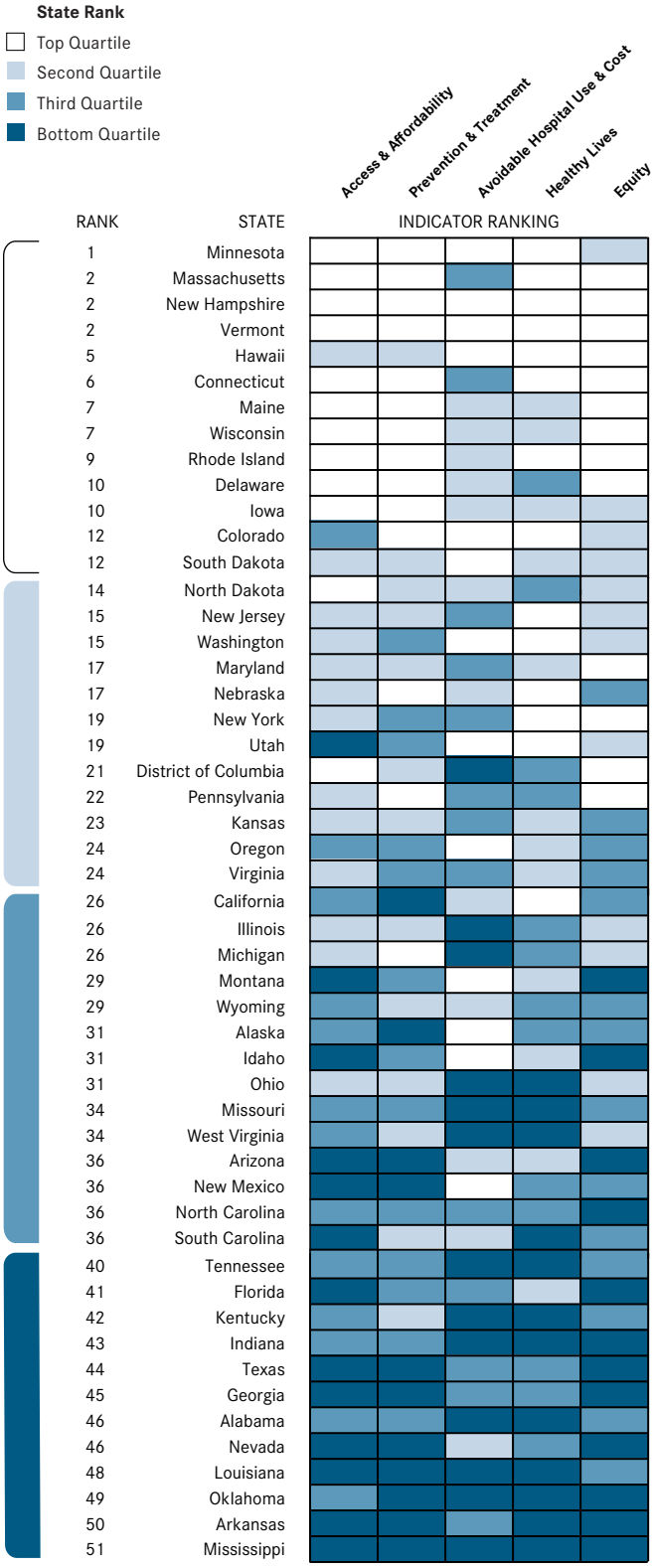
State Demographics: Disability and Nursing Home Utilization (2012)

State	Proportion of People Age 18-64 with ADL Disability	Proportion of People Age 65+ with ADL Disability	Proportion of People Age 18-64 with Any Disability	Proportion of People Age 65+ with Any Disability	Nursing Home Residents per 1,000 People Age 65+ (2010)
United States	**1.9%**	**8.7%**	**10.1%**	**35.9%**	**35**
Alabama	2.8%	11.1%	14.9%	42.7%	35
Alaska	1.6%	10.1%	10.6%	40.1%	12
Arizona	1.7%	7.0%	9.7%	33.8%	13
Arkansas	2.5%	9.6%	14.7%	41.4%	45
California	1.6%	10.6%	7.9%	36.6%	24
Colorado	1.4%	6.5%	8.5%	32.4%	30
Connecticut	1.4%	7.2%	8.2%	31.7%	52
Delaware	1.9%	6.7%	10.0%	32.0%	33
District of Columbia	1.6%	7.7%	9.5%	33.6%	37
Florida	1.9%	7.7%	10.0%	33.3%	22
Georgia	2.0%	10.2%	10.6%	38.2%	33
Hawaii	1.5%	8.0%	8.1%	34.4%	19
Idaho	1.9%	8.1%	11.0%	35.1%	22
Illinois	1.7%	8.2%	8.4%	35.0%	47
Indiana	2.0%	7.7%	11.1%	36.1%	47
Iowa	1.5%	6.5%	9.2%	32.1%	57
Kansas	1.8%	7.1%	10.3%	35.1%	51
Kentucky	2.8%	9.6%	15.5%	42.6%	41
Louisiana	2.4%	11.4%	13.4%	42.7%	46
Maine	2.1%	6.1%	13.5%	35.4%	30
Maryland	1.4%	7.7%	8.3%	32.7%	35
Massachusetts	1.6%	8.2%	8.9%	33.7%	48
Michigan	2.4%	8.5%	12.0%	36.0%	29
Minnesota	1.5%	6.6%	8.2%	31.7%	43
Mississippi	2.8%	11.7%	15.1%	44.5%	43
Missouri	2.2%	8.0%	12.4%	37.9%	46
Montana	2.0%	6.7%	10.3%	36.1%	33
Nebraska	1.1%	6.1%	8.4%	33.8%	53
Nevada	1.7%	6.9%	10.4%	35.8%	15
New Hampshire	1.6%	5.7%	9.5%	31.4%	39
New Jersey	1.4%	8.0%	7.7%	32.7%	39
New Mexico	2.7%	10.3%	12.9%	41.4%	21
New York	1.5%	9.2%	8.4%	33.8%	42
North Carolina	2.1%	8.9%	11.2%	36.6%	30
North Dakota	1.0%	5.6%	8.2%	32.6%	58
Ohio	2.1%	7.9%	11.8%	35.3%	49
Oklahoma	2.4%	9.0%	13.7%	40.8%	39
Oregon	1.9%	8.7%	11.7%	37.5%	14
Pennsylvania	1.9%	7.7%	10.9%	34.6%	41
Rhode Island	1.9%	5.8%	10.6%	33.4%	53
South Carolina	2.4%	9.1%	12.4%	37.1%	27
South Dakota	1.7%	5.5%	10.2%	34.9%	56
Tennessee	2.6%	10.4%	13.5%	39.8%	38
Texas	1.8%	10.3%	10.0%	39.1%	35
Utah	1.3%	6.9%	8.2%	34.6%	21
Vermont	1.8%	6.7%	11.6%	31.4%	32
Virginia	1.5%	8.6%	8.7%	33.6%	29
Washington	1.7%	7.9%	10.2%	35.2%	22
West Virginia	3.2%	10.6%	17.0%	43.4%	32
Wisconsin	1.8%	6.9%	9.4%	32.1%	39
Wyoming	1.7%	5.9%	9.7%	36.6%	35

Data: U.S. Census Bureau, 2012 American Community Survey; AARP Public Policy Institute Across the States 2012
Source: State Long-Term Services and Supports Scorecard, 2014.

Exhibit A23

2014 State Scorecard Summary of Health System Performance Across Dimensions



Source: Commonwealth Fund Scorecard on State Health System Performance, 2014.

Appendix B1. *Scorecard* Advisory Process

In 2010, the AARP Public Policy Institute formed an initial advisory body, the National Advisory Panel (NAP). The purpose of the NAP was to develop a working definition of long-term services and supports (LTSS) and a vision of what would constitute a high-performing LTSS system. Their consensus definition was used in the first edition of the *Scorecard* as well as in this current edition. Members of the NAP were:

- Lisa Alecxih of The Lewin Group
- Brian Burwell of Truven Health Analytics
- Lynn Feinberg of the AARP Public Policy Institute
- Penny Feldman of the Visiting Nurse Service of New York
- Melissa Hulbert of the Centers for Medicare & Medicaid Services
- Rosalie Kane of the University of Minnesota
- Ruth Katz of the U.S. Department of Health and Human Services
- James Knickman of the New York State Health Foundation
- Joseph Lugo of the U.S. Administration on Aging
- William Scanlon of the National Health Policy Forum

In 2010, the AARP Public Policy Institute subsequently formed the Technical Advisory Panel (TAP), an advisory panel formed to provide advice specifically on the data that would comprise the 2011 *Scorecard.* Members of the TAP were:

- Lisa Alecxih of The Lewin Group
- Robert Applebaum of Miami University of Ohio
- Brian Burwell of Truven Health Analytics
- Charlene Harrington of the University of California, San Francisco
- Lauren Harris-Kojetin of the National Center for Health Statistics
- Carol Irvin of Mathematica Policy Research
- Kathy Leitch, formerly of the Washington State Aging and Disability Services Administration
- Chuck Milligan, formerly of the Hilltop Institute
- Terry Moore of Abt Associates
- Vince Mor of Brown University
- D.E.B. Potter of the Agency for Healthcare Research and Quality

In 2012, to provide expert guidance from a broad range of knowledgeable stakeholders, the AARP Public Policy Institute formed an advisory committee, the Scorecard National Advisory Panel (SNAP). Members of the SNAP were:

- Lisa Alecxih of The Lewin Group
- Robert Applebaum of Miami University of Ohio
- Shawn Bloom of the National PACE Association
- Jennifer Burnett of the Centers for Medicare & Medicaid Services
- Brian Burwell of Truven Health Analytics
- Penny Feldman of the Visiting Nurse Service of New York
- Mike Fogarty of the Oklahoma Health Care Authority

- Charlene Harrington of the University of California, San Francisco
- Lauren Harris-Kojetin of the National Center for Health Statistics
- Bob Hornyak of the U.S. Administration on Aging
- Carol Irvin of Mathematica Policy Research
- Rosalie Kane of the University of Minnesota
- Ruth Katz of the U.S. Department of Health and Human Services
- Kathleen Kelly of the National Center on Caregiving, Family Caregiver Alliance
- Mary B. Kennedy of the Association for Community Affiliated Plans
- Alice Lind of the Washington State Health Care Authority
- Kevin Mahoney of Boston College
- Vince Mor of Brown University
- Lee Page of Paralyzed Veterans of America
- Pamela Parker of the State of Minnesota Department of Human Services
- D.E.B. Potter of the Agency for Healthcare Research and Quality
- Martha Roherty of the National Association of States United for Aging and Disabilities
- Elaine Ryan from AARP State Advocacy & Strategy Integration
- Paul Saucier of Truven Health Analytics
- William Scanlon of the National Health Policy Forum
- Mark Sciegaj of Penn State University
- James Toews of the U.S. Department of Health and Human Services, Administration for Community Living
- Jed Ziegenhagen of the Colorado Department of Health Care Policy and Financing

The purpose of the SNAP was to provide expert guidance to the Scorecard team from a broad range of knowledgeable stakeholders, as well as experts in LTSS data. Their task was to advise the AARP project team on how to expand and update the indicator set to reflect changes in available data since the publication of the first Scorecard, including expanding the Scorecard to include a fifth dimension of a high-performing LTSS system: Effective Transitions.

Furthermore, the SNAP advised the AARP project team on how best to present change over time between Scorecard editions. To guide deliberations among the AARP project team, funders, and members of the SNAP, we contracted with Leslie Hendrickson, a former assistant Medicaid commissioner in New Jersey, to conduct an environmental scan of available sources of data that could serve as indicators of state performance in the Effective Transitions dimension. At the first SNAP meeting, the team deliberated the environmental scan of the fifth dimension and reviewed the impact of the 2011 *Scorecard*. The second SNAP meeting considered the possible indicators developed by the AARP project team. The third SNAP meeting reviewed the preliminary results of the collected data.

Advice from the SNAP was augmented by individual interviews and group discussion with additional stakeholders to ensure representation of diverse views and areas of expertise. These individuals are acknowledged at the beginning of the report.

In addition to the SNAP, AARP's Public Policy Institute convened a Disability and Work Roundtable in 2013 to explore how the 2014 *Scorecard* could better capture measures that are important to working-age adults with physical disabilities. The meeting also focused on issues that affect the ability of adults with disabilities to find and retain employment. The panelists were:

- Cheryl Bates-Harris of the National Disability Rights Network
- Carol Boyer of the U.S. Department of Labor, Office of Disability Employment Policy
- Debbie Chalfie of the AARP State and National Group
- Henry Claypool of the American Association of People with Disabilities
- Bruce Darling of the Center for Disability Rights, Inc.
- Speed Davis of the U.S. Department of Labor, Office of Disability Employment Policy
- Wendy Fox-Grage of the AARP Public Policy Institute
- Ilene Henshaw of AARP State Advocacy and Strategic Integration
- Jamie Kendall of the U.S. Department of Health and Human Services, Administration for Community Living
- Rita Landgraf of the Delaware Department of Health and Social Services
- Kevin Mahoney of Boston College
- Brian Posey of AARP Delaware
- Susan Prokop of Paralyzed Veterans of America
- Nanette Relave of the Center for Workers with Disabilities
- Colin Schwartz of the American Association of People with Disabilities
- David Stapleton of Mathematica Policy Research
- Lori Trawinski of the AARP Public Policy Institute

While the SNAP and other advisors provided guidance throughout the process, the responsibility for final decisions rested with the Scorecard team at AARP in consultation with our funders. Any errors or omissions are the responsibility of the authors.

Appendix B2. State LTSS Scorecard Indicator Descriptions and Data Sources

Complete references for data sources are provided in Appendix B.3

Indicator	Description
1	**Median annual nursing home private pay cost as a percentage of median household income age 65+:** The ratio of the median daily private-room rate (multiplied by 365 days) divided by the median household income for households headed by someone aged 65 or older. Cost data are from the *Genworth 2013 Cost of Care Survey* (Genworth, 2013), and income data are from the AARP Public Policy Institute analysis of the 2012 American Community Survey Public Use Microdata Sample (U.S. Census Bureau, ACS PUMS 2012). The ratio of the median nursing home cost to median income was calculated at the "region" level (437 regions defined by Genworth based on Metropolitan Statistical Areas established by the U.S. Office of Management and Budget) and then averaged across all regions in a state, weighted by the proportion of the state population in each region. Baseline cost data are from the *Genworth 2010 Cost of Care Survey* (Genworth, 2010), and income data are from the 2009 American Community Survey (U.S. Census Bureau, ACS PUMS 2009).
2	**Median annual home care private pay cost as a percentage of median household income age 65+:** The ratio of the median annual private pay cost of licensed home health aide services (based on 30 hours of care per week multiplied by 52 weeks) divided by the median household income for households headed by someone aged 65 or older. Cost data are from the *Genworth 2013 Cost of Care Survey* (Genworth, 2013), and income data are from the AARP Public Policy Institute analysis of the 2012 American Community Survey Public Use Microdata Sample (U.S. Census Bureau, ACS PUMS 2012). The ratio of the median nursing home cost to median income was calculated at the "region" level (437 regions defined by Genworth based on Metropolitan Statistical Areas established by the U.S. Office of Management and Budget) and then averaged across all regions in a state, weighted by the proportion of the state population in each region. Baseline cost data are from the *Genworth 2010 Cost of Care Survey* (Genworth, 2010), and income data are from the 2009 American Community Survey (U.S. Census Bureau, ACS PUMS 2012).
3	**Private long-term care insurance policies in effect per 1,000 people age 40+:** Number of individual and group private long-term care insurance policies in force (for people of all ages) per 1,000 population aged 40 or older in the state. Data obtained from *LIMRA Individual and Group In-Force Lives, Long-Term Care Insurance Policies in Effect* report (LIMRA, 2011) and U.S. Census Bureau population estimates (U.S. Census Bureau, 2011). This is not exactly the proportion of people aged 40 and older with private LTCI because data on the age of policyholders at the state level are not available. In 2009, 74 percent of group policyholders and 95 percent of individual policyholders were aged 40 or older. Baseline data are from a previous *LIMRA Individual and Group In-Force Lives, Long-Term Care Insurance Policies in Effect* report (LIMRA, 2009) and U.S. Census Bureau population estimates (U.S. Census Bureau, 2009).
4	**Percent of adults age 21+ with ADL disability at or below 250% of poverty receiving Medicaid or other government assistance health insurance:** Percent of adults aged 21 or older with a self-care difficultly (difficulty dressing or bathing; a reasonable approximation to activities of daily living disability) at or below 250 percent of the poverty threshold who have health insurance through Medicaid, medical assistance, or any kind of government assistance plan for those with low incomes or a disability. We chose 250 percent of poverty in order to fully capture the effect of state policies extending Medicaid eligibility for LTSS up to 300 percent of Supplemental Security Income. AARP Public Policy Institute analysis of 2011 and 2012 American Community Survey Public Use Microdata Sample (U.S. Census Bureau, ACS PUMS 2011–2012). Baseline data are from the 2008 and 2009 American Community Survey (U.S. Census Bureau, ACS PUMS 2008–2009).
5	**Medicaid LTSS participant years per 100 adults age 21+ with ADL disability in nursing homes or at/below 250% poverty in the community:** The number of participant months (divided by 12) of Medicaid LTSS for adults aged 65-plus or aged 21-plus with a physical disability divided per 100 people aged 21-plus with a self-care difficulty at or below 250 percent of the poverty threshold, or of any age living in a nursing home. We chose 250 percent of poverty in order to fully capture the effect of state policies extending Medicaid eligibility for LTSS up to 300 percent of SSI. LTSS participant years from Mathematica Policy Research analysis of 2008 and 2009 Medicaid Analytic eXtract (CMS, MAX 2008–2009). Participants must have met the following criteria: they were either 65 or older by December 31, 2009, or were aged 21 to 64 by December 31, 2009, and (1) had an eligibility code of "disabled/blind," (2) did not use ICF-MR or psychiatric facility services, and (3) were not enrolled in a 1915(c) waiver for people with mental retardation/developmental disability or mental illness. Beneficiaries were determined to be users of institutional services during a month if they had a claim in the 2009 MAX LT file indicating a nursing home stay; they were determined to be users of HCBS if their records in the 2009 outpatient service (OT) or person summary (PS) files indicated they were enrolled in a 1915(c) waiver or used waiver services or had claims that indicated the use of state plan personal care services, residential care, adult day care, in-home private duty nursing, or at least four consecutive months of home health care. In order to assess whether home health care services provided during January, February, and March 2009 were part of a block of four consecutive months of service, we also analyzed home health use in October, November, and December 2008. Denominator population from AARP Public Policy Institute analysis of 2009 American Community Survey Public Use Microdata Sample (U.S. Census Bureau, ACS PUMS 2009) for community residents and analysis of CMS Online Survey and Certification Reporting by C. Harrington and H. Carrillo, reported in AARP Public Policy Institute's *Across the States 2012* (CMS, OSCAR n.d.) for nursing home residents. Baseline data are from Mathematica Policy Research analysis of 2006 and 2007 Medicaid Analytic eXtract (CMS, MAX 2006–2007), 2007 American Community Survey (U.S. Census Bureau, ACS PUMS 2007), and Harrington and Carrillo analysis reported in AARP Public Policy Institute, *Across the States 2009* (CMS, OSCAR n.d.).

Appendix B2. State LTSS Scorecard Indicator Descriptions and Data Sources (continued)

Complete references for data sources are provided in Appendix B.3

Indicator **Description**

6 **ADRC functions (composite indicator, scale 0–70):** This composite indicator comprises functional assessment scores reported by The Lewin Group for Aging and Disability Resource Centers (ADRCs) in each state, as part of providing technical assistance to states for the ADRC program. Assessments rated state progress toward developing fully functional ADRCs using 30 criteria typically provided by ADRCs across six domains:

1. Information, Referral, and Awareness (5 criteria)
2. Options Counseling (4 criteria)
3. Streamlined Eligibility for Public Programs (7 criteria)
4. Person-Centered Transitions (2 criteria)
5. Consumer Populations, Partnerships, and Stakeholders (6 criteria)
6. Quality Assurance and Continuous Improvement (6 criteria)

States were awarded a point value on the functional status of each criterion, as well as a service area coverage component: 2 points (fully functional), 1 point (partially functional), 0 points (not functional), and up to 10 points (statewide reach based on the percentage of the state population covered by ADRCs). State scores were summed across all criteria. In addition to 60 possible points from these functionality criteria, up to an additional 10 points are given for statewide reach (full credit for statewide ADRCs, otherwise proportional to the percentage of the state that is served by an ADRC). Data from The Lewin Group, Findings of State ADRC System Assessments Across Criteria of Fully Functioning Aging and Disability Resource Centers, 2012 (The Lewin Group, 2013). Baseline data are from the 2010 Fully Functioning Assessment (The Lewin Group, 2011).

7 **Percent of Medicaid and state-funded LTSS spending going to HCBS for older people and adults with physical disabilities:** Proportion of Medicaid LTSS and home health spending for older people and adults with physical disabilities (defined as nursing homes, personal care, aged/disabled waivers, home health, private duty nursing, and other programs used primarily by older people and adults with physical disabilities) going to HCBS, including Medicaid and state-funded services. Because of data limitations, 2010 data were used for New Mexico and Rhode Island, and an average of 2010–2011 data were used for Georgia. Medicaid fee-for-service spending from *Medicaid Expenditures for Long-Term Services and Supports in 2011* (Truven Health Analytics, Revised October 2013). State-funded LTSS data from AARP Public Policy Institute Survey (AARP PPI, 2012b). Baseline fee-for-service spending data are from the same source. State-funded LTSS data from AARP Public Policy Institute's *Weathering the Storm* report (AARP PPI, 2011).

8 **Percent of new Medicaid aged/disabled LTSS users first receiving services in the community:** Proportion of Medicaid LTSS beneficiaries in 2009 who did not receive any LTSS in 2008, who in the first calendar month of receiving LTSS received HCBS only and not institutional services. Participants must have met the following criteria: they were either 65 or older by December 31, 2009, or were aged 21 to 64 by December 31, 2009, and (1) had an eligibility code of "disabled/blind," (2) did not use ICF-MR or psychiatric facility services, and (3) were not enrolled in a 1915(c) waiver for people with MR/DD or mental illness. Beneficiaries were determined to be users of institutional services during a month if they had a claim in the 2009 MAX LT file indicating a nursing home stay; they were determined to be users of HCBS if their records in the 2009 PS or OT files indicated they were enrolled in a 1915(c) waiver, used waiver services, or had claims that indicated the use of state plan personal care services, residential care, adult day care, in-home private duty nursing, or at least four consecutive months of home health care. In order to assess whether home health care services provided during January, February, and March 2009 were part of a block of four consecutive months of service, home health use in October, November, and December 2008 was also analyzed. Data from Mathematica Policy Research analysis of 2008 and 2009 Medicaid Analytic eXtract (CMS, MAX 2008, 2009). Baseline data are from Mathematica Policy Research analysis of 2006 and 2007 Medicaid Analytic eXtract (CMS, MAX 2006–2007).

9 **Number of people participant-directing services per 1,000 adults age 18+ with disabilities**: Number of people receiving participant-directed services per 1,000 adults aged 18-plus with disabilities. Note that not all people with disabilities have LTSS needs. Number of people receiving participant-directed services from National Inventory of Participant-Directed Supports and Services, WAVE TWO, 2013 survey data (NRCPDS, 2013). Number of people with disabilities from 2012 American Community Survey (U.S. Census Bureau, ACS 2012).

10 **Home health and personal care aides per 1,000 population age 65+:** Number of personal care, nursing, psychiatric, and home health aide direct care workers per 1,000 population aged 65 or older. Data from 2010, 2011, and 2012 American Community Survey Public Use Microdata (ACS PUMS, 2010–2012) and 2010–2012 U.S. Census Bureau Population Estimates (U.S. Census Bureau, 2010, 2011, 2012). Aides are those with occupation code 4610 (personal care aide) or 3600 (nursing, psychiatric, home health aide) and industry code 8170 (home health care services), 8370 (social services), or 9290 (private households). Baseline data are from the 2007, 2008, and 2009 American Community Survey (U.S. Census Bureau, ACS PUMS 2007–2009).

11 **Assisted living and residential care units per 1,000 people age 65+:** Number of assisted living and residential care units per population aged 65 or older. AARP Public Policy Institute analysis of assisted living and residential care unit data from state licensing websites and the AARP Public Policy Institute Assisted Living and Residential Care Survey (AARP PPI, 2013a), and U.S. Census Bureau 2012 population estimates (U.S. Census Bureau, 2012). Data are not available for Connecticut because the state licenses assisted living service agencies (ALSAs) rather than facilities, and the number of units covered by ALSAs are not reported. Baseline data are from the State LTSS Scorecard Survey (AARP PPI, 2010) and 2010 population estimates (U.S. Census Bureau, 2010).

12 **Percent of adults age 18+ with disabilities in the community usually or always getting needed support:** Percent of adults limited in any way in any activities because of physical, mental, or emotional problems who usually or always received needed social and emotional support. Data from the 2010 Behavioral Risk Factor Surveillance System (BRFSS) (NCCDPHP, BRFSS 2010). Baseline data from 2009 BRFSS (NCCDPHP, BRFSS 2009).

13 **Percent of adults age 18+ with disabilities in the community satisfied or very satisfied with life:** Percent of adults limited in any way in any activities because of physical, mental, or emotional problems who were satisfied or very satisfied with their life. Data from 2010 BRFSS (NCCDPHP, BRFSS 2010). Baseline data from 2009 BRFSS (NCCDPHP, BRFSS 2009).

Appendix B2. State LTSS Scorecard Indicator Descriptions and Data Sources (continued)

Complete references for data sources are provided in Appendix B.3

Indicator	Description

14 **Rate of employment for adults with ADL disability age 18 to 64 relative to rate of employment for adults without ADL disability age 18 to 64:** Relative rate of employment (full or part time) for people aged 18 to 64 with a self-care difficulty (difficulty dressing or bathing; a reasonable approximation to ADL disability) compared to people aged 18 to 64 without self-care difficulty. Employment rate is calculated as the percentage of all people who are employed, including those who are not in the labor force, as many people with disabilities are not in the labor force even though they may have the skills and desire to work. Data from 2011 and 2012 American Community Survey, American FactFinder Table B18120, Employment Status by Disability Status and Type (U.S. Census Bureau, ACS 2011–2012). Baseline data from 2008 and 2009 American Community Survey, (U.S. Census Bureau, ACS 2008–2009).

15 **Percent of high-risk nursing home residents with pressure sores:** Percent of long-stay nursing home residents impaired in bed mobility or transfer, comatose, or suffering malnutrition who have pressure sores (stage 2–4) on target assessment. Data from CMS, Minimum Data Set (MDS) 3.0 for Nursing Homes, Q1–Q3, 2013, accessed on Nursing Home Compare in January 2014 (CMS, MDS 3.0 n.d.).

16 **Nursing home staffing turnover: ratio of employee terminations to the average number of active employees:** The ratio of full- and part-time employee terminations that occurred during the year, regardless of cause, to the average number of active employees on the payroll during the same time period. Data from American Health Care Association, reported in *Report of Findings: 2010 Nursing Facility Staffing Survey* (AHCA, 2011). Baseline data from *Report of Findings: 2008 Nursing Facility Staff Vacancy, Retention and Turnover Survey* (AHCA, 2010).

17 **Percent of long-stay nursing home residents who are receiving an antipsychotic medication:** The percentage of long-stay nursing home residents, defined as 100 or more cumulative days in the nursing facility, who are receiving antipsychotic medication on target assessment. Criteria exclude nursing home residents with a diagnosis of bipolar disorder, schizophrenia, Tourette's syndrome, and Huntington's disease. Data from CMS, MDS 3.0 for Nursing Homes, Q1–Q3, 2013 (CMS, MDS 3.0 n.d.).

18 **Legal and system supports for family caregivers (composite indicator, scale 0–14.5):** This indicator is constructed along six components:

Family medical leave. This component evaluates the extent to which states exceed the federal FMLA requirements for covered employers, covered employee eligibility, length of leave, and type of leave allowed. Scoring: States received scores for the degree to which they exceeded federal FMLA requirements up to a total of 4.0 possible points. Data from *Expecting Better for All Working Families: A Special Section of the Second Edition of Expecting Better* (NPWF, 2012). Legislative updates from National Partnership for Women & Families *Work & Family Policy Database*, last accessed December 13, 2013 (NPWF, 2013). Baseline data from 2008 National Conference of State Legislatures, (NCSL, 2008).

Mandatory paid family leave and sick days. The extent to which states offer additional benefits beyond FMLA to family caregivers, including requirements that employers provide paid family leave and mandate the provision of paid sick days. Scoring: 2.0 points for paid family leave, 1.0 point for statewide mandatory paid sick days, and 0.3 points if not statewide. Data from *Expecting Better for All Working Families: A Special Section of the Second Edition of Expecting Better* (NPWF, 2012). Legislative updates from National Partnership for Women & Families *Work & Family Policy Database*, last accessed December 13, 2013 (NPWF, 2013). Baseline data from 2008 National Conference of State Legislatures, (NCSL, 2008).

Unemployment insurance. The extent to which state unemployment insurance laws or regulations address "good cause" for job loss due to an illness or disability of a member of the individual's immediate family. Scoring: States received 1.0 point if unemployment insurance laws or regulations include illness or disability of a member of the individual's immediate family as "good cause" for voluntarily leaving a job. Data from National Employment Law Project May 2012 Briefing Paper *Modernizing Unemployment Insurance: Federal Incentives Pave the Way for State Reforms* (NELP, 2012). Supporting details from *Expecting Better for All Working Families: A Special Section of the Second Edition of Expecting Better* (NPWF, 2012). Baseline data from same source.

State policies that protect family caregivers from employment discrimination. The extent to which a state (or locality) law expressly includes family responsibilities, including care provided to aging parents or ill or disabled spouses of family members, as a protected classification in the context that prohibits discrimination against employees who have family responsibilities. Scoring: 1.0 point for statewide laws prohibiting discrimination and 0.3 points if not statewide. Data from AARP Public Policy Institute, with support from The SCAN Foundation and The Commonwealth Fund, *Protecting Family Caregivers from Employment Discrimination* (AARP PPI, 2012a). Baseline data from the Center for WorkLife Law (WLL, 2009).

State policies on financial protection for spouses of Medicaid beneficiaries who receive HCBS. This component evaluated the extent to which the state Minimum Maintenance of Needs Allowance permits the community spouse to retain the federal maximum income allowance and asset resource protections, and whether spouses of HCBS waiver recipients receive the full level of income and asset protection afforded to spouses of nursing home residents. Scoring: States were awarded 1.0 point each for using the maximum income and asset protections, and for treating spouses of waiver recipients equivalently to spouses of nursing home residents. Data for 2012 current year scores were obtained from "Part I Medicaid" in *Tax, Estate & Financial Planning for the Elderly: Forms and Practice*, by Eric M. Carlson (Bender, 2012). Data for 2009 rebased scores were obtained from APS Asset Preservation Strategies (APS, 2013).

State assessment of family caregiver needs. The extent to which a state conducts a mandatory or optional assessment of family caregivers for their own needs when an older adult or adult with physical disabilities for whom they are caring is being assessed for one or more LTSS programs. Programs for which the caregiver assessment tool is used included: (1) 1915(c); (2) 1115 demonstration; (3) Medicaid state plan personal care services; (4) 1915(i); (5) 1915(j); (6) Medicaid state plan (k)—Community First Choice; (7) National family caregiver support program (OAA); (8) nursing facilities; (9) Medicaid-managed LTSS; (10) state-funded family caregiver support program; (11) state-funded HCBS; and (12) other. Scoring: 1.0 point if the caregiver assessment is mandatory and 0.3 points if the assessment is optional and is used in at least 1 of the 12 programs listed above for older adults and/or adults with physical disabilities for a maximum of 1.0 point. States are awarded 0.3 points for each additional program (up to 5 programs) beyond the first program linked to a mandatory or optional assessment for a maximum of 1.5 points. Data from AARP Public Policy Institute LTSS Economic Survey (AARP PPI, 2012b).

Appendix B2. State LTSS Scorecard Indicator Descriptions and Data Sources (continued)

Complete references for data sources are provided in Appendix B.3

Indicator	Description
19	**Number of health maintenance tasks able to be delegated to LTSS workers (out of 16 tasks):** Number of 16 tasks that can be performed by a direct care aide through delegation by a registered nurse. Data collected from AARP Public Policy Institute survey on nurse delegation in home settings (AARP PPI, 2013b). Baseline data from a 2011 National Council of State Boards of Nursing survey (NCSBN, 2011).
20	**Family caregivers without much worry or stress, with enough time, well rested:** This composite indicator measures the emotional well-being of family caregivers using data from the Gallup Healthways Well-Being Index. The Gallup Healthways Well-Being Index is a daily tracking survey that interviews 1,000 adults each day. Caregiver questions were asked of a full sample in 2010 but asked of only half of the sample during 2011 and 2012. The composite includes four well-being variables related to caregivers: (1) caregivers reporting not a lot of worry yesterday; (2) not a lot of stress yesterday; (3) felt well rested yesterday; and (4) had enough time yesterday to do everything you needed to do. Data for 2011 and 2012 were combined to obtain a full sample comparable to baseline survey data used from 2010. The measure calculates the average percent of caregivers reporting not having a lot of worry, not having a lot of stress, feeling well rested, and having enough time. Data from MIT AgeLab analysis of 2010, 2011, and 2012 Gallup Healthways Well-Being Index survey data (Gallup, 2010–2012).
21	**Percentage of nursing home residents with low care needs:** Percentage of nursing home residents aged 65 and older who met the criteria of having low care needs. Low care status is met if a resident does not require physical assistance in any of the four late-loss ADLs (bed mobility, transferring, using the toilet, and eating) and is not classified in either the "Special Rehab" or "Clinically Complex" Resource Utilization Group (RUG-III) groups. Low care status may apply to a resident who is also classified in either of the lowest two of the 44 RUG-III groups. Analysis of 2010 MDS data as reported in LTCFocUS.org by V. Mor at Brown University, under a grant funded by the National Institute on Aging Program Project grant (#P01-AG027296, Shaping Long-Term Care in America). State-Level Care Data (CMS, MDS n.d.). Baseline data from same source.
22	**Percent of home health patients with a hospital admission:** Percent of home health care patients who were hospitalized for an acute condition. Data from CMS, 2012 Home Health Compare Outcome and Assessment Information Set-C (CMS, OASIS-C n.d.).
23	**Percent of long-stay nursing home residents hospitalized within a six-month period:** Percent of long-stay residents (residing in a nursing home relatively continuously for 100 days prior to the second quarter of the calendar year) who were ever hospitalized within 6 months of baseline assessment. Analysis of Medicare enrollment data and MEDPAR file by V. Mor at Brown University, under a grant funded by the National Institute on Aging Program Project grant (#P01-AG027296, Shaping Long-Term Care in America). (CMS, MEDPAR, 2010). Baseline data from previous analysis under the same grant (CMS, MEDPAR, 2008).
24	**Percent of nursing home residents with moderate to severe dementia with one or more potentially burdensome transitions at end of life:** Percent of nursing home residents with moderate to severe dementia with one or more potentially burdensome transitions at end of life: A potentially burdensome transition is defined as: (1) any transfer in the last 3 days of life; (2) a lack of continuity of a nursing home before and after a hospitalization in the last 90 days of life (i.e., going from nursing home A to the hospital and then to nursing home B); (3) two or more hospitalizations for pneumonia, urinary tract infection, dehydration, or sepsis in the last 120 days of life; (4) three or more hospitalizations for any reason in the last 90 days of life. Residents who leave a nursing home to die are not counted as a burdensome transition. A change of residence to a residential care facility is also not deemed to be a burdensome transition. The study population was identified using data from the MDS, which captures data on nursing home resident assessments, and Medicare claims data between January 1, 2009 to December 31, 2009. Subject eligibility criteria included the following: (1) insured by Medicare fee-for-service; (2) a resident of a nursing home within 120 days prior to death; (3) aged 66 or older; and (4) moderate to severe cognitive impairment (defined by a cognitive performance score of 4, 5, or 6 on the MDS assessment completed closest to 120 days before death). State scores refer to residents in nursing homes in that state at 120 days before death. 2009 analysis of MDS by J. Teno and V. Mor at Brown University, under a grant funded by the National Institute on Aging grant (#P01-AG027296, Shaping Long-Term Care in America) and in part by the Robert Wood Johnson Foundation. (CMS, MDS 2.0 n.d.).
25	**Percent of new nursing home stays lasting 100 days or more:** A measure of the proportion of new nursing home residents in a given year whose stay lasts for 100 days or more. Analysis of the 2009 Chronic Conditions Warehouse (CCW) Timeline file by Mathematica Policy Research (CCW, 2009). The CCW Timeline file includes a daily service use status for all Medicare enrollees during the calendar year 2009, with each enrollee being assigned a single status for each day of the year. For the purposes of the *Scorecard*, statuses were collapsed to four values: nursing home (including Medicare skilled nursing), in-patient, community (including home health and assisted living), or deceased. Nursing home stays were categorized as "new" if they were immediately preceded by an inpatient day, and the enrollee was not in a nursing home for at least 30 consecutive days before the beginning of the stay. Intervening events are addressed by considering in-patient stays after which the enrollee returns to a nursing home to be part of a continuous nursing home stay. A stay is deemed to have lasted 100 days or more if the person is either (1) in a nursing home on day 100, and was in a nursing home for at least 75 percent of the 100-day period, or (2) alive on day 100 and with no intervening days in the community. A person is assumed to have returned to the community before 100 days if they (3) spent more than 25 percent of the 100 days out of the nursing home, or (4) were alive but not in a nursing home on day 100 and had at least one day in the community. People dying before either 100 days or 26 community days, whichever comes first, were excluded from the analysis.
26	**Percent of people with 90+ day nursing home stays successfully transitioning back to the community:** A measure of the proportion of people with 90-plus-day nursing stays who successfully transition back to the community. Analysis of the 2009 Chronic Conditions Warehouse (CCW) Timeline file by Mathematica Policy Research (CCW, 2009). The CCW Timeline file includes a daily service use status for all Medicare enrollees during the calendar year 2009, with each enrollee being assigned a single status for each day of the year. For the purposes of the *Scorecard*, statuses were collapsed to four values: nursing home (including Medicare skilled nursing), in-patient, community (including home health and assisted living), or deceased. A person is considered to have a 90-plus day if there exists a 90-day period in which they were in a nursing home on day 1 and day 90, and at least 75 percent of the days in between. Successful transitions back to the community are defined as 30 consecutive days not in a nursing home after the 90-plus-day stay, at least 75 percent of which were community days.

Appendix B3. Complete References for Data Sources

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Appendix B4. Changes to Indicators from the First *Scorecard*

Changes to Data Indicators

There are several differences in data indicators between the first and second *Scorecards*. In this appendix, we take a dimension-by-dimension look at the changes to the indicators between the 2011 *Scorecard* and the current *Scorecard*. The 26 indicators in the 2014 *Scorecard* can be classified as shown below in Exhibit B4.1 (repeated from Exhibit 6 in the Introduction):

Exhibit B4.1

Status Relative to 2011 *Scorecard*	Count of Indicators
Repeated without change	12
Indicator changed; revised baseline available for comparing change over time	6
Indicator changed; data not comparable to first *Scorecard*	3
Total Repeated Indicators	**21**
New indicator; prior data available for comparing change over time	1
New indicator; no prior data available	4
Total New Indicators	**5**
Total Indicators in 2014 Scorecard	**26**
Dropped Indicators (in 2011 *Scorecard*, but not in 2014 *Scorecard*)	4

Twelve indicators—about half—are repeated from the first *Scorecard* without change. For these indicators, the data from the first *Scorecard* can be used as a baseline to analyze change over time. Another 6 indicators are updates with some change in methodology for which prior year data are available to create a revised baseline that can be used to analyze change over time. Another 3 indicators are continued from the first *Scorecard*, but due to properties of the underlying data source, comparability to prior years is not possible. In one way or another, 21 of the 25 indicators in the first *Scorecard* are continued into the second *Scorecard*.

In addition, four measures from the first *Scorecard* were dropped—due to discontinuation of the underlying data source or to widespread improvement on the measures (a good thing!) that leaves little variation between states, so that the measure no longer effectively differentiates between high- and low-performing states. In their place, five new measures have been added to the second *Scorecard*. These are:

- Percent of long-stay nursing home residents who are receiving an antipsychotic medication.
- Family caregivers without much worry or stress, with enough time, well rested.
- Percent of nursing home residents with moderate to severe dementia with one or more potentially burdensome transitions at end of life.
- Percent of new nursing home stays lasting 100 days or more.
- Percent of people with 90+ day nursing home stays successfully transitioning back to the community.

Affordability and Access

The *Scorecard* repeats all six indicators used in 2011 to measure the affordability and accessibility of LTSS in a state. Five of these indicators are repeated without change from the first *Scorecard* (see Exhibit B4.2).

Exhibit B4.2

Indicator	Change over Time	Status Relative to 2011 *Scorecard*
Median annual nursing home private pay cost as a percentage of median household income age 65+	Yes	Repeated without change
Median annual home care private pay cost as a percentage of median household income age 65+	Yes	Repeated without change
Private long-term care insurance policies in effect per 1,000 population age 40+	Yes	Repeated without change
Percent of adults age 21+ with ADL disability at or below 250% of poverty receiving Medicaid or other government assistance health insurance	Yes	Repeated without change
Medicaid LTSS participant years per 100 adults age 21+ with ADL disability in nursing homes or at/below 250% poverty in the community	Yes	Repeated without change
Aging Disability Resource Center functions (composite indicator, scale 0–70)	Yes	Indicator scoring changed; revised baseline available for comparing change over time

There was, however, a change in the way that the composite indicator Aging Disability Resource Center (ADRC) functions was calculated. In the previous *Scorecard*, this indicator also included data on other state single-entry-point systems. Now established in all states, ADRCs are the predominant mechanism by which states provide access to information about LTSS; in addition, an analysis of the data found little effect of removing the data on other single-entry points. For ease of interpretation of this measure, the scoring was revised.

In the 2014 *Scorecard*, the ADRC functions indicator comprises 30 functionality criteria on which The Lewin Group assigns a score of 0 if the function is not performed, 1 for partially functional, or 2 for fully functional as part of providing technical assistance to states for the ADRC program. In addition to 60 possible points from these functionality criteria, up to an additional 10 points are given for statewideness (full credit for states that have a statewide ADRC, otherwise proportional to the percentage of the state that is served by an ADRC). The data used in the first *Scorecard* were rescored to be comparable to the current data; change over time is calculated for statewideness and those criteria measured in both current and baseline years (states were scored on only 26 criteria in the baseline data year).

Choice of Setting and Provider

Six of the seven indicators of choice that were measured in 2011 are repeated in this *Scorecard*; however, only five of them comprise the dimension. One indicator (the proportion of long-stay nursing home residents who have low care needs) was moved to the Effective Transitions dimension and is discussed in that section. The five indicators that now measure choice of setting and provider are shown in Exhibit B4.3.

Exhibit B4.3

Indicator	Change over Time	Status Relative to 2011 *Scorecard*
Percent of Medicaid and state-funded LTSS spending going to HCBS for older people and adults with physical disabilities	Yes	Indicator changed slightly; revised baseline available for comparing change over time
Percent of new Medicaid aged/disabled LTSS users first receiving services in the community	Yes	Repeated without change
Number of people participant-directing services per 1,000 adults age 18+ with disabilities	No	Repeated; data not comparable to first *Scorecard*
Home health and personal care aides per 1,000 population age 65+	Yes	New data source; revised baseline available for comparing change over time
Assisted living and residential care units per 1,000 population age 65+	Yes	Indicator changed slightly; revised baseline available for comparing change over time

Of the five remaining indicators, only one is repeated without change from the 2011 *Scorecard* (percent of new Medicaid users receiving HCBS).

The Medicaid spending balance indicator was revised slightly. As a result, baseline data do not exactly match the data reported in the 2011 *Scorecard* due to minor reporting changes and prior period adjustments. Current and revised baseline data presented in this *Scorecard* are comparable and can be used to show progress over time.

The assisted living supply measure was also revised slightly. Unit counts were updated in a handful of states due to missing data or double counting in the original responses; as well, the population estimates for the denominator were updated to be consistent with the year of data collection. Current and revised baseline data presented in this *Scorecard* are comparable and can be used to show progress over time.

A new source of data on residential care was developed under the auspices of the National Center for Health Statistics at the federal Centers for Disease Control. The National Survey of Long-Term Care Providers (NSLTCP) is a promising new source of high-quality data to monitor trends in all LTSS settings, both nationally and at the state level.[1] However, because the data source is new, we would not have been able to show change over time using these data; it is our hope that future editions of the *Scorecard* will use subsequent waves of the NSLTCP to measure the supply of assisted living and residential care units, as well as change in performance over time.

A new data source, with a different definition and different years of data, was used for the home health aide supply measures. In the 2011 *Scorecard*, the number of home health and personal care aides was taken from the Bureau of Labor Statistics Occupational Employment Statistics. After publication of the first *Scorecard*, there was some concern that this establishment survey undercounted home health aides in states where there were many self-employed, independent providers. To address this concern, a population-based data source (the American Community Survey) was used for this *Scorecard*. Current and revised baseline data presented in this *Scorecard* are comparable and can be used to show progress over time.

While the data collection for the number of people participant-directing services is consistent with the methodology for the 2011 *Scorecard*, and the national number of people found to be self-directing was similar, information about

the specific programs that authorized these services could not be completely matched between the two surveys. Differences between the 2013 and 2010 counts at the state level cannot be confidently attributed to a change in performance. Instead, issues with incomplete reporting (e.g., a program reported participants in the 2010 survey but not in the 2013 survey, or vice versa) or inconsistent reporting (widely varying numbers in an established program suggest different criteria were used; e.g., number eligible for participant direction, number actually directing services, or total program enrollment) appear to be driving many of the differences. Thus, we were unable to analyze change over time in state performance on this indicator.

The composite indicator "tools and programs to facilitate consumer choice" was dropped from this edition of the *Scorecard*. Since the data collection for the 2011 *Scorecard*, state variation on the policies included in this measure have changed: there is no longer enough variation between states to differentiate performance. In particular, on two of the four component measures states have nearly uniform high performance: nearly all states now have Money Follows the Person programs (45 states) and options counseling for people entering nursing homes (48 states).

There is still variation on the two other component measures: uniform assessment and presumptive eligibility for HCBS. More than half of the states report using a uniform assessment, and there has been substantial progress in this area; only about 13 states reported having presumptive eligibility for HCBS, unchanged from the last *Scorecard*. These remain important public policy objectives for states to enact, as both help ensure that consumers who wish to remain in their homes and communities have adequate choices to do so. It is unknown how the states' growing shift to managed LTSS will affect these practices.

Quality of Life and Quality of Care

The 2011 *Scorecard* contained nine indicators of quality across three areas: quality of life in the community for people with disabilities, quality of care in nursing homes, and quality of care provided by home health agencies. This report contains a total of six quality indicators in two areas, as described below (see Exhibit B4.4).

Exhibit B4.4

Indicator	Change over Time	Status Relative to 2011 *Scorecard*
Quality of Life in the Community		
Percent of adults age 18+ with disabilities in the community usually or always getting needed support	Yes	Repeated without change
Percent of adults age 18+ with disabilities in the community satisfied or very satisfied with life	Yes	Repeated without change
Rate of employment for adults with ADL disability ages 18–64 relative to rate of employment for adults without ADL disability ages 18–64	Yes	Repeated without change
Quality of Care in Nursing Homes		
Percent of high-risk nursing home residents with pressure sores	No	Change in the underlying data source; data not comparable to first *Scorecard*
Nursing home staffing turnover: ratio of employee terminations to the average number of active employees	Yes	Repeated without change
Percent of long-stay nursing home residents who are receiving an antipsychotic medication	No	New indicator; prior data not available

The three indicators of quality of life remain the same as those reported in the 2011 report and are repeated from the first *Scorecard* without change. For these indicators, the data from the first *Scorecard* can be used as a baseline to analyze change over time.

Three measures of quality of care in nursing homes are included. The 2011 *Scorecard* had four measures of quality of care in nursing homes. One of these, the percentage of long-stay nursing home residents with a hospital admission, was moved to the Effective Transitions dimension and is discussed in that section. Of the remaining three measures of quality of care in nursing homes from the 2011 *Scorecard*, two are retained and a third was replaced with a newer measure.

The percentage of high-risk nursing home residents with pressure sores was repeated. However, there was a change in the definition of pressure sores in an update of the underlying data source (MDS 2.0 to MDS 3.0) and, therefore, the measure in the current *Scorecard* is not comparable to what was reported in the first *Scorecard*. No prior data are available to measure change over time.

The measure of nursing home staffing turnover is repeated from the first *Scorecard* without change. The data from the first *Scorecard* can be used as a baseline to analyze change over time.

The percentage of long-stay nursing home residents who are receiving an antipsychotic medication is a new measure. No prior data are available to measure change over time. This measure replaces the percentage of nursing home residents who are physically restrained.

The physical restraints measure was dropped because most states have improved to a nearly uniform level of performance. Nationally, only 1.8 percent of nursing home residents were restrained in 2012 (down from 3.9 percent in the last *Scorecard* and approximately 10 percent in 2000, though there has been a change in definition due to updates to the data source). Moreover, 40 states performed in a narrow range between 0.9 percent and 2.9 percent. Once all states have reached this narrow range of performance, it becomes inappropriate to use ranks to differentiate level of performance.

As nursing homes endeavored to reduce or eliminate the use of physical restraints, concerns emerged that they inappropriately substituted antipsychotic medications. Attention to this issue surfaced at a hearing by the Senate Aging Committee in November 2011. The inspector general of the Department of Health and Human Services testified at this hearing.[2] This issue was of particular concern among people with dementia, prompting CMS to launch an initiative to reduce the inappropriate use of such medications.[3]

The 2011 *Scorecard* also had two measures of quality of home health care. One of these, the percentage of home health patients with a hospital admission, was moved to the Effective Transitions dimension and is discussed in that section. The other measure, the percentage of home health patients with a care plan to treat pressure sores, was dropped because most states have improved to a nearly uniform level of performance. Nationally, the rate improved from 90 percent in 2010 to 96 percent in 2012, with more than two-thirds of states clustered in a narrow range from 95.3 percent to 98.2 percent. Possible alternative measures of home health quality were considered, but none could be validated as appropriate measures of LTSS system performance.

Support for Family Caregivers

As in the 2011 *Scorecard*, this dimension contains three indicators (see Exhibit B4.5), two that are repeated and one that replaces a measure that could not be updated.

Exhibit B4.5

Indicator	Change over Time	Status Relative to 2011 *Scorecard*
Legal and system supports for family caregivers (composite indicator, scale 0–14.5)	Yes	Indicator scoring changed; revised baseline available for comparing change over time
Number of health maintenance tasks able to be delegated to LTSS workers (out of 16 tasks)	Yes	Repeated without change
Family caregivers without much worry or stress, with enough time, well rested	Yes	New indicator; revised baseline available for comparing change over time

The legal and system supports composite indicator is repeated from the first *Scorecard*, but with slight changes. This indicator is constructed from several factors including the extent to which the state exceeds federal requirements under the FMLA; paid family leave, mandatory paid sick days, and antidiscrimination provisions in the state or localities within the state; state policies on financial protection for the spouses of Medicaid beneficiaries who receive HCBS; caregiver assessment in public LTSS programs; and whether the state allows workers who leave their jobs to care for a family member who is sick or disabled to be eligible for unemployment benefits.

New data on caregiver assessments were included; only assessments that involve talking to the family caregiver are included. Further analysis of caregiver assessments completed after the first *Scorecard* found that many so-called caregiver assessments did not in fact meet this criterion.[4] The caregiver assessment data in this report, therefore, are not comparable to what was reported in the first *Scorecard*.

All other components are repeated from the first *Scorecard*, though for ease of interpretation of this measure, the scoring of several components was revised. The data used in the first *Scorecard* were rescored to be comparable to the current data; change over time is calculated for all comparable components (everything except caregiver assessment).

The number of important health maintenance tasks (from a list of 16 tasks) that can be delegated to LTSS workers is repeated without change from the first *Scorecard*.

The caregivers without a lot of worry or stress, well rested, having enough time indicator is new and replaces the measure "percentage of caregivers usually or always getting needed support" from the first *Scorecard*. That indicator was based on data from the Behavioral Risk Factor Surveillance System (BRFSS); unfortunately, the question that identified whether respondents were caregivers was dropped from the base survey, and so data are not available for most states. While a handful of states have opted to include the caregiver module as part of the BRFSS, which includes this and other questions about the caregiving experience, the lack of data for *all* or *almost all* states prevented us from repeating this indicator. Losing such a good source of data is a serious problem for researchers, analysts, and policy makers, raising again the need for advocacy to support rigorous data collection and maintenance.

To replace this measure, we added a composite of four items from the Gallup Healthways Well-Being Index, a large daily tracking survey that includes a question to identify caregivers. The Massachusetts Institute of Technology (MIT) AgeLab analyzed the data. This indicator is not the same as the previous BRFSS indicator of caregiver support, and it would be inappropriate to compare a state's performance on the "getting needed support" indicator from the 2011 *Scorecard* with the new indicator in this report. The MIT AgeLab analysis included multiple years of data from the Gallup Healthways Well-Being Index; prior year data are used to show change over time.

Effective Transitions

The effective transitions dimension is a new dimension for the 2014 *Scorecard*. It comprises six indicators, three of which were included in the Choice dimension or Quality dimension of the 2011 *Scorecard*, and three of which are new for this *Scorecard* (see Exhibit B4.6).

Exhibit B4.6

Indicator	Change over Time	Status Relative to 2011 *Scorecard*
Percent of nursing home residents with low care needs	Yes	Repeated without change
Percent of home health patients with a hospital admission	No	Change in the underlying data source; data not comparable to first *Scorecard*
Percent of long-stay nursing home residents hospitalized within a six-month period	Yes	Repeated without change
Percent of nursing home residents with moderate to severe dementia with one or more potentially burdensome transitions at end of life	No	New indicator; prior data not available
Percent of new nursing home stays lasting 100 days or more	No	New indicator; prior data not available
Percent of people with 90+ day nursing home stays successfully transitioning back to the community	No	New indicator; prior data not available

The three indicators moved from the Choice and Quality dimensions are:

- The percent of nursing home residents who have low care needs (previously in the Choice dimension).
- The percent of long-stay nursing home residents with a hospital admission (previously in the Quality dimension).
- The percent of home health patients with a hospital admission (previously in the Quality dimension).

The first two of these measures are repeated from the first *Scorecard* without change. For these indicators, the data from the first *Scorecard* can be used as baseline to analyze change over time. There was a change in the underlying data source for the home health hospital admission indicator (update from OASIS B to OASIS C), and the measure in the current *Scorecard* may not be comparable to what was reported in the first *Scorecard*. No prior data are available to measure change over time.

The three new indicators are:

- Percent of nursing home residents with moderate to severe dementia with one or more potentially burdensome transitions at end of life.
- Percent of new nursing home stays lasting 100 days or more.
- Percent of people with 90+ day nursing home stays successfully transitioning back to the community.

Only current year data are available for these measures; there are no prior year data to measure change over time.

Notes

1 For more information on the NSLTCP, see http://www.cdc.gov/nchs/nsltcp.htm.

2 Daniel R. Levinson, "Overprescribed: The Human and Taxpayers' Costs of Antipsychotics in Nursing Homes" (Washington, DC: U.S Department of Health and Human Services, November 30, 2011). Available at http://oig.hhs.gov/testimony/docs/2011/levinson_testimony_11302011.pdf.

3 Alice Bonner, "Improving Dementia Care and Reducing Unnecessary Use of Antipsychotic Medications in Nursing Homes" (Baltimore, MD: CMS, January 31, 2013). Available at http://doh.sd.gov/news/documents/cms_dementia_care.pdf.

4 Kathleen Kelly, Nicole Wolfe, Mary Jo Gibson, and Lynn Feinberg, "Listening to Family Caregivers: The Need to Include Family Caregiver Assessment in Medicaid Home- and Community-Based Service Waiver Programs" (Washington, DC: AARP Public Policy Institute, December 2013).

Appendix B5. Measuring Change in Performance Over Time

One of the main goals of this report is to assess how state long-term services and supports (LTSS) systems have improved (or not improved) over the 2 to 3 years prior to the most recent available data, which corresponds to the interval between the first *State LTSS Scorecard* and this second *State LTSS Scorecard*.

However, as discussed in depth in Appendix B4, the set of indicators in the current *Scorecard* differ substantially from the set in the first *Scorecard*. Only about half of the indicators in the first *Scorecard* are repeated without any change in the indicator specifications. As well, this *Scorecard* includes the fifth dimension of Effective Transitions for the first time; that change alone renders the overall ranks non-comparable. **As a result, ranks should not be compared between the current *LTSS Scorecard* and the 2011 *LTSS Scorecard*.**

However, it is still possible to assess change over time for the 19 indicators with baseline data. The best way to do so is to compare indicator by indicator to determine whether a state has made progress in the last 2 to 3 years of data availability. Comparing a state to its own baseline score is more informative than comparing state rank on the indicator to the baseline-year rank, as a state's level of LTSS progress is not dependent on what happens in other states. The number of indicators showing improvement, decline, or little or no change in performance can be used to illustrate performance across multiple indicators or multiple dimensions. See Exhibit A4 for a count of the number of indicators in which each state showed improvement, decline, or little or no change in performance.

Quantifying Change in Performance

To aid in interpreting change over time, a threshold of 10 percent was used to identify states with a meaningful change in performance for most indicators.

For count or ratio data, usually indicators of the form [(number of things)/(population subgroup)], a threshold of 10 percent change in the ratio was used. For example, if a state had 20 assisted living units per 1,000 people aged 65+, a ratio of 18 or lower in 2012–2013 would be classified as a decline, and a ratio of 22 or higher would be classified as an improvement. A ratio of 19, 20, or 21 would be classified as "little or no change" so as not to highlight small changes in the data that may not reflect meaningful change. This is particularly important for indicators based on survey data (e.g. American Community Survey, Behavioral Risk Factor Surveillance System, Gallup Healthways Well-Being Survey) where sampling error is present in the measure.

For percentage data, a threshold of 10 percent change in the odds was used instead in order for meaningful change to be possible for any starting value, and for the indication of change to be the same whether the indicator is expressed positively or negatively. The odds (or odds ratio) is the ratio of the probability of something happening (or the proportion of the time that it happens) to the probability of it not happening, or more generally odds = P/(1-P), where P is the proportion, percentage, or probability. For example, a percentage of 20 percent corresponds to an odds of 0.25 (20 percent/80 percent), and a percentage of 60 percent corresponds to an odds of 1.5 (60 percent/40 percent).

Several indicators were measured as a percent scale but were actually count or ratio data (nursing home and home health cost; nursing home staffing turnover); for these, a 10 percent change in ratio was used as a threshold. Similarly, several indicators are not true proportions but act approximately like a percentage (long-term care insurance, people with disabilities (PWD) with Medicaid LTSS, PWD rate of employment); for these, a 10 percent change in the odds was used for a threshold after converting to the appropriate scale. Exhibit B5.1 shows the thresholds used for each of the 19 indicators with baseline data.

Exhibit B5.1 Type of Change Threshold Used

Indicator	Threshold	Detail
Affordability and Access		
Nursing Home Cost	+/- 10%	
Home Care Cost	+/- 10%	
Long-Term Care Insurance	+/- 10% odds	
Low-Income PWD with Medicaid	+/- 10% odds	
Low-Income PWD with Medicaid LTSS	+/- 10% odds	
ADRC Functions	Special	+/- 5
Choice of Setting and Provider		
Medicaid LTSS Balance: Spending	+/- 10% odds	
Medicaid LTSS Balance: New Users	+/- 10% odds	
Home Health Aide Supply	+/- 10%	
Assisted Living Supply	+/- 10%	
Quality of Life and Quality of Care		
PWD* Getting Needed Support	+/- 10% odds	
PWD* Satisfied with Life	+/- 10% odds	
PWD* Rate of Employment	+/- 10% odds	
Nursing Home Staffing Turnover	+/- 10%	
Support for Family Caregivers		
Legal and System Supports	Special	+/- 0.10
Nurse Delegation	Special	Any change
Elements of Caregiver Well-Being	+/- 10%	
Effective Transitions		
Nursing Home Low Care Needs	+/- 10% odds	
Nursing Home Hospital Admissions	+/- 10% odds	

* PWD = people with disabilities

The three constructed indicators, incorporating multiple policy elements, had indicator-specific thresholds to identify states with any real changes in policy.

The Aging and Disability Resource Center functions indicator is highly volatile. A threshold of +/- 5 was used. This corresponds to increasing or decreasing the percentage of a state's population covered by an ADRC by 50 percent, or increasing or decreasing the functionality of about one-fifth of the criteria that have baseline data. Even with this fairly generous threshold, more than half of the states showed meaningful change.

The legal and system supports indicator incorporates a number of different state policies to support family caregivers. One policy is scored in relation to federal minimum and maximum income and asset protection amounts; a state using a specific intermediate amount instead could see a slight change in score even if state policy is unchanged. A small threshold of 0.10 points was used so as not to indicate meaningful change as a result; any real policy change exceeds the threshold.

The nurse delegation indicator is a count of the number of health maintenance tasks that can be delegated to a direct care worker. Any change was considered to be meaningful (only 15 states showed change).

Appendix B6 Glossary

Activities of Daily Living (ADLs): Basic personal activities that include eating, bathing, dressing, toileting, transferring from a bed or chair, and continence. ADLs often are used to measure how much assistance people need and whether they qualify for assistance from a public program or private long-term care insurance.

Adult Day Services: Daytime community-based programs for adults with LTSS needs. Such programs provide a variety of health, social, and related support services in a protective setting.

Ageism: Stereotyping or discrimination against individuals or groups on the basis of their age.

Aging and Disability Resource Centers (ADRCs): Publicly sponsored entities that are designed to help consumers and their families find information about the full range of long-term services and supports available in their community. ADRCs are for people of all incomes and all types of disability. By providing objective information, advice, counseling, and assistance, their purpose is to empower people to make informed decisions and more easily access available programs and services. Similar entities are sometimes referred to as "single entry point" or "no wrong door" systems.

Alternative Residential Settings: Residential settings that are neither private homes or apartments nor nursing homes. These settings include assisted living and small group housing in which services are delivered, usually for no more than 16 residents. An adult care home may be a single-family home in which services are provided to as few as two to three people with disabilities.

Antipsychotic Drug Use in Nursing Homes: Some nursing home residents receive antipsychotic medications to treat schizophrenia, Tourette's syndrome, and Huntington's disease. However, more than one-fifth of nursing home residents receive antipsychotic medications without a diagnosis for one of the three conditions listed. These "off label" prescriptions are a potentially inappropriate use of such medication, and potentially life-threatening to people with dementia.

Assisted Living: Residences that provide a "home with services" and that emphasize residents' privacy and choice. In many states, residents typically have private rooms or apartment-style units (shared only by choice) with bathrooms and lockable doors. Personal care services are available 24 hours a day.

Boomer: A person born between 1946 and 1964. The demographic irregularity of the post–WWII increase in fertility rates led to a large cohort of births during those years. As baby boomers age, they place an unprecedented strain on the nation's LTSS system, which is coping with more needs than ever before.

Burdensome Transition: For purposes of the *Scorecard*, we considered a "burdensome transition" to be (1) any transfer in the last 3 days of life, (2) a lack of continuity of a nursing home before and after a hospitalization in the last 90 days of life, or (3) multiple hospitalizations in the last 120 days of life.

Care Management: A process for assessing the needs of an older person or adult with disabilities, creating a service plan, and coordinating and monitoring the delivery of services. A care manager may operate privately or may be employed by social service agencies or public programs. Typically, care managers are nurses or social workers.

Centers for Medicare & Medicaid Services (CMS): a federal agency within the Department of Health and Human Services. CMS is responsible for administering the Medicare program and works with state governments to administer Medicaid and other health insurance programs.

Chronic Care: Care and treatment given to individuals who have health problems of a long-term and continuing nature. Chronic illnesses generally are not curable, require ongoing treatment, and affect a person's daily life.

Cognitive Impairment: Deterioration or loss of intellectual capacity, often resulting from Alzheimer's disease or other forms of dementia. People who have cognitive impairments often require supervision to protect them from injury or harm. Cognitive impairment may affect short- or long-term memory; orientation to person, place, and time; or reasoning capacity.

Dementia: A serious loss of cognitive ability affecting one's ability to learn, reason, and retain information, as well as causing other mental and behavioral problems. Alzheimer's disease, vascular dementia, and dementia with Lewy bodies are common varieties.

Disability: A limitation in physical, mental, cognitive, emotional, or social activity that results in difficulty performing daily activities or life tasks. Disability may involve not just individual characteristics, but also the relationship between the individual and his or her environment.

Family Caregiver: Any relative, partner, friend, or neighbor who has a significant personal relationship with and provides a broad range of assistance to an older person or adult with a chronic or disabling condition. These individuals may live with or separately from the person receiving services. Caregivers may provide emotional or financial support, as well as hands-on help with different tasks.

Family Caregiver Assessment: A systematic process of gathering information about a caregiving situation, to identify caregivers' own health, well-being, needs, strengths, and resources, as well as their ability to contribute to meeting the needs of the care recipient. The family caregiver assessment must include direct contact with the family caregiver.

Family and Medical Leave Act (FMLA): Allows 12 workweeks of leave in a 12-month period for specified family and medical reasons, including to care for the employee's spouse or parent who has a serious health condition. Leave is job-protected, unpaid, and guarantees a continuation of group health insurance coverage.

Group Home: Residence that offers housing and personal care services for a small number of residents (often three to eight). The owner or manager usually provides services such as meals, personal care, supervision, and transportation to residents. Residences are usually homelike and may be single-family homes.

Home- and Community-Based Services (HCBS): Services that are designed to support community living and delay or prevent admission to an institution for people with various disabilities. HCBS can be paid for out of pocket or by private long-term care insurance, or may be funded by Medicaid, state general revenues, the Older Americans Act, or other programs. Medicaid is the primary source of public funding. HCBS can include personal care (help with ADLs), transportation, shopping and meal preparation, home health aides, adult day services, and homemaker services. Assistance with managing medications or money also may be provided.

Home- and Community-Based Services Waivers: Section 1915(c) of the Social Security Act allows the secretary of the Department of Health and Human Services to waive Medicaid provisions in order to allow LTSS to be delivered in community settings. HCBS waivers allow states to offer Medicaid beneficiaries an alternative to receiving comprehensive services in institutional settings.

Home Health Agency: An organization that provides home health services supervised by a licensed health professional in the patient's home. Home health agencies may be for-profit or nonprofit entities. Most home health agencies also provide unskilled home care and personal care services.

Home Health Aide (also called Home Care Aide or Personal Care Aide): A person who provides personal care and assistance with household chores and other daily living needs, enabling people with functional and activity limitations to live independently in their homes. These individuals may be hired privately or through a home health agency.

Home Health Care: A wide range of health-related services delivered in a person's home, such as assistance with medications, wound care, and intravenous therapy provided by a nurse, as well as therapies including physical and occupational therapy. Care also may include help with basic needs such as bathing and dressing.

Homemaker Services: In-home help with meal preparation, shopping, light housekeeping, money management, personal hygiene and grooming, and laundry.

Instrumental Activities of Daily Living (IADLs): Routine household tasks needed for independent living, which includes using the telephone, taking medications, managing money, housework, preparing meals, laundry, and grocery shopping.

Long-Term Care Insurance: Private long-term care insurance is designed to help purchasers pay for the cost of LTSS, the majority of which is not covered by public or private health insurance. Purchasers must pass medical underwriting and continue to pay premiums until they develop a disability. The cost of the insurance is based on the purchaser's age and the amount of coverage selected. Once purchasers qualify for benefits, the policy may pay anywhere from $50 to $500 per day, and purchasers may pay for 1 year of coverage to lifetime benefits. Most policies sold today cover services delivered in a range of settings, including the home, assisted living, or a nursing home.

Long-Term Services and Supports (LTSS) (also called Long-Term Care): A diverse set of services designed to help people who have disabilities or chronic care needs. Services often include personal care, help with money or medication management, transportation, meal preparation, and health maintenance tasks. The need for services may be of varying duration but is generally expected to last for at least 90 days. Services can be provided in a person's home, in a community setting such as an adult day center, or in a group residential facility (e.g., small group home, assisted living, or nursing home).

Median: In a data sample, the median is the middle value, separating the higher half from the lower half. In an even-numbered sample, the median is the average of the two middle numbers. The median is often preferred as a measure of central tendency, as it is resistant to distortion from outlier values in the sample.

Medicaid: A federal and state program that provides health care and LTSS to people with low incomes and few assets. Within broad federal rules, states have considerable flexibility in determining who may qualify for Medicaid and what services they will receive. See page 28 for more information.

Medicare: A federal program that provides health care for people aged 65, people under age 65 with certain disabilities, and people of all ages with end-stage renal disease. While Medicare covers post-acute home health care and skilled nursing facility stays, Medicare does not pay for long-term services and supports.

Money Follows the Person (MFP): The Money Follows the Person Rebalancing Demonstration Grant, offered by the Centers for Medicare & Medicaid Services, helps states transition people with chronic conditions and disabilities from institutions back into the community. As part of the grant, technical assistance is made available to states. Forty-four states and the District of Columbia currently participate in the demonstration, and more than 31,000 people have been transitioned.

No Wrong Door: The concept of "no wrong door" pertains to a state's system by which individuals access public programs that provide LTSS. Even though various programs may be administered by different agencies within the state, a no-wrong-door system facilitates access by developing a single, coordinated system of information, referral, and access to aging and disability LTSS. (See also Single Entry Point.)

Nurse Delegation: The extent to which direct care workers can provide assistance with a broad range of health maintenance tasks. State Nurse Practice Acts usually

determine how broad or narrow the range of allowable tasks is in the state.

Nursing Home (or Nursing Facility): Facility licensed by the state to offer residents personal care as well as medical care 24 hours a day. These facilities provide the resident's room and board, as well as nursing care, personal care, supervision, medication, therapies, and rehabilitation. Rooms may be shared, and communal dining is common.

Participant Direction: A growing movement to allow participants in public programs to manage and direct their own services, as opposed to having the provision of services managed by a home care agency. Variously called "consumer direction," "self-direction," or "participant direction," this model allows the individual with disabilities to hire and fire a direct care worker. In some cases the participant has control over wages, services delivered, and the schedule for delivering services.

Person with Disabilities: Any person who has a physical or mental impairment that substantially limits one or more activities of daily living. Examples of impairment include hearing, mobility, and visual impairments. Examples of activities of daily living include eating, bathing, and dressing.

Personal Care: Assistance with activities of daily living—eating, bathing, dressing, toileting, transferring, and continence—that an individual cannot perform without help.

Pressure Sores (or Pressure Ulcers): Typically occurring over a bony prominence, pressure sores are localized injuries to the skin as a result of pressure to the skin, obstructing blood flow. Pressure sores are most commonly found in person unable to move about, but they are preventable with proper care and treatable if detected early.

Presumptive Eligibility: States have the option to "presume" Medicaid eligibility for individuals who are likely to qualify, facilitating timely access to HCBS.

Quartile: A descriptive statistic. In a data sample, the quartiles of a ranked set of data values are the four equal parts of the data sample, each containing 25 percent of the total sample.

Rehabilitation: Services designed to improve or restore a person's functioning, including physical therapy, occupational therapy, and speech therapy. These services may be provided at home or in long-term care facilities. Some people use rehabilitation of a short duration, whereas others require an extended period of rehabilitation services.

Residential Care: The provision of room, board, personal care, and other services delivered in the person's place of residence other than a private home or apartment. Residential care falls between the nursing care delivered in skilled and intermediate care nursing facilities and the assistance provided to individuals in private homes, although residents often receive services similar to those that are provided in a nursing home. It can be broadly defined as the provision of 24-hour supervision of individuals who, because of age or impairments, need assistance with the activities of daily living.

Respite Care: Services designed to allow family caregivers to have time away from their caregiving role. Trained professionals or volunteers may come into the home to provide short-term care (from a few hours to a few days). Alternatively, the person who needs LTSS may spend time in an adult day center or even, in some cases, a temporary stay in a nursing facility.

Revised Baseline: When developing the second edition of the *Scorecard*, the methodology had changed for several publically available data sources. Consequently, when making a comparison of change in performance across time, we revised the 2011 results to reflect this new methodology, creating a new revised baseline for performance.

Single Entry Point (SEP): A statewide system to enable consumers to access all LTSS through an agency, organization, coordinated network, or portal that provides information regarding the availability of such services, how to apply for services, referrals to service providers, and determinations of financial and functional eligibility. These systems also may authorize services from one or more funding sources and perform other care management or care coordination functions. ADRCs may function as, or provide access to, single-entry-point systems. (See also No Wrong Door.)

Supplemental Security Income (SSI): A federal income support program for low-income aged, blind, and disabled persons, established by Title XVI of the Social Security Act. States may supplement the basic federal benefit amount.

Transitions: Changes in the setting in which people receive services—between a hospital, a nursing facility, and their place of residence—are called transitions. Transitions are important because people are vulnerable to breakdowns in care and poor communication among service providers at these times. Some systems and providers are attempting to improve transitions between settings in order to improve health outcomes for people with chronic conditions or LTSS needs.

About the Authors

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Dr. Reinhard is a former faculty member at the Rutgers College of Nursing. She is a fellow in the American Academy of Nursing and member of the National Academy of Social Insurance. She holds many governance positions, including vice chair of the Center for Health Policy Development, which includes the National Academy for State Health Policy. She holds a master's degree in nursing from the University of Cincinnati and a PhD in sociology from Rutgers, The State University of New Jersey.

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Leslie Hendrickson, PhD, is a former Medicaid budget analyst and Medicaid manager in Oregon and New Jersey. As an assistant commissioner in New Jersey, he was responsible for Medicaid and state-funded home- and community-based programs, nursing home reimbursement, and eight field offices for providing case management and preadmission screening for long-term services and supports eligibility. As a visiting professor, he has worked with the Rutgers Center for State Health Policy, providing technical assistance to some 30 states awarded Real Choice System Change Grants.

Recent work includes a 300-page study of California's long-term living programs and statewide studies in Colorado, Florida, South Carolina, and Texas. He has testified as an expert witness in local zoning board hearings involving the location of health care treatment programs and has prepared testimony for three federal district courts involving Olmstead litigation. As a consultant, he works with national research organizations on rate setting and cost analysis, statewide assessments of long-term services and supports, and behavioral health programs.

Robert Mollica, EdD, has an extensive 30-year career in developing state health policy and conducting health and long-term services and supports (LTSS) research and analysis. He serves as an advisor to the AARP State LTSS Scorecard project. Dr. Mollica managed and coauthored national studies on state assisted living policy and regulation for the National Academy for State Health Policy under grants from the Administration on Aging, the Department of Health and Human Services, the Agency for Healthcare Research and Quality, and the Retirement Research Foundation. Over the years, he has contributed to steady improvement in how states manage their LTSS options and programs. He has provided technical assistance to the National Governors Association and State Unit on Aging, Medicaid directors, and officials at the Area Agency on Aging in more than a dozen states. Dr. Mollica has published numerous articles and journal papers on LTSS issues. With Dr. Susan Reinhard, he provided technical assistance to more than 30 states in the Real Choice Systems Change initiative of the Centers for Medicare & Medicaid Services. He also provided technical assistance to Money Follows the Person Rebalancing Demonstration grantees.

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