Selected Characteristics of 10 States With the Greatest Change in Long-Term Services and Supports System Balancing, 2012–2016

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Background

Each year, most states make steady, incremental progress toward rebalancing their long-term services and supports (LTSS) systems from institutional care to home and community-based services (HCBS). They achieve this rebalancing by increasing expenditures on HCBS, decreasing expenditures on institutional services, or both, resulting in a larger share of total LTSS expenditures for HCBS. The average increase in the HCBS share of expenditures across all states was about 2 percentage points per year between 2012 and 2016, but 10 states increased their HCBS share of expenditures by nearly twice that much.[1]

This brief discusses programmatic changes and economic indicators of the 10 states that made the greatest progress on rebalancing their LTSS systems between 2012 and 2016: Missouri, Massachusetts, New York, New Jersey, Connecticut, Colorado, South Carolina, Illinois, Nevada, and Arkansas. At first glance, these states do not appear to have much in common. In terms of their 2016 LTSS balance, half were below the national average and half were above (Figure 1). They represent most regions of the country, from the Northeast to the Southwest. Their populations range from small to large, and affluence varies substantially. Yet these 10 states were identified as having the greatest percentage point change in system balance from 2012 to 2016.

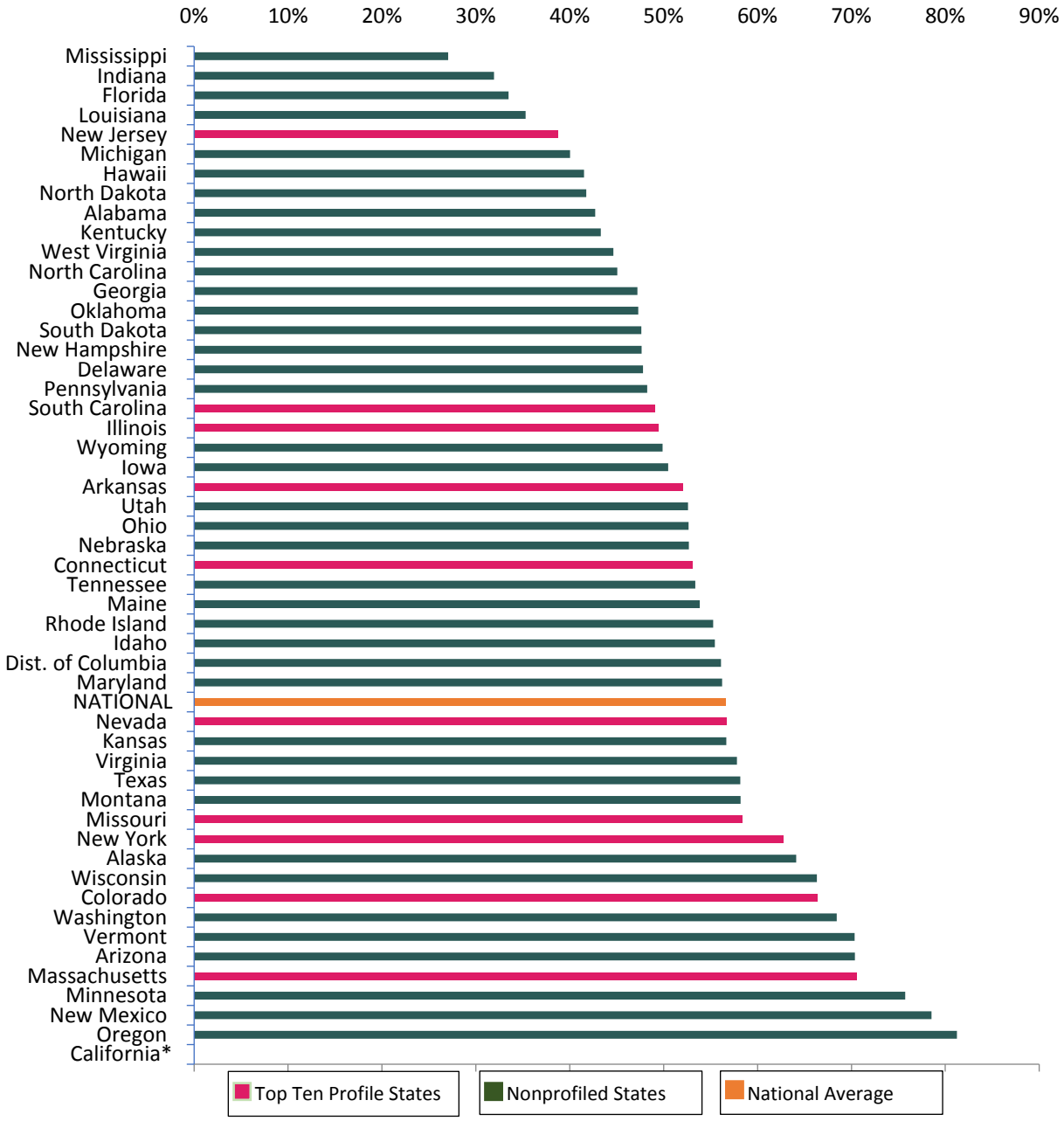
Approach

Eiken et al. identified the 10 states with the greatest increase in HCBS expenditures as a percentage of total LTSS expenditures between 2012 and 2016.[1] We began with that list of states and dropped two of them (Ohio and Texas) because of data anomalies during the study period that could have confounded our analyses.[a] We replaced these states with the two states that had the next highest positive change in LTSS balance for the study period: Nevada and Arkansas.

Next, we analyzed the LTSS expenditure data for the profiled states at the subpopulation and service-line levels to ascertain whether progress could be associated with increases in specific types of HCBS targeted to specific groups. We then used publicly available information sources such as state Medicaid waivers and program descriptions to identify policy and program changes implemented by the profiled states during the study period. Programs reviewed included HCBS Section 1915(c) waivers, time-limited federal initiatives such as the Balancing Incentive Program (BIP) and Money Follows the Person (MFP), demonstrations such as the Financial Alignment Initiative, managed LTSS (MLTSS) initiatives, and implementation of Medicaid State Plan Options such as health homes and Community First Choice. Table 1 presents a list and description of each of the programs, services, and demonstrations studied for this report and indicates which of the profiled states implemented these options.

[a] In Ohio, rehabilitative services expenditures increased by more than 300 percent from 2013 to 2014 because of expanded data availability in 2014. In Texas, the state made an unusually large adjustment of $1.6 billion to its LTSS expenditures for 2015.

Figure 1. Medicaid HCBS Expenditures as a Percentage of Total Medicaid LTSS Expenditures by State, Fiscal Year 2016



Abbreviations: HCBS, home and community-based services; LTSS, long-term services and supports.

Note: See Appendix Table A1 for information on the change in percentages from 2012 through 2016.

*California was excluded from this figure because details about a high proportion of LTSS delivered through managed care were not available for California for Fiscal Year 2016.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

We also examined several demographic, economic, and state budget indicators from 2012 through 2016 to ascertain whether similarities could be detected across the profiled states. Demographic indicators included the share of each state's population that was over the age of 85 years, had disabilities, was dually eligible for Medicare and Medicaid, or resided in a certified nursing facility. Economic indicators included employment and hourly wage in LTSS occupations,[b] gross domestic product (GDP), personal income, and employment. Budget measures included total state revenue and expenditures for Medicaid, which can be considered a proxy for states' flexibility to use funding to pay for new or different policies. Demographic, economic, and budget indicators for the profiled states are provided in Table 2. Finally, the draft report was sent to the profiled states for their review and feedback.

Table 1. Presence of Program Options in the Profiled States During the Study Period

Program Options Used by States	MO	MA	NY	NJ	CT	CO	SC	IL	NV	AR
Balancing Incentive Program: Federal grants and enhanced FMAP to support LTSS structural reforms to expand access to HCBS.[a] A total of 21 states were approved for this program.	√	√	√	√	√			√	√	√
Money Follows the Person: Federal grants for states to transition people from institutional care to HCBS.[b] A total of 43 states and the District of Columbia participated in the Money Follows the Person program.	√	√	√	√	√	√	√	√	√	√
State Plan Personal Care: An optional Medicaid service to provide personal care services.[c]	√	√	√	√					√	√
Health homes related to LTSS: An optional Medicaid service to improve coordination for beneficiaries with chronic conditions.[d]			√	√						
Section 1915(c) waivers: Waivers that allow states to develop HCBS programs as a cost-effective alternative to institutional care.[e]	√	√	√		√	√	√	√	√	√
Section 1115(a) demonstrations related to HCBS: Demonstration programs that test budget neutral innovations that promote the objectives of the Medicaid program.[f]			√	√						
Managed LTSS: LTSS provided through capitated plans under multiple Medicaid authorities.[g]		√	√	√			√	√		
Financial Alignment Initiative: Initiative that tests models to improve alignment of Medicare and Medicaid for those who have both.[h]		√	√			√	√	√		
Section 1915(i) HCBS: A Medicaid State Plan Option to offer HCBS to participants who do not meet institutional level of care criteria.[i]					√	√			√	
Section 1915(j) Self-Directed Assistance Services Program State Plan Option (Cash and Counseling): A Medicaid State Plan Option to offer self-direction of state plan personal care services and/or HCBS waiver services.[j]				√						√

[b] LTSS-related employees were considered to be home health aides, personal care aides, and nursing assistants.

Program Options Used by States	MO	MA	NY	NJ	CT	CO	SC	IL	NV	AR
Section 1915(k) Community First Choice: A Medicaid State Plan Option with enhanced FMAP to offer attendant services and related supports to participants who meet eligibility criteria.[k]			√		√					
Medicaid expansion: Optional expansion of coverage for individuals aged 19–64 years with incomes effectively under 138 percent of FPL. Benefits may or may not align with the Medicaid state plan.		√	√	√	√	√		√	√	√[l]

Abbreviations: FMAP, Federal Medical Assistance Percentage; HCBS, home and community-based services; LTSS, long-term services and supports, FPL, Federal Poverty Level.

[a] Centers for Medicare & Medicaid Services. Balancing Incentive Program. https://www.medicaid.gov/medicaid/ltss/balancing/incentive/index.html

[b] Centers for Medicare & Medicaid Services. Money Follows the Person. https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html

[c] Centers for Medicare & Medicaid Services. List of Medicaid benefits. https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html

[d] Centers for Medicare & Medicaid Services. Health homes. https://www.medicaid.gov/medicaid/ltss/health-homes/index.html

[e] Centers for Medicare & Medicaid Services. Home and Community-Based Services 1915(c). https://www.medicaid.gov/medicaid/hcbs/authorities/1915-c/index.html

[f] Centers for Medicare & Medicaid Services. About Section 1115 demonstrations. https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html

[g] Centers for Medicare & Medicaid Services. Managed long-term services and supports. https://www.medicaid.gov/medicaid/managed-care/ltss/index.html

[h] Centers for Medicare & Medicaid Services. Financial Alignment Initiative. Updated November 29, 2018. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html

[i] Centers for Medicare & Medicaid Services. Home and Community-Based Services 1915(i). https://www.medicaid.gov/medicaid/hcbs/authorities/1915-i/index.html

[j] Centers for Medicare & Medicaid Services. Self-directed personal assistant services 1915(j). https://www.medicaid.gov/medicaid/hcbs/authorities/1915-j/index.html

[k] Centers for Medicare & Medicaid Services. Community First Choice 1915(k). https://www.medicaid.gov/medicaid/hcbs/authorities/1915-k/index.html

[l] Arkansas elected to expand Medicaid through use of the Private Option. Kaiser Family Foundation. Status of state action on the Medicaid expansion decision. 2018. https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Table 2. Summary of All Indicators for Profiled States, 2012 and 2016

Indicator	MO	MA	NY	NJ	CT	CO	SC	IL	NV	AR	US
2012											
Demographic											
Over 85 years, %	1.9	2.2	2.0	2.0	2.4	1.4	1.5	1.8	1.2	1.7	1.8
With disabilities, per 1,000 SR	137.0	110.7	107.5	98.1	104.0	96.6	134.7	101.5	106.9	164.5	118.2
Dually eligible, per 1,000 SR	28.0	40.2	39.3	22.5	41.8	16.0	31.3	25.7	15.9	41.6	30.2
Residents in NF, per 1,000 SR (2013)	6.3	6.3	5.4	5.1	6.8	3.1	3.6	5.6	1.7	6.0	4.4
Employment in LTSS per 1,000 SR	12.1	11.8	18.0	10.3	12.2	9.0	8.3	9.6	5.7	13.9	10.5
Economic											
State GDP, $ per SR	44,504.6	66,167.5	67,070.5	58,525.0	67,034.6	54,096.2	37,700.6	55,472.4	46,387.0	37,452.7	51,890.1
Personal income, $ per SR	40,137.7	58,041.2	54,317.7	55,790.0	65,424.7	46,403.5	35,936.3	45,820.9	39,911.9	36,574.4	44,978.1
Disposable personal income, $ per SR	36,216.7	50,242.3	46,495.9	49,006.6	56,232.3	40,999.2	32,743.8	40,290.0	36,241.6	33,321.1	40,093.9
Total employment per 1,000 SR	590.4	648.7	589.7	575.0	622.7	647.4	530.1	580.0	562.1	537.0	579.3
Budget											
Revenue, $ per SR	1,227.1	5,074.8	2,993.5	3,368.1	5,196.1	1,534.1	1,265.1	2,635.5	1,139.6	2,030.9	2,176.2
Medicaid – state share, $ per SR	659.1	560.8	761.9	551.6	1,648.0	670.1	293.5	527.3	342.8	439.6	537.3
State Medicaid as a share of revenue, %	53.7	11.1	25.5	16.4	31.7	43.7	23.2	20.0	30.1	21.6	24.7
2016											
Demographic											
Over 85 years, %	2.0	2.3	2.2	2.2	2.5	1.5	1.7	1.9	1.3	1.8	1.9
With disabilities, per 1,000 SR	141.7	114.8	111.1	102.9	107.2	102.6	143.1	107.1	127.9	166.0	123.3
Dually eligible, per 1,000 SR	28.7	45.5	43.8	23.9	48.6	21.8	32.9	28.0	22.6	42.8	33.2
Residents in NF, per 1,000 SR	6.3	5.9	5.3	5.0	6.4	3.1	3.5	5.3	1.8	5.9	4.2
Employment in LTSS per 1,000 SR	15.2	16.0	21.8	11.5	14.4	10.5	9.3	11.0	6.4	13.4	11.8
Economic											
State GDP, $ per SR	49,024.9	75,004.2	76,159.7	64,632.5	71,626.9	60,411.3	43,618.0	62,007.9	52,204.0	40,854.4	58,105.6
Personal income, $ per SR	43,162.2	64,898.0	59,707.2	61,672.2	69,076.7	53,757.7	40,551.3	51,614.9	45,115.1	39,986.2	49,952.5
Disposable personal income, $ per SR	38,290.9	54,749.6	49,598.4	53,171.8	58,267.5	46,953.5	36,445.8	44,994.7	40,387.8	36,085.2	43,804.9
Total employment per 1,000	612.8	700.1	624.0	605.3	641.6	681.2	557.3	608.8	603.7	550.0	608.0

Indicator	MO	MA	NY	NJ	CT	CO	SC	IL	NV	AR	US
Budget											
Revenue, $ per SR	1,450.1	3,471.3	3,475.9	3,696.5	4,954.9	1,958.1	1,621.4	2,318.2	1,320.5	2,174.1	2,391.6
Medicaid – state share, $ per SR	729.9	966.9	856.4	566.3	1,006.5	672.3	385.3	413.6	264.2	498.1	649.4
State Medicaid as a share of revenue, %	50.3	27.9	24.6	15.3	20.3	34.3	23.8	17.8	20.0	22.9	27.2

Abbreviations: NF, certified nursing facility; GDP, gross domestic product; SR, state resident; LTSS, long-term services and supports.

Source: Analysis of data from U.S. Census Bureau. American Community Survey. https://www.census.gov/acs/www/data/data-tables-and-tools/; Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office. Monthly enrollment snapshots. 2018. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html; National Association of State Budget Officers. State expenditure reports 2012–2016. 2018. https://www.nasbo.org/reports-data/state-expenditure-report; Kaiser Family Foundation. *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016*. 2018. https://www.kff.org/medicaid/report/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016/; U.S. Department of Commerce, Bureau of Economic Analysis. Regional economic accounts. 2018. https://www.bea.gov/data/economic-accounts/regional; and U.S. Department of Labor, Bureau of Labor Statistics. Local area unemployment statistics. 2018. https://www.bls.gov/data/#unemployment

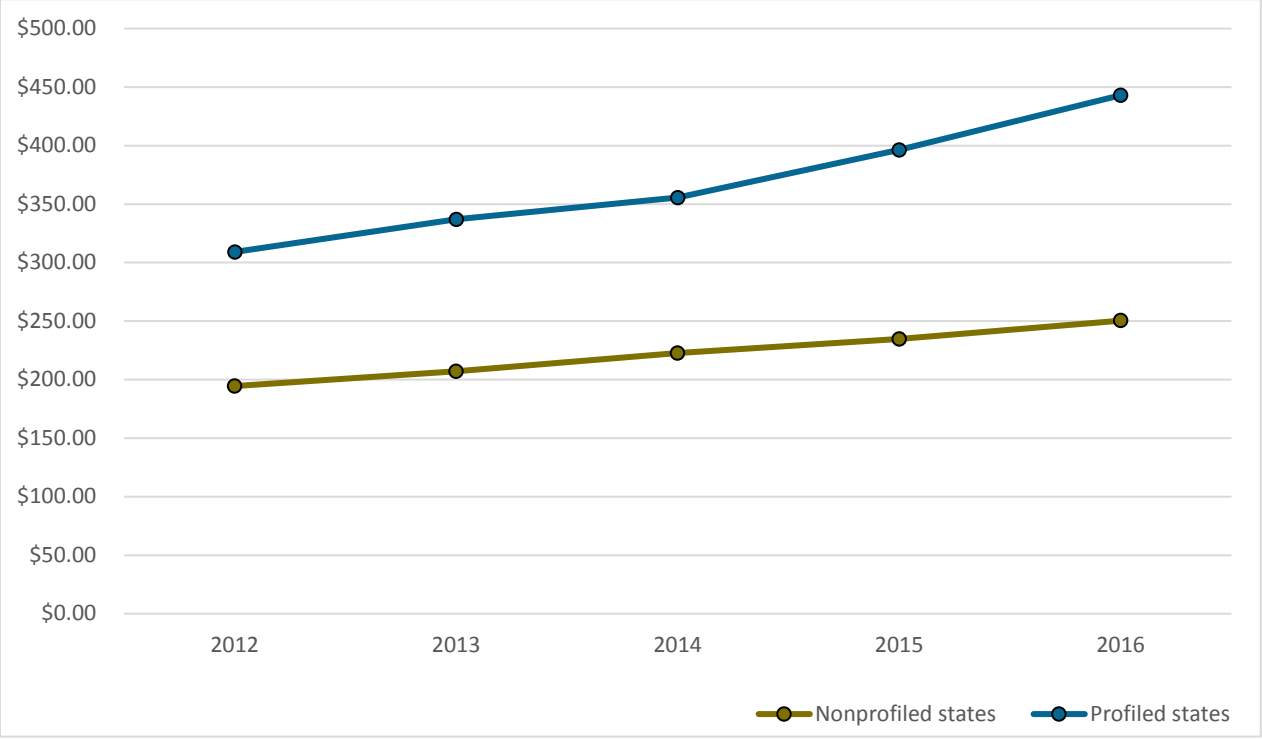
Findings

Each of the profiled states developed unique strategies for increasing HCBS expenditures as a percentage of total LTSS expenditures. These strategies are described in the individual state profiles that follow this section. However, we detected some patterns when we compared the profiled states with the remaining states. Overall, a distinguishing feature of the profiled states is that they made progress on both parts of the rebalancing ratio—HCBS and institutional expenditures. As a group, compared with the remaining states the profiled states increased HCBS spending faster, and they decreased institutional spending, whereas the remaining states had flat institutional expenditures during the study period.

Faster Growth in HCBS Expenditures

On average, profiled states increased HCBS spending per state resident faster than the remaining states during the study period, as shown in Figure 2. Throughout this paper, when values per state resident are presented, this includes all state residents regardless of Medicaid eligibility. HCBS expenditures rose by 43 percent per state resident in the profiled states and by 29 percent in the remaining states. The profiled states achieved a higher rate of growth despite starting at a higher base rate of spending in 2012, when the profiled states averaged $309 per state resident and the remaining states averaged $195. By 2016, these figures had risen to $443 and $250, respectively.

Figure 2. Profiled and Nonprofiled State HCBS Expenditures per State Resident, 2012–2016



Abbreviation: HCBS, home and community-based services.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

HCBS growth in the profiled states was driven largely by a 48 percent increase in per state resident spending on Section 1915(c) waiver programs for older adults and people with physical disabilities, but per state resident spending on Section 1915(c) waiver programs for people with intellectual or developmental disabilities (I/DD) also grew in the study period, by 27 percent (analysis of data from Eiken et al.[1-7]). At baseline, states generally had higher HCBS expenditures per resident for people with I/DD than for other groups. Because the denominator is larger, a dollar increase in HCBS spending for people with I/DD results in a lower growth rate than a dollar increase in spending for older adults and people with physical disabilities.

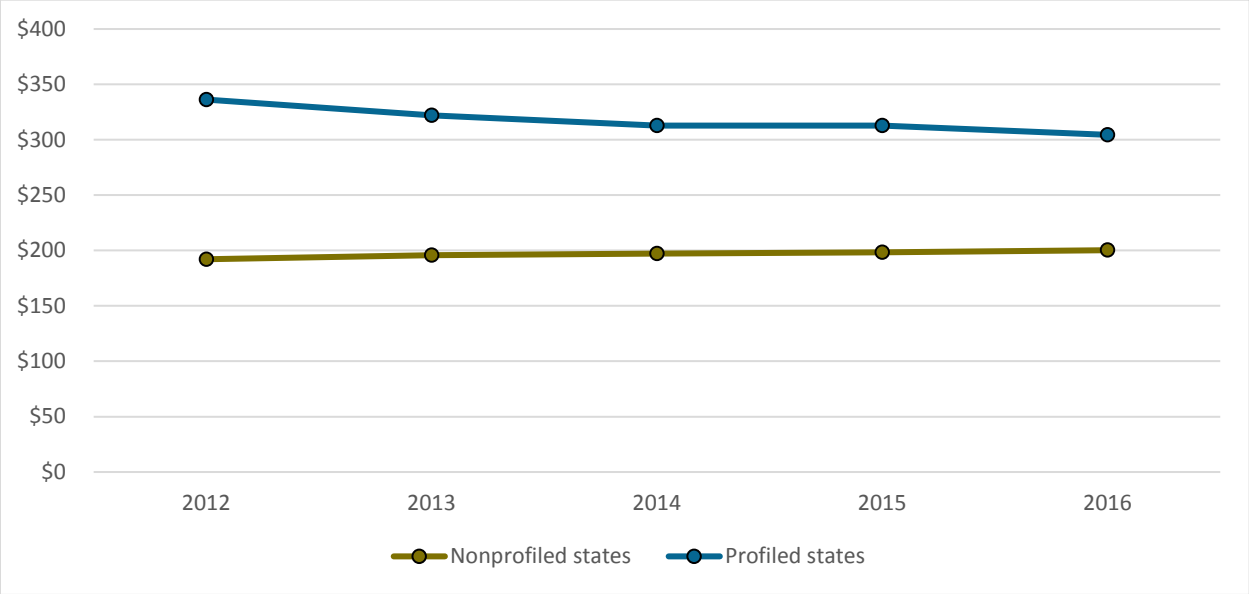
Profiled states had higher rates of growth than did the remaining states for state plan HCBS, including personal care and non-school-based rehabilitative services (analysis of data from Eiken et al.[1-7]). Whereas personal care may include multiple population groups, rehabilitative services most often are targeted at people with a mental or substance use disorder diagnosis.[8]

Home health spending per state resident fell, with greater decreases in most profiled states (4.2 percent average annual decrease per state resident) than in the remaining states (1.1 percent average annual decrease per state resident) (analysis of data from Eiken et al.[4,5]). This decrease was offset by increased expenditures for personal care, as noted above (profiled states were up 8.7 percent and remaining states were up 1.8 percent per state resident on average annually).

Actual Declines in Institutional Expenditures

Profiled states decreased institutional expenditures per state resident over the study period by an average of 9.5 percent, whereas the remaining states averaged a slight increase of 4.2 percent per state resident, as shown in Figure 3. The actual decrease in institutional spending may have contributed to the profiled states' ability to increase HCBS spending faster than the remaining states.

Figure 3. Profiled and Nonprofiled State Institutional LTSS Expenditures per State Resident, 2012–2016



Abbreviation: LTSS, long-term services and supports.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

Not all of the profiled states decreased institutional expenditures overall. Colorado, Massachusetts, and Nevada all increased total institutional expenditures per state resident during the study period. However, all 10 profiled states decreased at least one type of institutional expenditure. The most common reduction (eight states) was in intermediate care facilities for individuals with intellectual disabilities (ICF/IID), followed by institutions for mental disease (IMDs) (six states), and nursing facilities (four states) (analysis of data from Eiken et al.[4,5]).

Other Program Characteristics

Eight out of the 10 profiled states (80 percent) elected to expand Medicaid as an option offered through the Affordable Care Act. Nationally, 31 states and the District of Columbia (63 percent) had elected Medicaid expansion by the end of 2016.[9] Although Medicaid expansion generally has not resulted in significant expansion of the number of LTSS-eligible beneficiaries, expansion may indicate a state's policy preference for increasing access to public programs, including HCBS.

The profiled states made progress regardless of service delivery model. Half of the profiled states have implemented MLTSS systems, whereas the other half continue to use fee-for-service delivery models, suggesting that substantial progress is possible in either service delivery model.

Demographic, Economic, and State Budget Indicators

Profiled states may be experiencing a greater demographic imperative to balance LTSS spending than the remaining states, although regional emphasis differs across the profiled states (Table 2). In 2016, the four northeastern states (Connecticut, Massachusetts, New Jersey, and New York) had a relatively high percentage of residents over the age of 85 years, ranging from 2.0 to 2.4 percent, compared with the national average of 1.8 percent. In the same year, three states from the South or Midwest (Arkansas, Missouri, and South Carolina) had more residents per thousand with a disability, ranging from 135 to 165 (compared with the national average of 118).

Compared with nonprofiled states, profiled states experienced a 2 percent higher average annual increase per 1,000 state residents in employment in LTSS-related industries (home health aides, personal care aides, and nursing assistants). In profiled states, the number of home health aides increased by 5 percent annually, compared with a 5 percent annual decrease in nonprofiled states.[10] This relative increase in the supply of LTSS-related workers makes sense, given that the profiled states expanded HCBS more rapidly than the remaining states. Whether profiled states did anything specific to expand the LTSS workforce or general economic conditions resulted in greater availability of workers is unknown. This pattern also suggests that a lack of available LTSS workers may have constrained progress in the remaining states.

The profiled states showed a wide range of financial capacity to invest in HCBS, as indicated by GDP, state revenue, and state share of Medicaid expressed as a percentage of state revenue (Table 2). Six of the profiled states had a GDP that was higher than the U.S. average in 2016, whereas four had a GDP that was lower. Four profiled states had revenue per state resident that was higher than the U.S. average, whereas six had revenue that was lower. Finally, three profiled states spent a greater percentage of their revenue on Medicaid than the U.S. average, whereas the other seven spent a smaller percentage. Judging by indicators in the profiled states, general economic and budget factors do not appear to be significant factors in states' decisions to invest in HCBS.

Although some patterns can be detected across the profiled states, the specific approaches they used were tailored to their cultural, legal, and political contexts and evolved from their existing infrastructure. The following profiles of the selected states illustrate the unique strategies employed by each of them. Other states may find the profiles useful in identifying potential programmatic initiatives that can be tailored to their specific situations.

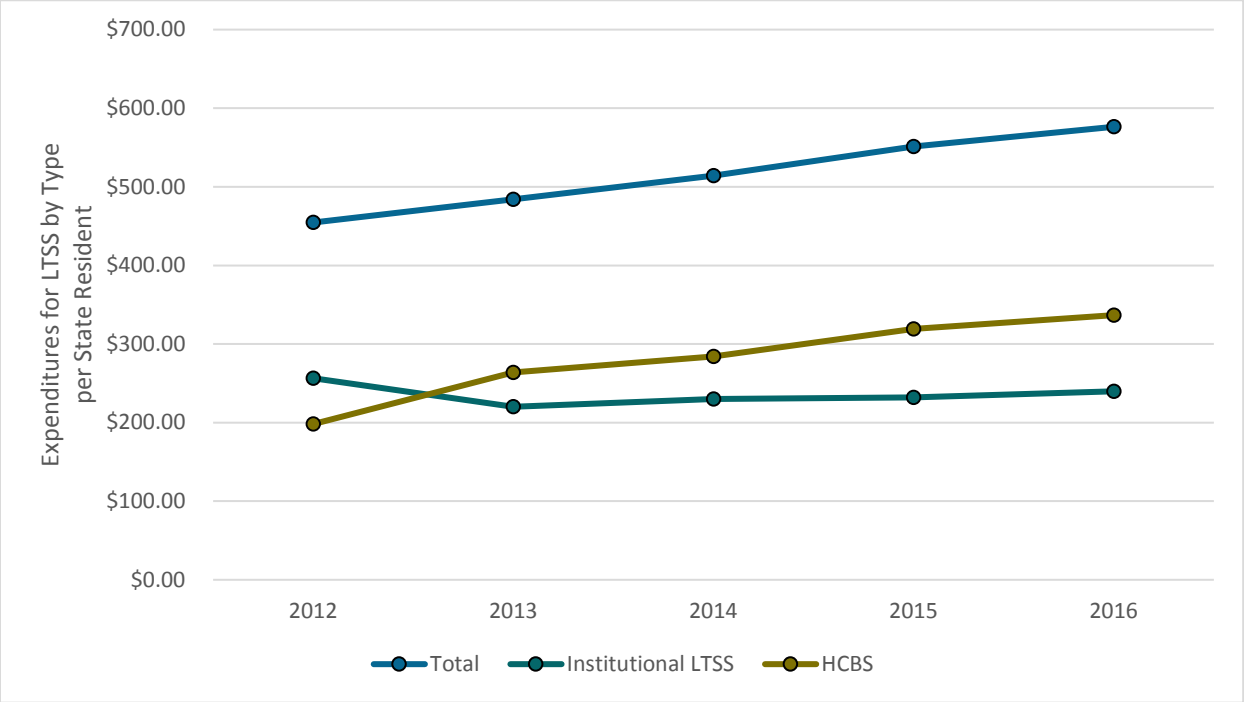
Profiles of the Studied States

The 10 profiled states are presented in order of their progress on increasing spending on HCBS as a percentage of total LTSS expenditures, beginning with the state showing the greatest increase between 2012 and 2016—Missouri.

1. Missouri

Missouri achieved the highest rate of improvement toward rebalancing from 2012 to 2016, increasing the share of LTSS expenditures that went to HCBS by 14.9 percentage points. Figure 4 shows the trends in LTSS spending per resident in Missouri. Although total expenditures and HCBS expenditures per state resident increased, institutional expenditures decreased from 2012 to 2013 and then remained flat for the remainder of the study period.

Figure 4. Missouri LTSS Spending per State Resident by Type of LTSS Program, 2012–2016



Abbreviations: HCBS, home and community-based services; LTSS, long-term services and supports.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

As measured in raw dollars, Missouri's LTSS rebalancing from 2012 to 2016 was characterized by an increase in HCBS expenditures (from $1,190 million to $2,051 million) and a slight decrease in institutional LTSS expenditures (from $1,544 million to $1,460 million). Table A2 contains additional information about this analysis for all states.

Missouri has pursued multiple program initiatives available under Medicaid authority that may have contributed to this result (see Table 3).

Table 3. Program Initiatives: Missouri

Program	Participation
Balancing Incentive Program	Yes
Money Follows the Person	Yes
Section 1915(i) state plan home and community-based services	No
State plan personal care services	Yes
Health homes related to long-term services and supports	No
Section 1915(c) waivers	Yes
Section 1115 demonstration related to home and community-based services	No
Managed long-term services and supports	No
Section 1915(j) self-directed personal care	No
Financial Alignment Demonstration	No
Section 1915(k) Community First Choice	No
Medicaid expansion	No

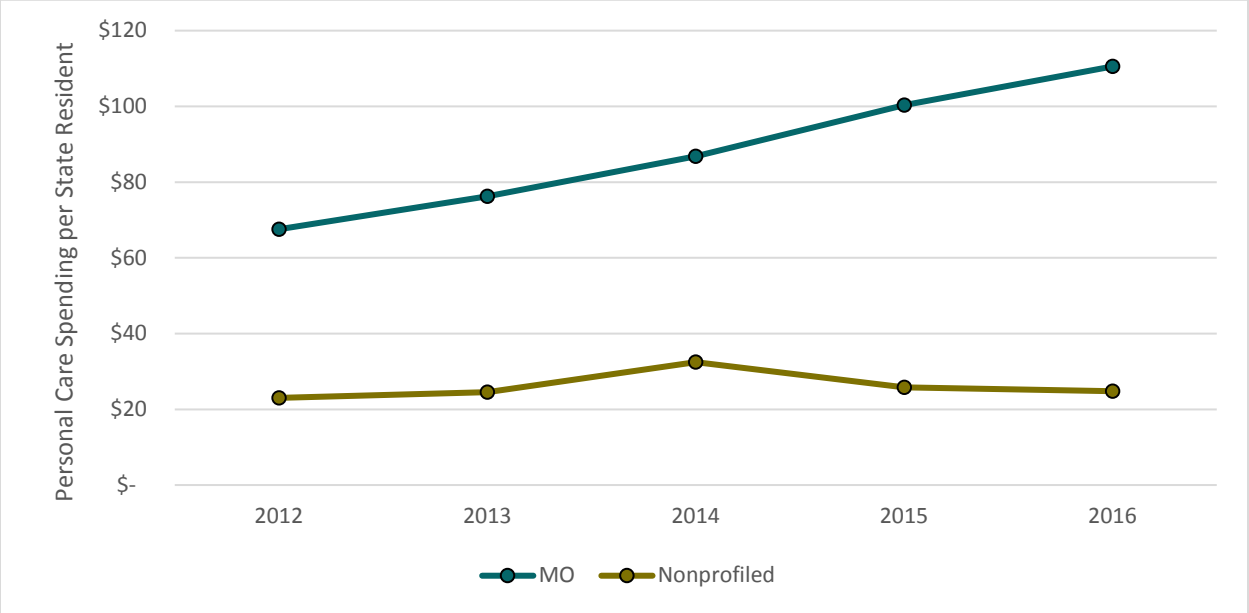
Missouri participated in BIP, which offered an enhanced Federal Medical Assistance Percentage (FMAP) rate for HCBS for states that improved access to HCBS by (1) transforming their LTSS system through offering a No Wrong Door or Single Entry Point to access services, (2) implementing a standardized assessment tool for those seeking services, and (3) developing conflict-free case management strategies.[11] Missouri's BIP project began in July 2012, with an award amount totaling $110.5 million.[11] Missouri used the enhanced FMAP rate to fund structural changes and to add 3,000 participants to the section 1915(c) HCBS waiver programs available in the state.[12]

Additionally, Missouri was a grantee state in MFP, which offered grants to states to support participants with transitioning from an institutional to a community setting. Missouri used this funding to support transitions to the community for 1,487 participants through December 31, 2016.[13] This included the Department of Health and Senior Services completing transitions for 372 older adults and 707 participants with physical disabilities, and the Department of Mental Health completing transitions for 370 participants with I/DD.[13]

Further, Missouri has 10 active Section 1915(c) HCBS waivers, one of which was added during the study period.[2,7] Missouri eliminated its waiting list for HCBS, reducing the number of people on the waiting list from 301 in 2011[14] to none in 2016.[15] Finally, it should be noted that Missouri experienced two separate Olmstead lawsuits, one of which resulted in a settlement agreement to address whether residents of a nursing home were being served in the most integrated setting appropriate to their needs and whether the setting addressed basic elements of resident care.[16]

Other Medicaid options that Missouri has implemented include health homes and state plan personal care services. Missouri's health home implementation thus far has been targeted toward improving coordination of primary care. Although Missouri elected state plan personal care services several years before 2012, it experienced 13.1 percent average annual growth in personal care service expenditures between 2012 and 2016 (see Figure 5), the highest of any profiled state. Nonprofiled states focused less on personal care, with 1.8 percent average annual growth. The only nonprofiled state that spent more per state resident than Missouri was Minnesota.

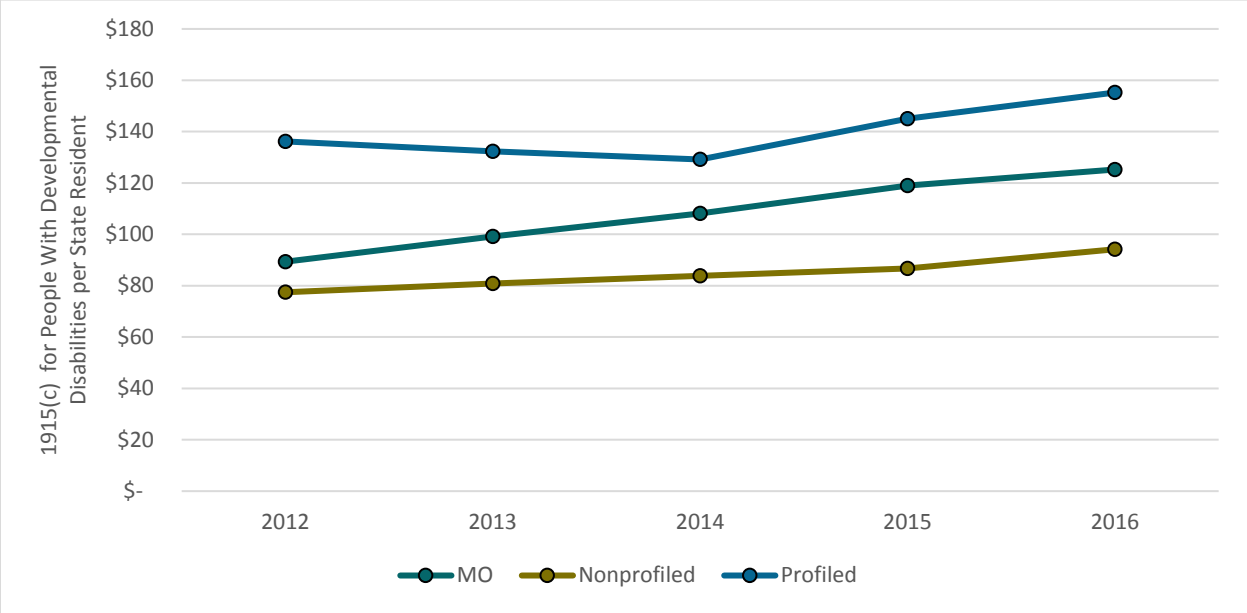
Figure 5. Personal Care Expenditures per State Resident in Missouri, 2012–2016



Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

Demographic and geographic changes occurring in Missouri also may lend context to Missouri's success in LTSS rebalancing. As shown in Figure 6, Missouri's change in spending on the population of people with DD was more similar to that of the nonprofiled states than to that of the other profiled states. Missouri directed a consistently increasing amount of HCBS spending per state resident toward people with I/DD, averaging 8.8 percent annual growth of Section 1915(c) waiver program spending from a base in line with nonprofiled states.

Figure 6. Changes in HCBS Spending for People with Developmental Disabilities per State Resident in Missouri, 2012–2016



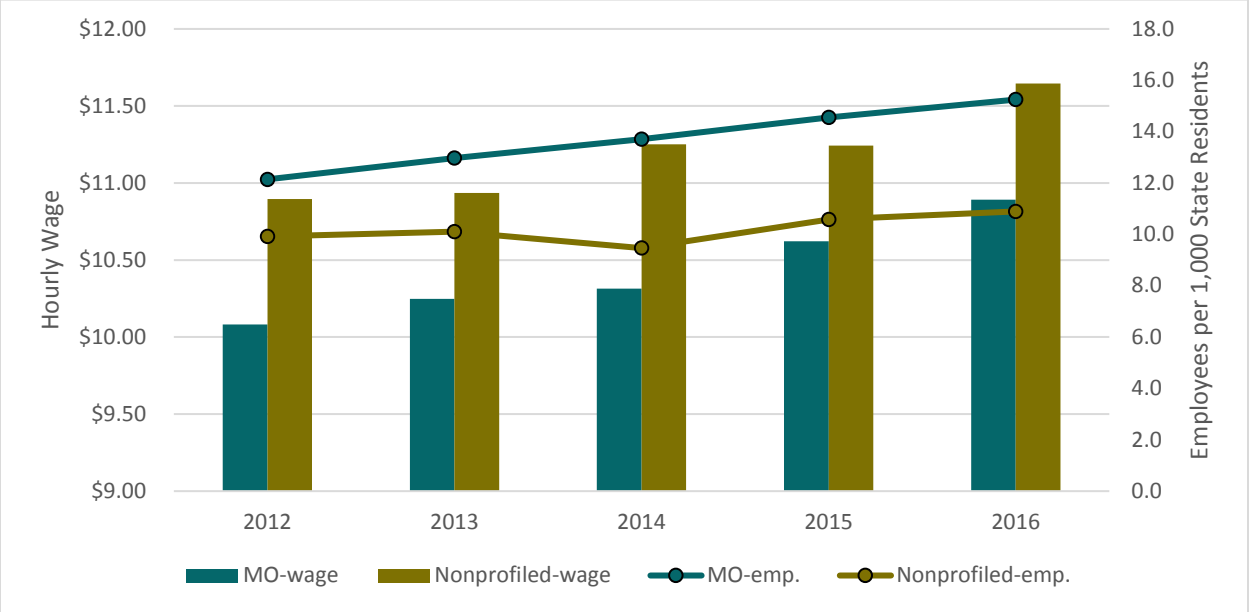
Abbreviation: HCBS, home and community-based services.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

Profiled states already had a baseline spending on individuals with I/DD of $59 more spending per state resident than did nonprofiled states in 2012, and they increased spending over the 5-year period on this population from 2012 to 2016 at a rate of 3.3 percent annually, roughly in line with consumer price index (CPI) growth. (CPI growth is a measure of average changes in prices paid by consumers over time, an indicator of inflation.[17]) Over the same period, the spending of nonprofiled states grew 5.0 percent annually, which resulted in a slightly larger gap of $61 per state resident in 2016. Even though nonprofiled states increased spending on this population at a faster average annual rate than profiled states (3.3 percent vs. 5.0 percent) the profiled states increased spending by $19 per state resident—more than the nonprofiled states, which had a $17 per state resident increase.

Nursing assistants, home health aides, and personal care aides are three major providers of direct care in the LTSS industry. As shown in Figure 7, employment of LTSS workers in Missouri, defined as the number of LTSS employees per 1,000 state residents, increased by 5.9 percent annually. In nonprofiled states, employment on average increased by 2.4 percent in these employment classifications from 2012 to 2016. Additionally, during the same period Missouri saw the wage rate for these groups increase at a slightly higher rate, 1.9 percent annually, than the rate of nonprofiled states, 1.7 percent annually.

Figure 7. Wage and Employment in LTSS Occupations in Missouri and in Nonprofiled States, 2012–2016

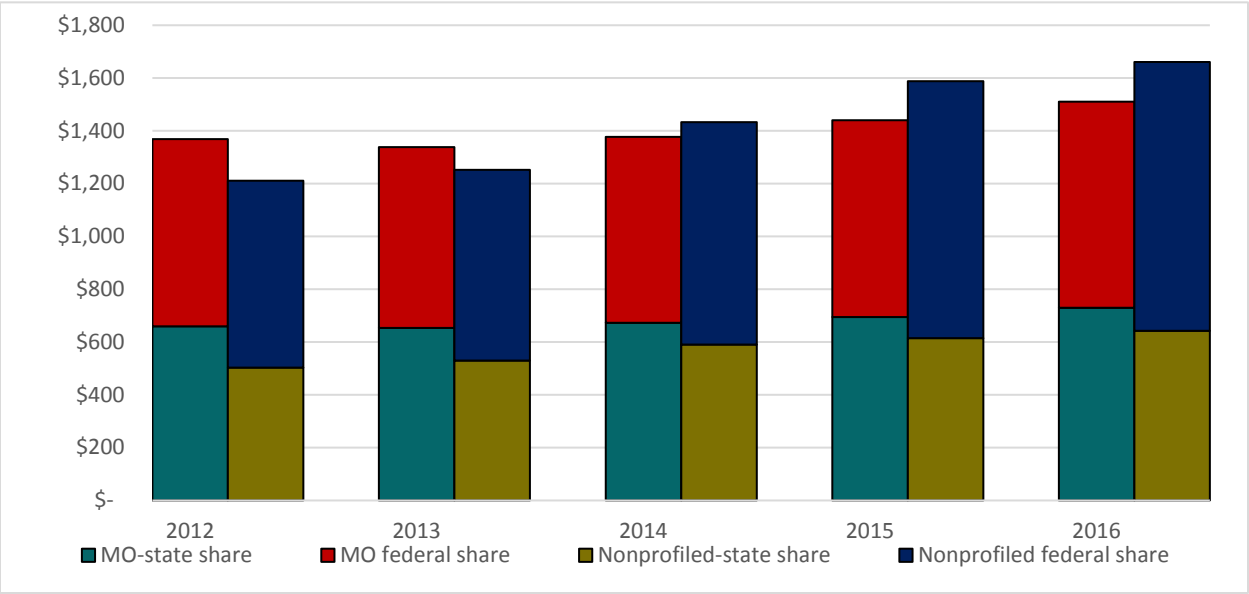


Abbreviation: emp., employment; LTSS, long-term services and supports; emp, employment in LTSS occupations.

Source: Analysis of data from U.S. Department of Labor, Bureau of Labor Statistics. Local area unemployment statistics. 2018. https://www.bls.gov/data/#unemployment

Although Missouri has greatly improved the state's balancing of LTSS, the state has done so without sizably increasing spending on Medicaid on a per state resident basis (see Figure 8). The state share of Missouri's Medicaid spending has grown at 2.6 percent annually, slightly faster than the CPI. Nonprofiled states have seen meaningful increases, with state spending per state resident increasing by 6.3 percent annually.

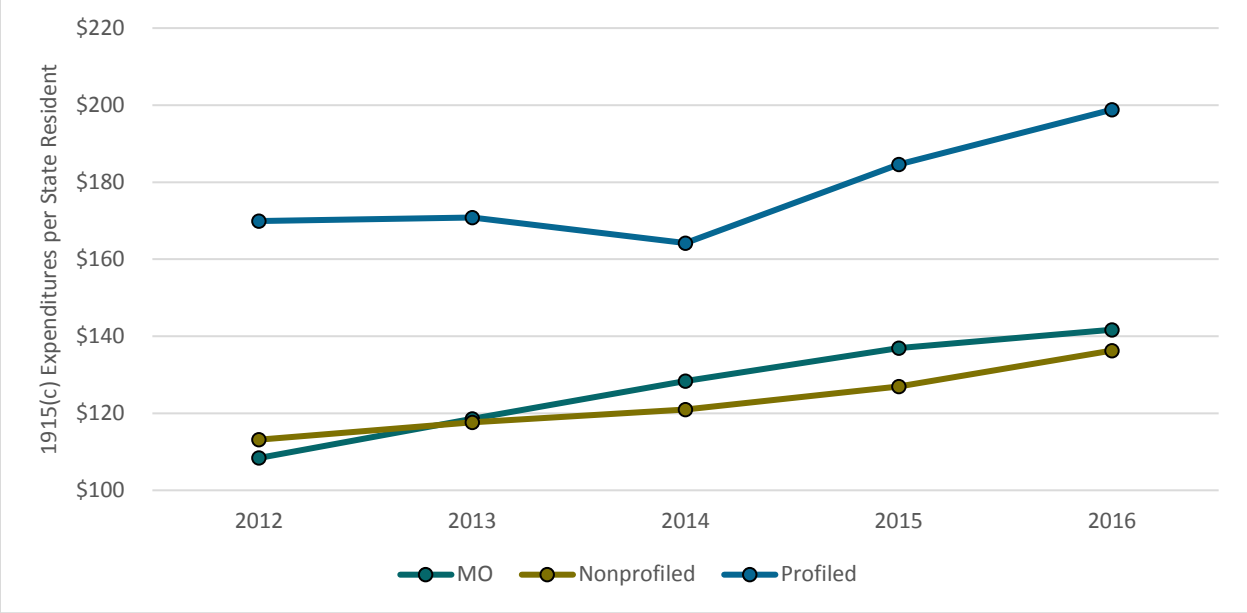
Figure 8. Distribution and Amount of State and Federal Share of Medicaid Spending per State Resident in Missouri and in Nonprofiled States, 2012–2016



Source: Analysis of data from National Association of State Budget Officers. State expenditure reports 2012–2016. 2018. https://www.nasbo.org/reports-data/state-expenditure-report

Figure 9 indicates that 2012 to 2016 was a time of rapid expansion of Section 1915(c) HCBS waiver program expenditures in Missouri, with waiver expenditures increasing by 6.9 percent annually. Other profiled states on average saw waiver program expenditures increase by about half that amount; however, Missouri started from a much lower base, resulting in similar dollar changes per state resident, increasing by $33 over the study period compared with a $29 increase for profiled states. In nonprofiled states, Section 1915(c) waiver program expenditures increased by 4.7 percent annually, from a base similar to that of Missouri.

Figure 9. Section 1915(c) Waiver Program Expenditures per State Resident in Missouri and in Profiled and Nonprofiled States, 2012–2016



Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

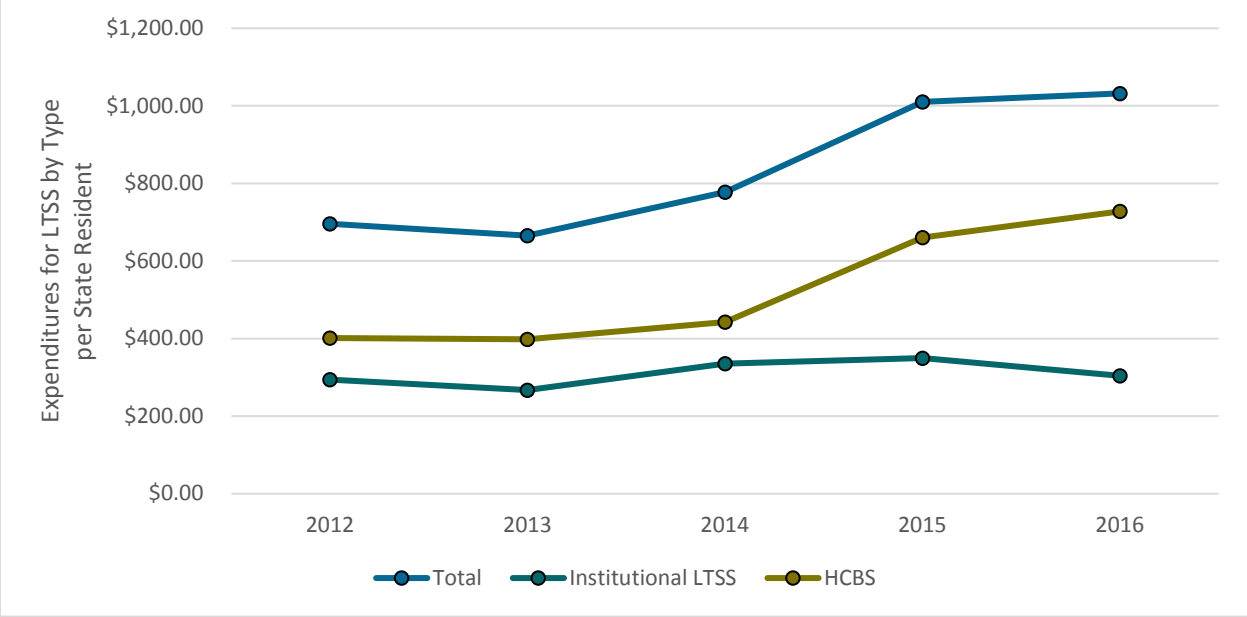
Key Takeaways: Missouri

From the data presented, the expansion of state plan personal care services and the increase in expenditures on those services appear to be the greatest contributing factor to Missouri's rebalancing from institutional to HCBS spending. Although Missouri is one of two profiled states that did not expand Medicaid, it did leverage BIP and MFP programs to further support the availability of HCBS in the state, including adding new waiver program slots and a new waiver during the study period. This also may have supported the state's efforts to rebalance LTSS expenditures. These changes account for the increase in HCBS spending resulting in an increased investment in Section 1915(c) HSBC waiver program at a faster rate than the United States as a whole.

2. Massachusetts

Massachusetts achieved a 14.1 percentage point increase in HCBS expenditures as a percentage of total LTSS expenditures from 2012 to 2016, the second greatest increase among the profiled states (see Figure 10).

Figure 10. Massachusetts LTSS Spending per State Resident by Type of LTSS Program, 2012–2016



Abbreviations: HCBS, home and community-based services; LTSS, long-term services and supports.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

In contrast to Missouri, Massachusetts already was in the top half of states nationally—more than 50 percent of its total LTSS expenditures went toward HCBS before 2012. Figure 10 indicates that institutional spending remained mostly flat whereas HCBS spending rose during the study period, a combination that distinguishes profiled states from nonprofiled states.

From 2012 to 2016, LTSS rebalancing in Massachusetts was characterized by a steady rate of spending for institutional LTSS care (ranging from $2,010 million to $2,076 million) and an increased rate of spending for HCBS (from $2,599 million to $4,967 million), as measured in raw dollars.

Massachusetts implemented several program initiatives that may help explain the increases in spending on HCBS (see Table 4).

Table 4. Program Initiatives: Massachusetts

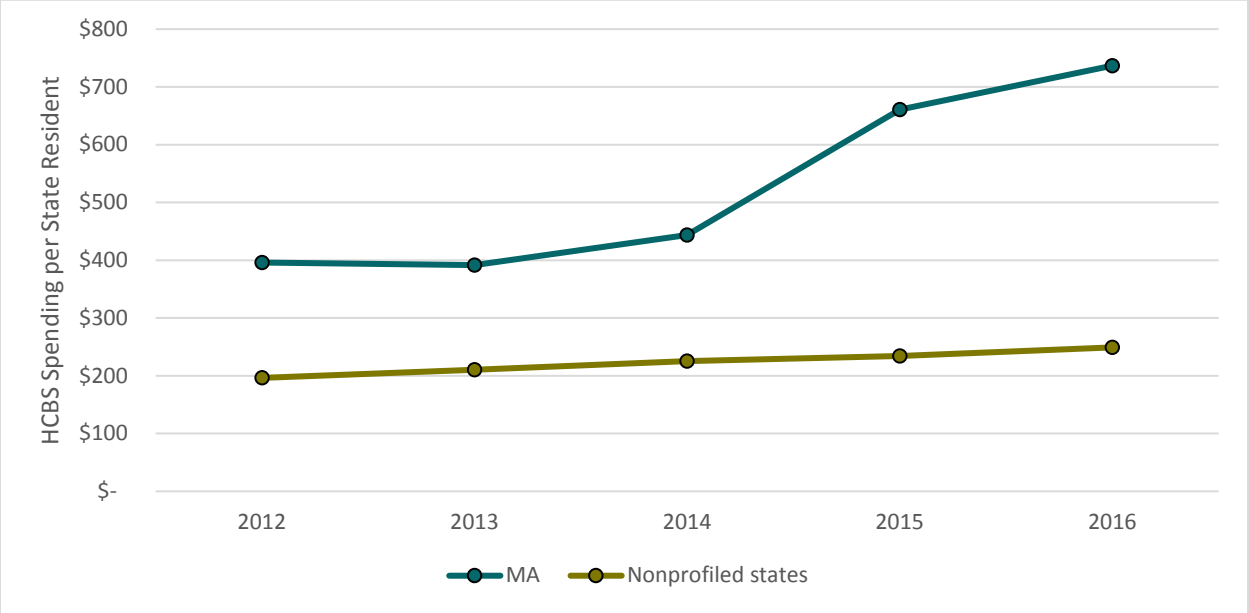
Program	Participation
Balancing Incentive Program	Yes
Money Follows the Person	Yes
Section 1915(i) state plan home and community-based services	No
State plan personal care services	Yes
Health homes related to long-term services and supports	No
Section 1915(c) waiver programs	Yes
Section 1115 demonstration related to home and community-based services	No
Managed long-term services and supports	Yes
Section 1915(j) self-directed personal care	No
Financial Alignment Demonstration	Yes
Section 1915(k) Community First Choice	No
Medicaid expansion	Yes

Massachusetts pursued several program initiatives before the study period that may have contributed to the rebalancing of its LTSS system. For example, the state implemented Senior Care Options, a managed care program for dually eligible older adults, beginning in 2004, and covered personal care services under the state plan before 2012. Massachusetts also participated in Medicaid expansion, providing coverage for individuals aged 19–64 years under 133 percent of the federal poverty level —in addition to enacting reforms that achieved near universal insurance coverage prior to the Affordable Care Act, another difference from Missouri.[9]

Massachusetts was one of the states selected for BIP and received its award beginning in April 2014. In 2009, 44.8 percent of LTSS spending was aimed at HCBS, but by 2015, this share had increased to 66.8 percent.[c,11] Massachusetts used the enhanced FMAP rate to expand its communication about community LTSS offerings, by improving its existing information hotlines, expanding capacity for Aging and Disability Resource Centers to offer on-site options counseling, hiring LTSS financial eligibility experts, and increasing branding and marketing for the No Wrong Door website.[18] Additionally, Massachusetts used this funding to increase direct care worker wages and to increase community placements of participants with severe mental illness.[18] Their participation in this program and the timing of their initial award likely contributed to the sharp increase in HCBS spending per state resident from 2014 to 2015, as shown in Figure 11, relative to the nonprofiled states, which showed a slower increase in HCBS spending per state resident over the study period.

[c] BIP calculated a state's percent of HCBS expenditures using a different methodology from that used for the analysis presented in the annual LTSS expenditures reports; in some states, these numbers may not be consistent because of the differences in the methodologies.

Figure 11. HCBS Spending per State Resident in Massachusetts and in Nonprofiled States, 2012–2016



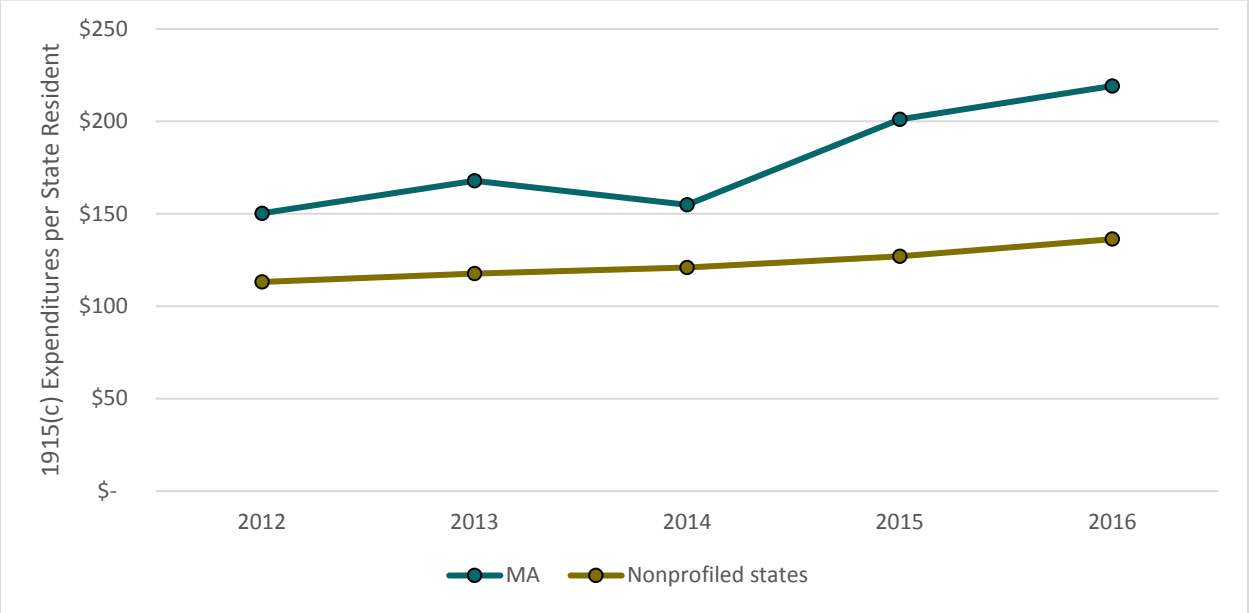
Abbreviation: HCBS, home and community-based services.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

Further, Massachusetts received an MFP grant, initially awarded in April 2011.[13] By the end of the MFP grant period in 2016, the state had completed 2,151 community transitions for participants in institutional placements.[13] The target population with the highest number of community transitions were older adults (990 transitions) and participants with physical disabilities (930 transitions).[13] Related to Massachusetts' experience in MFP, two new Section 1915(c) waiver programs were introduced in 2013, targeting adults over the age of 18 years with physical disabilities or mental illness, for the purpose of transitioning these individuals from institutional care to a community setting.[d] As noted with the start date of the waivers and the number of community transitions completed by the end of 2016, the initiation of these waivers may have contributed to the increased HCBS spending following 2013, as depicted in Figure 12.

[d] Analysis of Section 1915(c) waiver applications, retrieved from www.medicaid.gov

Figure 12. Section 1915(c) Waiver Program Spending per State Resident in Massachusetts and in Nonprofiled States, 2012–2016

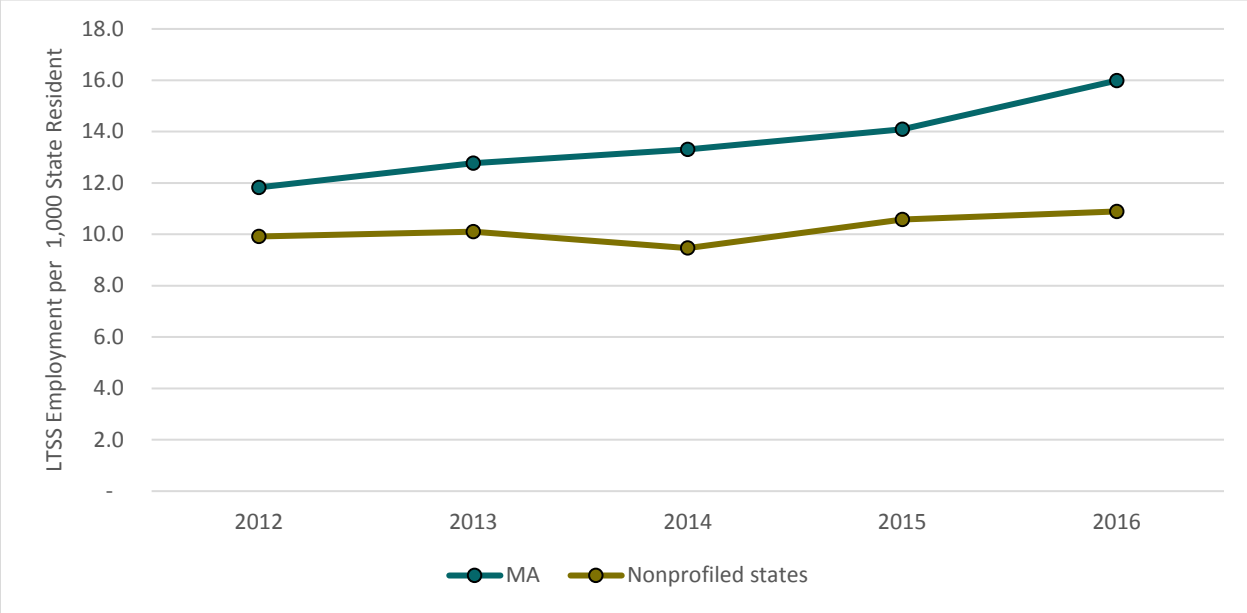


Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

During this study period, Massachusetts also implemented a Financial Alignment Initiative demonstration called OneCare. This program began in 2013, and as of December 1, 2016, it covered 14,331 nonelderly adults with disabilities (aged 21 to 64 years at the time of enrollment) who were dually eligible for Medicaid and Medicare.[19] The program does not cover children or older adults. Participants may be enrolled through passive enrollment but may opt out at their discretion. The program aims to improve care coordination between Medicaid and Medicare to optimize the participant's experience of services, including medical, behavioral health, and LTSS.[20]

Massachusetts' increased spending in LTSS affected employment in three important employment groups: nursing assistants, home health aides, and personal care aides. It had the highest annual average increase of employment for these three combined groups of any state in the nation, growing at an average annual rate of 7.8 percent (see Figure 13). The increase in demand for employees in this industry did not seem to affect the wage rates in the Massachusetts; the average annual increase in wages for these three employment categories was similar to that of the United States as a whole.

Figure 13. LTSS Employment per 1,000 State Residents in Massachusetts and in Nonprofiled States, 2012–2016



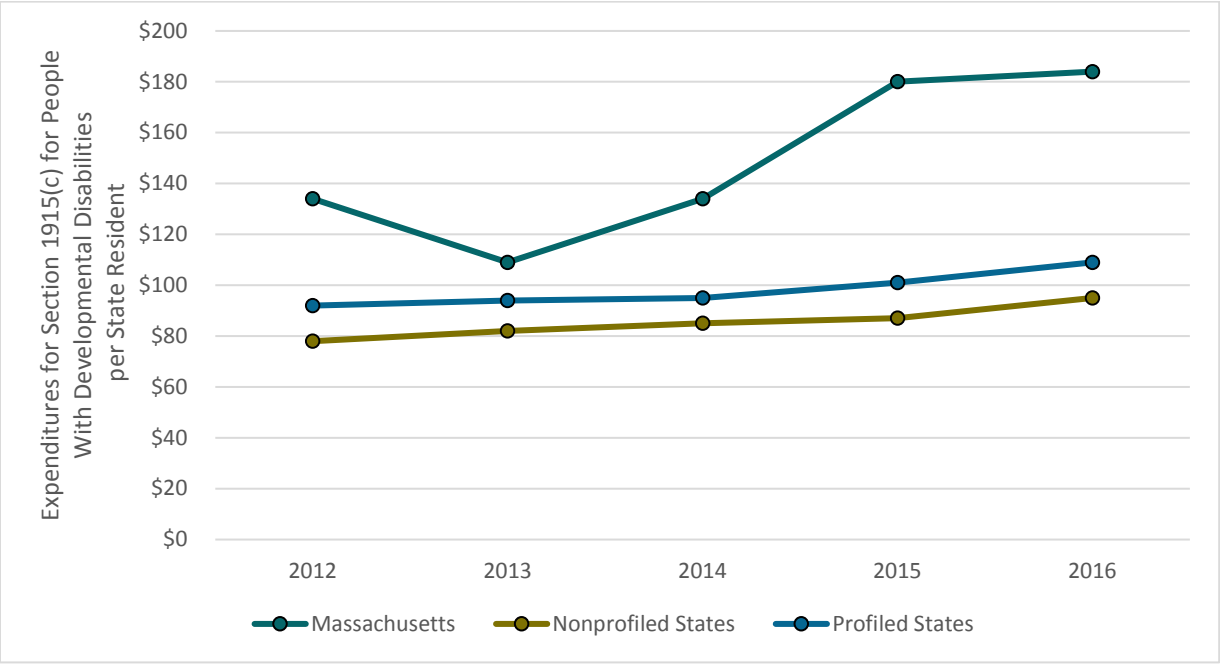
Abbreviation: LTSS, long-term services and supports.

Source: Analysis of data from U.S. Department of Labor, Bureau of Labor Statistics. Local area unemployment statistics. 2018. https://www.bls.gov/data/#unemployment

Massachusetts also pursued expansion of its Section 1915(c) HCBS waiver programs during the study period. Over the course of the currently approved waiver cycle, Massachusetts was approved to add 1,400 slots to the Intensive Supports Waiver and 2,200 slots to the Adult Supports Waiver.[e] Both of these waiver programs increased available slots for participants with I/DD; this investment may reflect the increase in spending per state resident in Massachusetts on HCBS for this population, with an average annual increase of 8.1 percent. Massachusetts spending on this target population within the Section 1915(c) HCBS waiver programs was higher than the average of both the profiled and the nonprofiled states (see Figure 14). After an initial decrease in spending between 2012 and 2013, expenditures increased over the last 3 years in the study period. Massachusetts currently has no waiting list for HCBS.[15]

[e] Analysis of Section 1915(c) waiver applications, retrieved from www.medicaid.gov

Figure 14. HCBS Section 1915(c) Waiver Program Spending for People With Developmental Disabilities per State Resident in Massachusetts and in Profiled and Nonprofiled States, 2012–2016



Abbreviations: HCBS, home and community-based services.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

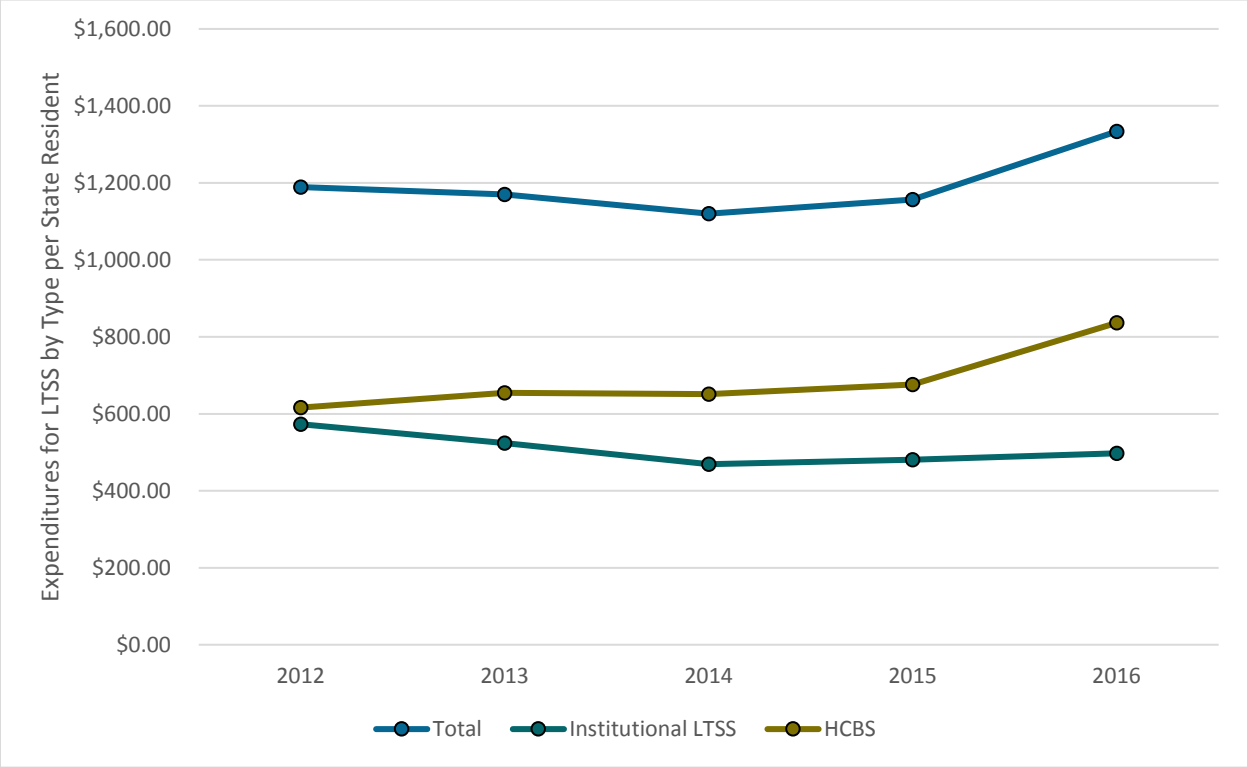
Key Takeaways: Massachusetts

Massachusetts is an example of a state that accelerated progress toward HCBS despite already being among the top half of states nationally before the study period. Massachusetts expanded capacity in waivers serving individuals with I/DD and implemented improvements in Medicare-Medicaid coordination through an existing managed care program for older adults as well as a new Financial Alignment Initiative program for adults with disabilities aged 21 to 64 years at the time of enrollment. Massachusetts also participated in two federally funded programs (BIP and MFP) and leveraged these funds to offer two new Section 1915(c) waiver programs. Finally, Massachusetts implemented two additional waivers to provide services to those transitioning from institutional care to the community as part of the MFP grant. All of these policy initiatives may have contributed to the continued increases in the percentage of HCBS expenditures in Massachusetts—these policy initiatives were undertaken despite already having achieved true rebalancing.

3. New York

New York improved 11.9 percentage points in the percentage of LTSS expenditures for HCBS between 2012 and 2016 (see Figure 15). This change was characterized by higher spending overall in New York than in the other profiled states, a slight decrease and then a flat rate of institutional spending, and a flat rate of HCBS spending followed by an increase.

Figure 15. New York LTSS Spending per State Resident by Type of LTSS Program, 2012–2016



Abbreviations: HCBS, home and community-based services; LTSS, long-term services and supports.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

From 2012 to 2016, New York's LTSS rebalancing was characterized by a decrease in institutional LTSS spending (from $11,774 million to $9,866 million) and an increase in HCBS spending (from $12,162 million to $16,589 million), as measured in raw dollars.

New York has pursued a set of policy initiatives different from those pursued by other profiled states to rebalance LTSS spending from institutional care to HCBS care (see Table 5). New York currently provides HCBS with no waiting list[15] and participated in Medicaid expansion, providing coverage for individuals aged 19–64 years effectively under 138 percent of the federal poverty limit.[9]

Table 5. Program Initiatives: New York

Program	Participation
Balancing Incentive Program	Yes
Money Follows the Person	Yes
Section 1915(i) state plan home and community-based services	No
State plan personal care services	Yes
Health homes related to long-term services and supports	Yes
Section 1915(c) waiver programs	Yes
Section 1115 demonstration related to home and community-based services	Yes
Managed long-term services and supports	Yes
Section 1915(j) self-directed personal care	No
Financial Alignment Demonstration	Yes
Section 1915(k) Community First Choice	Yes
Medicaid expansion	Yes

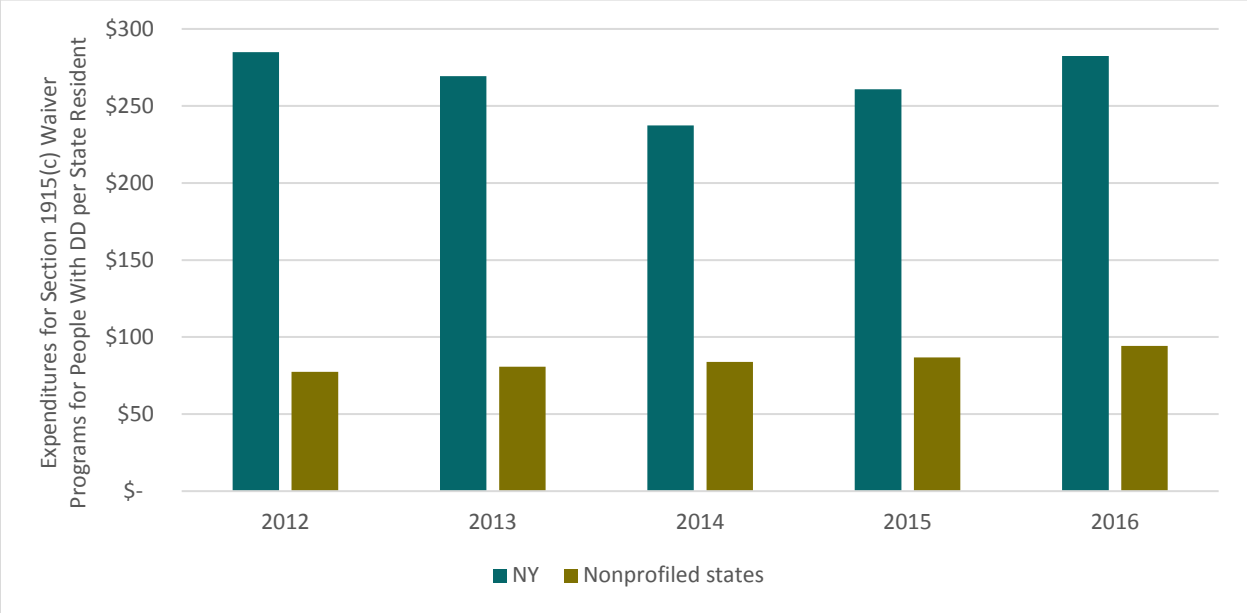
New York is one of the nine states in the nation that has received approval for the Community First Choice (1915(k)) State Plan Option. New York's state plan amendment authorizing this service was approved effective July 1, 2015, and expenditures for Community First Choice services doubled between 2015 and 2016, from $58.90 per state resident in 2015 to $119.15 per state resident in 2016. This service package offered an avenue for HCBS in combination with the state's existing waiver programs and targeted those who may not already be receiving waiver services.

New York also accessed the enhanced FMAP offered in BIP, receiving authorization to earn up to $674.3 million dollars over the course of this initiative.[21] This funding is credited as a contributing factor for the increase from 46.7 percent of LTSS expenditures going toward HCBS in 2009 to 57.9 percent of LTSS expenditures going toward HCBS in 2015.[21] The enhanced FMAP rate was used to increase community capacity and encourage community placement. The funds also helped adjust provider rates for services such as supported employment, family care, and rehabilitative services and created a provider innovation fund for providers to offer their own plans for improving access to HCBS.[22]

Similarly, New York took advantage of the MFP program, first awarded to the state before the study period, in 2007.[13] A total of 2,400 individuals had been transitioned back to the community by the end of 2016, evenly split between older adults, people with physical disabilities, and people with traumatic brain injury and slightly fewer transitions for participants with I/DD.[13] Further, whereas the number of active Section 1915(c) HCBS waiver programs in New York remained constant at 11 waivers between 2012 and 2016, the most recent renewal of the New York State Office of People With Developmental Disabilities Comprehensive Waiver indicates that it is projected to grow by 10,000 slots through 2021, signifying a commitment to increase access to the services offered to that population.[f]

[f] Analysis of Section 1915(c) waiver applications, retrieved from www.medicaid.gov

Figure 16. New York Spending on Section 1915(c) Waiver Programs for People With Developmental Disabilities per State Resident, 2012–2016



Abbreviation: DD, developmental disability.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

Despite New York's work toward improving HCBS for participants with I/DD, the state was one of four nationwide, and the only profiled state, to have an overall decrease in spending per state resident for Section 1915(c) HCBS waiver programs for people with I/DD (see Figure 16). This does not mean that New York has low HCBS spending; even after the decrease, New York had more spending per state resident than any other state in the nation. Further, the state spent almost three times as much as nonprofiled states per state resident on HCBS for this population.

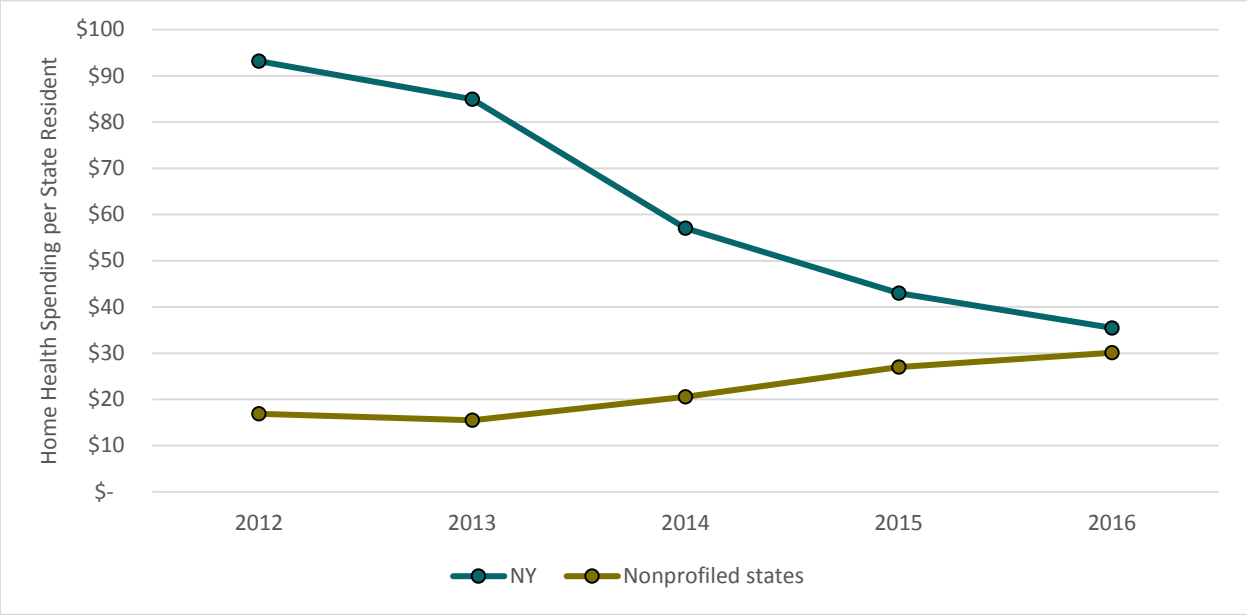
New York also has embraced MLTSS, having a total of four programs in operation by the end of 2016. All four of the MLTSS programs have an expressed goal of improving access to HCBS but are built to serve different target populations. The oldest MLTSS program, the Managed Long-Term Care Partial Cap program, began in 1998 as part of the state's Section 1115 demonstration focusing on delivery system redesign. The second program, Medicaid Advantage Plus (MAP), is also part of the Section 1115 demonstration and began in 2007. Both programs serve older adults and people with physical disabilities and focus on dually eligible beneficiaries, but MAP offers enhanced care coordination between Medicare and Medicaid.[23] In 2015, the state received approval for a Financial Alignment Demonstration for its Fully Integrated Duals-Advantage (FIDA) Plan, targeting older adults and people with physical disabilities who are dually eligible.[24] New York added a second FIDA plan for individuals with I/DD in 2016.[25]

More recently, New York appears to be focused on improving community resources for those with severe mental illness, as part of a settlement agreement following an Olmstead lawsuit, *United States v. New York (2013)*.[26] This case focused on approximately 4,000 adults with mental illness who were

residents of 23 large adult homes; the state agreed to assist with providing community housing and community-based mental health services to those affected by unnecessary placements in these adult homes.[26] Possibly influenced by this resolution, New York's spending per state resident on Section 1915(c) HCBS waiver programs for behavioral health increased by an average annual change of 12.3 percent during the study period.

New York spending on home health services per state resident dropped 21 percent annually, decreasing from $93 per state resident in 2012 to $35 per state resident in 2016 (Figure 17). During the same period, the state increased spending on personal care from a rate of $199 per state resident in 2012 to $281 per state resident in 2016. The state historically has spent more than other states on home health, and this reduction may have been a substitution of personal care spending for some home health spending. The implementation of Community First Choice in 2015 also may have contributed to the decrease in home health service expenditures, as another possible service substitution.

Figure 17. Spending on Home Health Services per State Resident in New York and in Nonprofiled States, 2012–2016



Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

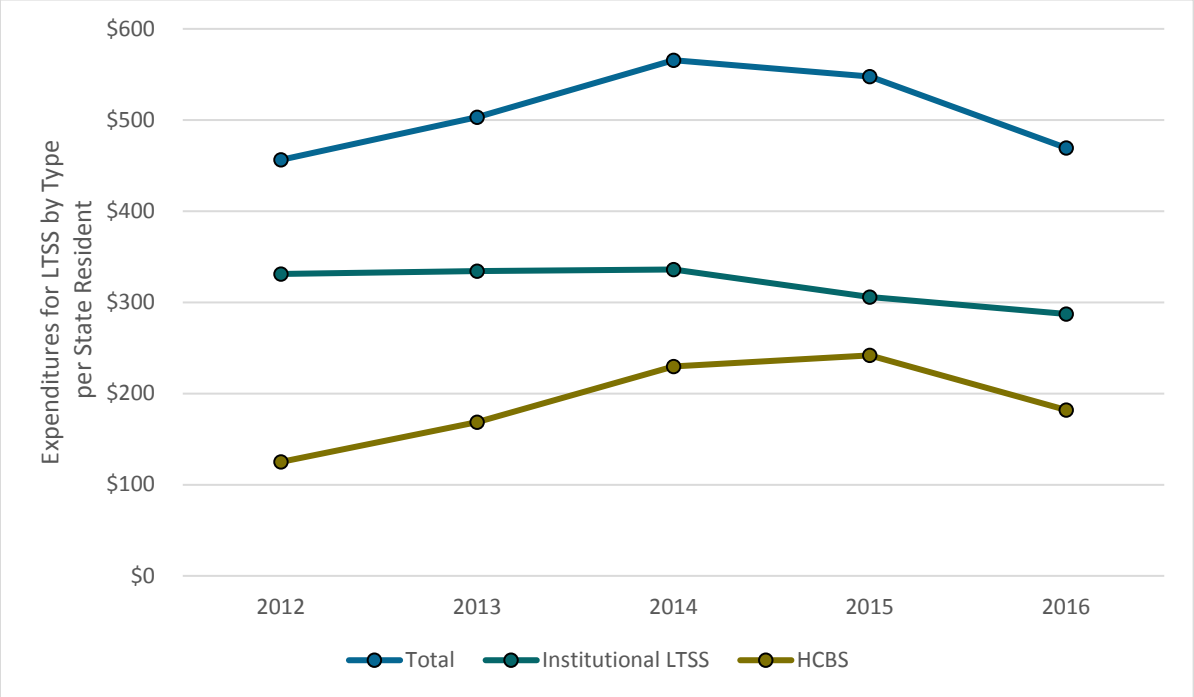
Key Takeaways: New York

Through BIP and MFP, New York leveraged enhanced federal funding to improve capacity to serve participants in the community and expand available waiver slots. Additionally, New York's commitment to the Community First Choice Option approved in 2015 appears to be one of several possible contributing factors to its efforts at rebalancing the LTSS system in the state. Finally, New York may have capitalized on implementation of various MLTSS programs to improve access to HCBS for additional populations—yet another possible factor in its success at LTSS system rebalancing.

4. New Jersey

New Jersey's progress toward rebalancing has involved strategies that are different from those used by the other profiled states. As shown in Figure 18, institutional spending per state resident declined during the study period, particularly from 2014 to 2016. At the same time, HCBS spending per resident increased through 2015 but decreased from 2015 to 2016. As of 2016, New Jersey had increased the percentage of LTSS expenditures going to HCBS by 11.7 percentage points over the study period but had not yet achieved a true rebalancing of spending—that is, more than 50 percent of the state's total spending on LTSS was for institutional services.

Figure 18. New Jersey LTSS Spending per State Resident by Type of LTSS Program, 2012–2016



Abbreviations: HCBS, home and community-based services; LTSS, long-term services and supports.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

As measured in raw dollars, New Jersey's LTSS rebalancing from 2012 to 2016 was characterized by a decrease in institutional LTSS expenditures (from $2,937 million to $2,580 million) and an increase in HCBS expenditures (from $1,093 million to $1,634 million).

New Jersey's participation in certain federal programs may have affected the state's progress toward rebalancing its LTSS system (see Table 6).

Table 6. Program Initiatives: New Jersey

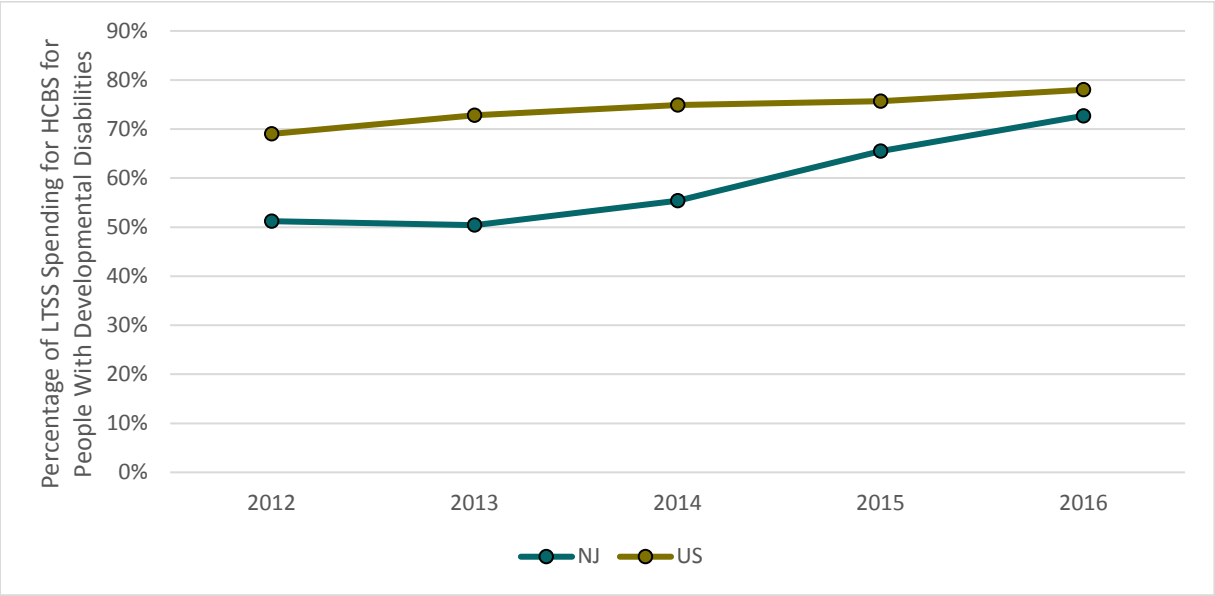
Program	Participation
Balancing Incentive Program	Yes
Money Follows the Person	Yes
Section 1915(i) state plan home and community-based services	No
State plan personal care services	Yes
Health homes related to long-term services and supports	Yes
Section 1915(c) waiver programs	No
Section 1115 demonstration related to home and community-based services	Yes
Managed long-term services and supports	Yes
Section 1915(j) self-directed personal care	Yes
Financial Alignment Demonstration	No
Section 1915(k) Community First Choice	No
Medicaid expansion	Yes

As shown in Figure 18, the decrease in institutional LTSS expenditures occurred in 2014, the same year that New Jersey implemented MLTSS through a comprehensive 1115 demonstration, FamilyCare. Through FamilyCare, enrollment in a managed care plan is mandatory. The MLTSS program became effective as of July 1, 2014, with the transition of 12,036 LTSS participants from Section 1915(c) waiver programs to the Section 1115 demonstration, per state report. As of June 30, 2016, enrollment in the program had increased to 28,731 LTSS participants.[27] This program encompassed LTSS within its capitation rates, and all of New Jersey's Section 1915(c) HCBS waiver programs ultimately were integrated into the 1115 demonstration.

New Jersey credits this shift to MLTSS with increasing access to HCBS, specifically noting that when the program started in 2014, only 29.4 percent of LTSS recipients received their care in their home or in community settings; by April 2018, nearly half (49.4 percent) of LTSS recipients were receiving care in their home or community.[28] New Jersey's MLTSS demonstration also led to a decrease in the number of nursing facility residents, with the census decreasing by 1,600 since the beginning of the demonstration.[28]

Figure 19 shows the percentage of LTSS for people with I/DD who received HCBS in New Jersey compared with the entire United States during the study period. New Jersey had the second highest rate of increase in the ratio of LTSS spending on HCBS for people with I/DD, growing from 51 percent in 2012 to 73 percent in 2016.

Figure 19. Percentage of LTSS Expenditures for HCBS for People With Developmental Disabilities in New Jersey and Nationally, 2012–2016



Abbreviations: HCBS, home and community-based services; LTSS, long-term services and supports.

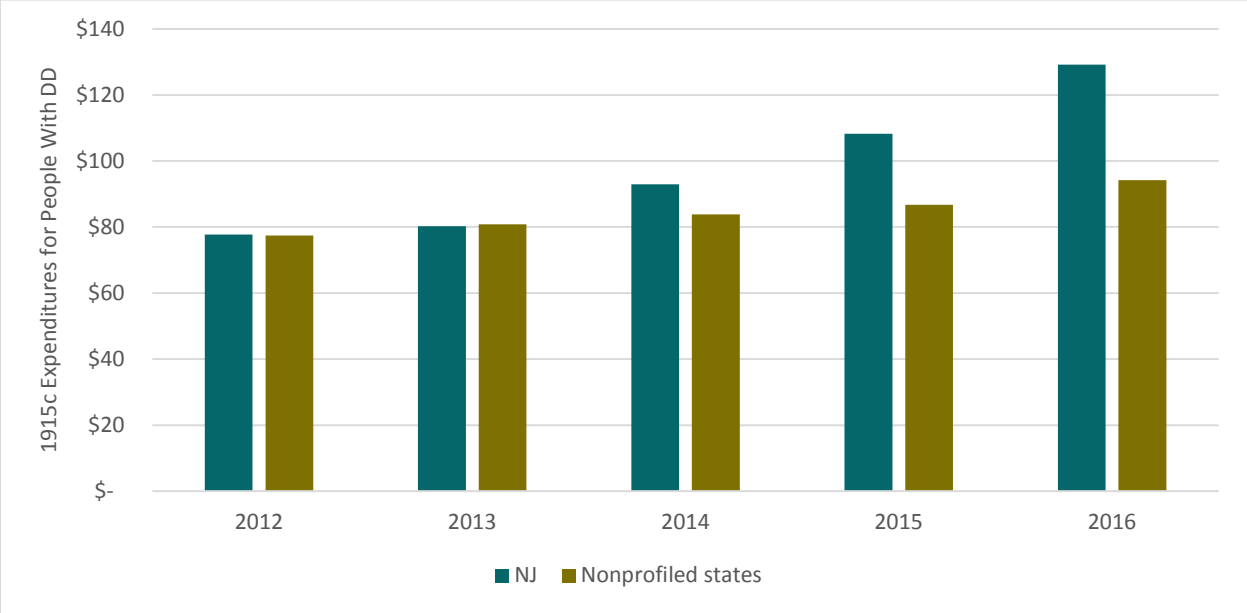
Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

Like many of the other profiled states, New Jersey was a recipient of enhanced FMAP funds through BIP. Its award began in April 2013, and it received a total of $110 million in funding.[11] This funding was used to expand HCBS for Medicaid recipients through its Section 1115 demonstration waiver and improved support for mental health transitions by covering supportive services.[29] New Jersey was noted to have a benchmark of 26.0 percent of LTSS spending for HCBS in 2009 and to have improved to 51.2 percent in 2015 as measured by BIP.[21]

New Jersey took advantage of the MFP grant as well, initially awarded in 2007 before the study period began.[13] By the end of 2016, New Jersey had completed 1,958 community transitions, with 759 transitions for individuals with I/DD, 640 transitions for older adults, and 559 transitions for people with physical disabilities.[13]

Figure 20 shows the Section 1915(c) expenditures per state resident for people with I/DD in New Jersey compared with the nonprofiled states during the study period. In addition to individuals with I/DD having the largest share of community transitions under MFP by the end of 2016, New Jersey greatly increased the rate of spending per state resident on individuals with I/DD. In 2012, the state's section 1915(c) waiver program spending for people with I/DD was identical to that of nonprofiled states. However, from 2012 until 2016, New Jersey increased spending per state resident at a rate of 13 percent per year, whereas nonprofiled states increased spending by only 5 percent per year.

Figure 20. Section 1915(c) Waiver Program Expenditures per State Resident for People With Developmental Disabilities in New Jersey and in Nonprofiled States, 2012–2016



Abbreviation: DD, developmental disabilities.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

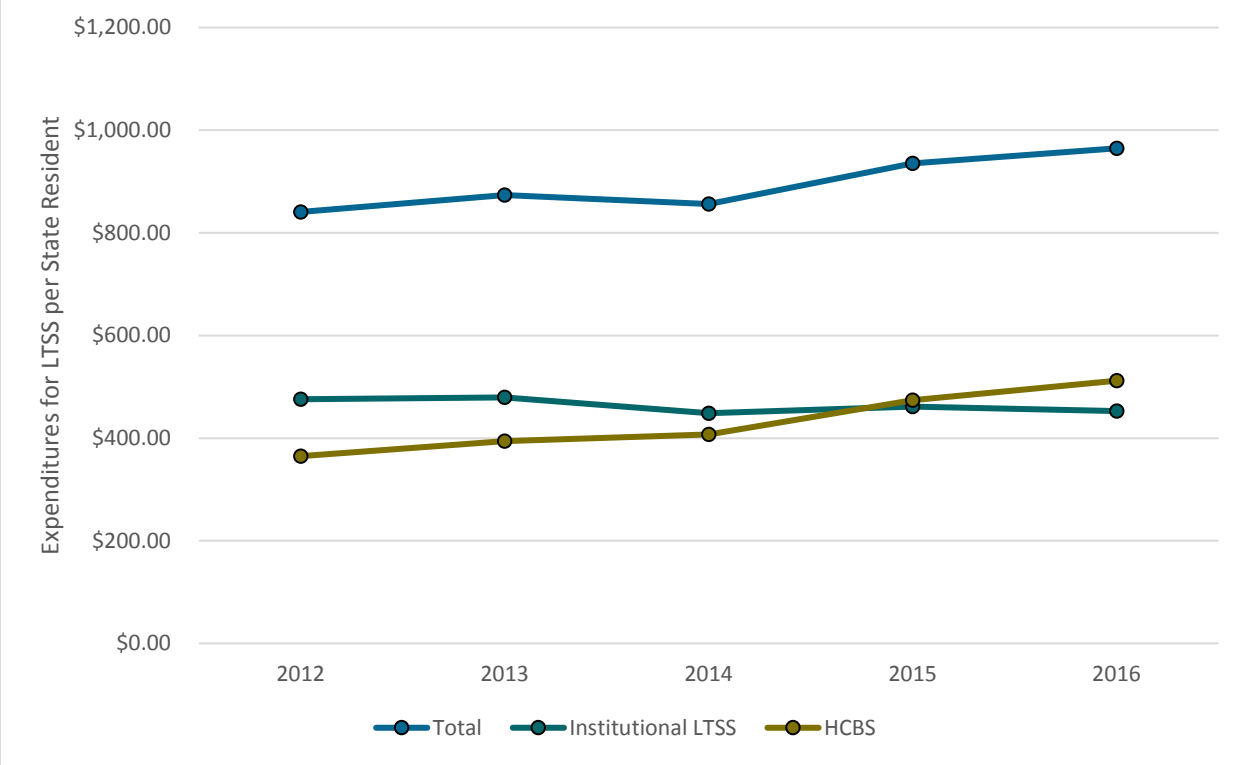
Key Takeaways: New Jersey

For New Jersey, the transition to MLTSS represented the greatest programmatic change during the study period and was identified by the state as a contributing factor in its rebalancing efforts. New Jersey also leveraged enhanced federal funding available to facilitate community transitions, even as it moved toward full MLTSS implementation in the state.

5. Connecticut

Connecticut is an example of a state that implemented fewer program initiatives than other profiled states during the study period but appears to have been very effective in its use of these programs to improve its LTSS expenditures. As seen in Figure 21, Connecticut decreased institutional LTSS spending while increasing HCBS spending, leading to rebalancing in 2015. The share of LTSS spending for HCBS in Connecticut increased by 9.8 percentage points over the study period.

Figure 21. Connecticut LTSS Spending per Resident by Type of LTSS Program, 2012–2016



Abbreviations: HCBS, home and community-based services; LTSS, long-term services and supports.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

From 2012 to 2016, Connecticut's LTSS rebalancing was characterized by a decrease in institutional LTSS spending (from $1,721 million to $1,625 million) and an increase in HCBS spending (from $1,311 million to $1,837 million), as measured in raw dollars.

Table 7 identifies the initiatives in which Connecticut participated.

Table 7. Program Initiatives: Connecticut

Program	Participation
Balancing Incentive Program	Yes
Money Follows the Person	Yes
Section 1915(i) state plan home and community-based services	Yes
State plan personal care services	No
Health homes related to long-term services and supports	No
Section 1915(c) waiver programs	Yes
Section 1115 demonstration related to home and community-based services	No
Managed long-term services and supports	No
Section 1915(j) self-directed personal care	No
Financial Alignment Demonstration	No
Section 1915(k) Community First Choice	Yes
Medicaid expansion	Yes

Connecticut is another of the nine states that have received approval for a section 1915(k) Community First Choice Medicaid state plan option. Initially effective July 1, 2015, Connecticut received approval for Community First Choice to offer five services to assist those in the community or to help them transition from institutional care back to the community.[30] Although expenditures in 2015 amounted to only $2.9 million, or $0.80 per state resident, utilization of these services increased meaningfully in 2016, up to $49.4 million, or $13.78 per state resident.[1]

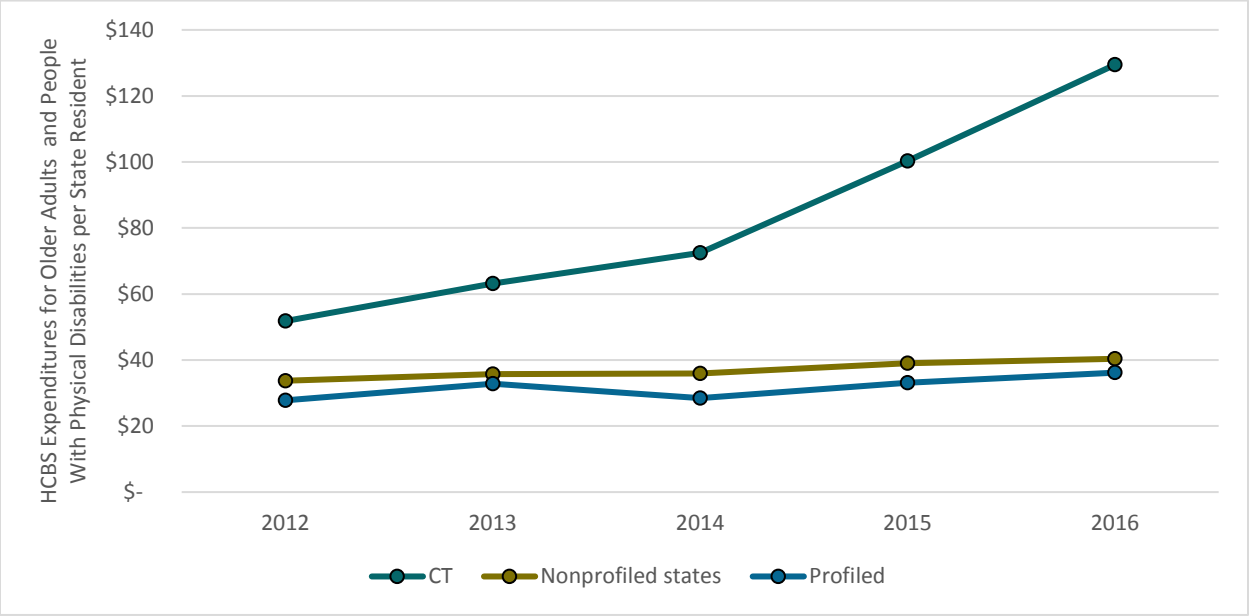
Connecticut also implemented HCBS through the section 1915(i) Medicaid state plan option, first effective February 1, 2012, and now extended through January 31, 2022.[31] The program is targeted at older adults who are at risk of hospitalization or short-term nursing home placement if they do not receive a moderate amount of home care, defined as assistance with one or two critical activities of daily living needs.[32] With this state plan HCBS option available, Connecticut could provide community-based services to this population to meet lower levels of need. Providing services to this population at a point where services of low intensity can meet their needs may prevent or delay the need for more intensive services.

Additional program initiatives that may have contributed to Connecticut's rebalancing efforts include BIP and MFP. Connecticut received its initial BIP award in January 2013, and the benchmark for the state's HCBS spending in 2009 was 44.1 percent.[11] By 2015, this spending had increased to 54 percent.[11] Connecticut used the enhanced FMAP to expand offerings for HCBS, including Community First Choice, and to expand slots in its existing section 1915(c) waiver programs.[33] Connecticut's MFP grant funds were first awarded prior to the study period in 2007.[13] One of the strategies it used to ensure adequate housing resources to complete transitions to the community was to match up people who were seeking roommates in their community residences.[34] By using such strategies, Connecticut succeeded in transitioning 3,934 participants by the end of 2016, with the greatest impact felt among older adults (1,832) and people with physical disabilities (1,587).[13]

Connecticut's expenditures for HCBS targeting older adults and people with physical disabilities increased by an annual average of 26 percent over the course of the study period. As shown in Figure 22, Connecticut's spending showed a slight increase from 2012 to 2014 and then a much greater

increase from 2014 to 2016 which may have been related to the impact of implementing BIP, MFP, Community First Choice, and HCBS State Plan Options.

Figure 22. HCBS Spending for Older Adults and People With Physical Disabilities per State Resident in Connecticut and in Nonprofiled and Profiled States, 2012–2016



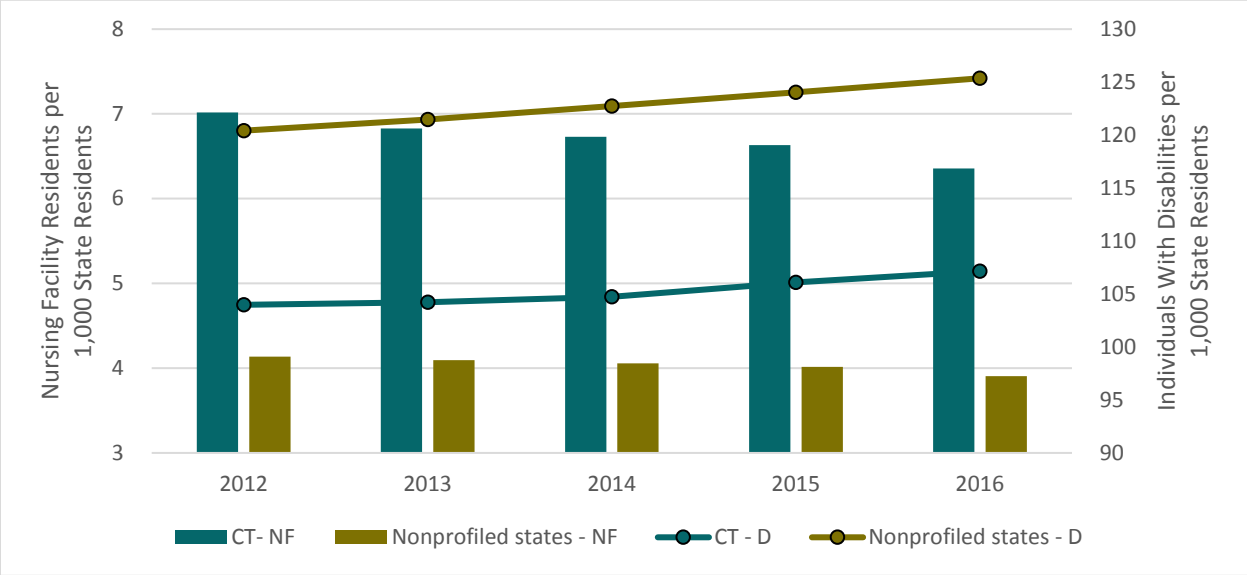
Abbreviation: HCBS, home and community-based services.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

Connecticut also had a number of waiver activities undertaken during this time. During the study period, the state added three waivers and terminated one, for a total of 11 active Section 1915(c) HCBS waivers in 2016.[2,7] Finally, the number of people on Connecticut's waiting list is reported to have increased during the study period, from 1,177 in 2011[14] to 2,903 in 2016.[15] The increase in the waiting list simply may reflect an increased number of people now eligible for services following the state's implementation of new programs.

All profiled states except Colorado experienced a decrease in the number of residents at certified nursing facilities per state resident, but Connecticut's number of certified nursing facility residents decreased most quickly, with an annual decline of 2.5 percent. In addition to this rapid decrease in certified nursing facility residents, the state had the second slowest growth, after Arkansas, in the population of civilian noninstitutionalized individuals with disabilities per state resident. Figure 23 illustrates these trends in Connecticut compared with the nonprofiled states.

Figure 23. Populations of Interest in Connecticut and in Nonprofiled States, 2012–2016

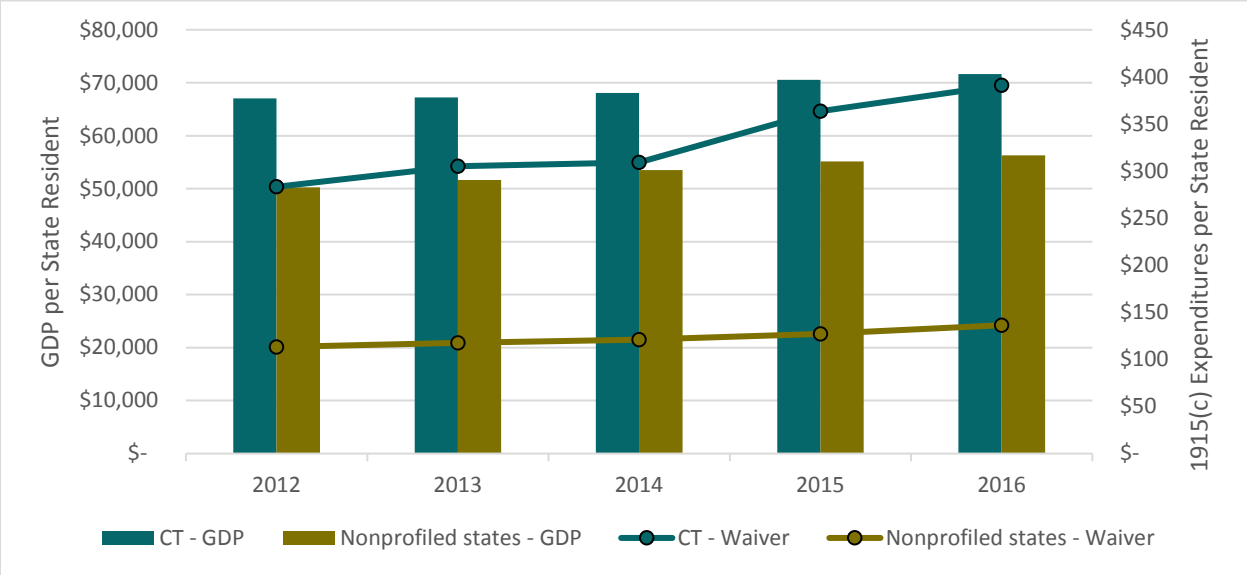


Abbreviation: NF, certified nursing facility; D, disability.

Source: Analysis of data from Kaiser Family Foundation. *Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2009 Through 2016.* 2018. https://www.kff.org/medicaid/report/nursing-facilities-staffing-residents-and-facility-deficiencies-2009-through-2016/ and U.S. Census Bureau. American Community Survey. 2018. https://www.census.gov/acs/www/data/data-tables-and-tools/

Connecticut experienced stagnant population growth over the study time frame, as well as very slow economic growth. It had the slowest growth per state resident of GDP, personal income, disposable income, and total employment of any profiled state and was also below the national average for growth in all categories. Yet at the same time, the state increased total Section 1915(c) HCBS waiver program expenditures per state resident faster than all other profiled states except Massachusetts (see Figure 24).

Figure 24. GDP and Section 1915(c) Waiver Program Expenditures per State Resident in Connecticut and in Nonprofiled States, 2012–2016



Abbreviation: GDP, gross domestic product.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

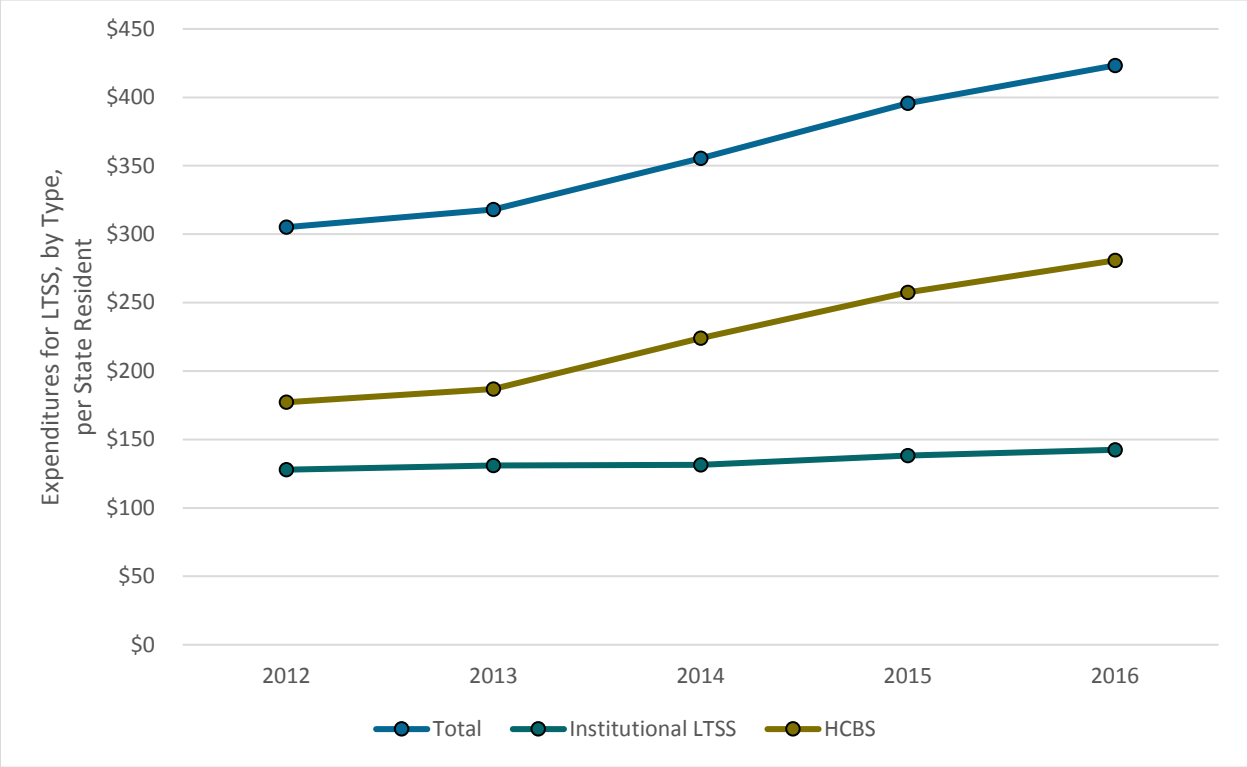
Key Takeaways: Connecticut

Connecticut leveraged multiple resources and policy initiatives to accelerate its balancing efforts, including BIP, MFP, and HCBS Medicaid State Plan Options through Sections 1915(i) and 1915(k), but it did not implement other program initiatives such as MLTSS. The state experienced sizable increases in HCBS spending for older adults and individuals with physical disabilities during the study period.

6. Colorado

Colorado's efforts to rebalance its LTSS system resulted in an 8.5 percentage point increase in the share of LTSS spending going to HCBS from 2012 to 2016. Figure 25 indicates that Colorado's spending on institutional care remained essentially flat, whereas HCBS spending increased steadily from 2013 to 2016.

Figure 25. Colorado LTSS Spending per State Resident by Type of LTSS Program, 2012–2016



Abbreviations: HCBS, home and community-based services; LTSS, long-term services and supports.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

From 2012 to 2016, Colorado's LTSS rebalancing was characterized by an increase in HCBS expenditures (from $917 million to $1,553 million) and a smaller increase in institutional LTSS expenditures (from $669 million to $788 million) in raw dollars.

In contrast to many of the other profiled states, Colorado did not participate in BIP. Colorado also had fewer program initiatives implemented during the study period compared with other profiled states (see Table 8).

Table 8. Program Initiatives: Colorado

Program	Participation
Balancing Incentive Program	No
Money Follows the Person	Yes
Section 1915(i) state plan home and community-based services[a]	Yes
State plan personal care services[b]	No
Health homes	No
Section 1915(c) waivers	Yes
Section 1115 demonstration related to home and community-based services	No
Managed long-term services and supports	No
Section 1915(j) Self-Directed Personal Care	No
Financial Alignment Demonstration	Yes
Section 1915(k) Community First Choice	No
Medicaid expansion	Yes

[a] Colorado recently received approval from the Centers for Medicare & Medicaid Services to discontinue the 1915(i) state plan HCBS. This program primarily provided options for consumer direction that previously were not available but since have been expanded.

[b] Although Colorado (as well as other profiled states) does not elect the personal care state plan option, personal care services may be provided through other benefits, such as early periodic screening, diagnosis, and treatment as required for children up to age 21 years and other programs such as section 1915(c) waiver programs for those who meet the prescribed level of care criteria.

No single program initiative stands out as the factor that contributes most significantly to Colorado's rebalancing efforts. Colorado appears to have combined a number of small steps that contributed to a cumulative improvement in rebalancing.

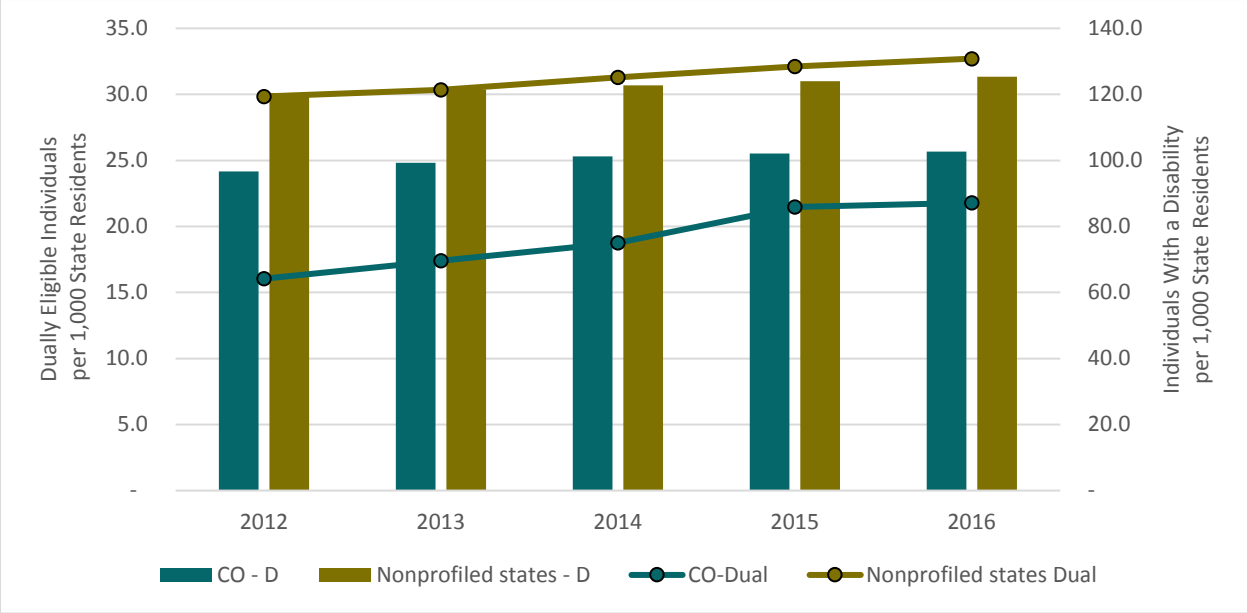
For example, Colorado participated in the MFP grant and received its initial award in April 2011.[13] Its strategy for improving community transitions was to improve training for nursing facilities, specifically focused on Section Q of the Minimum Data Set, which can help determine whether a resident desired to return to the home or community.[34] The state also contracted with Aging and Disability Resource Centers to provide options counseling for nursing facility residents who affirmed that they wanted to return to the community. Further, the state focused on creating a comprehensive list of affordable housing options on an online search tool to assist transition coordinators with successful transitions out of nursing facilities.[34] The state also (1) established an interagency agreement with the Division of Housing to expand housing options for the MFP population that was financed with MFP funds and (2) partnered on a Section 811 grant offered through the Department of Housing and Urban Development. As a result of these efforts, Colorado completed 214 transitions through the end of December 2016, with individuals with physical disabilities having the most transitions to the community (75).[13]

Colorado conducted an initiative to reduce the waiting list by securing funding to provide HCBS. During the study period, the waiting list for HCBS decreased from 4,307 in 2011[14] to 3,194 in 2016[15]—a 26 percent decrease.

Further, compared with other profiled states, from 2012 to 2016 Colorado had the second highest rate of growth in the number of individuals who were dually eligible for Medicare and Medicaid and in the number of individuals with a disability per state resident (Figure 26). Additionally, over the same period the state had a higher rate of growth in the share of individuals over the age of 85 years compared with

the national average, reflecting an above-average overall growth in populations using LTSS services. Although Colorado experienced high growth in these populations (i.e., individuals dually eligible for Medicare and Medicaid and those with a disability), its share of state residents in both of these populations was still lower than that of nonprofiled states.

Figure 26. Changes in Colorado's Populations of Interest, 2012–2016



Abbreviation: D, disability.

Source: Analysis of data from U.S. Census Bureau. American Community Survey. 2018. https://www.census.gov/acs/www/data/data-tables-and-tools/ and Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office. Monthly enrollment snapshots. 2018. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html

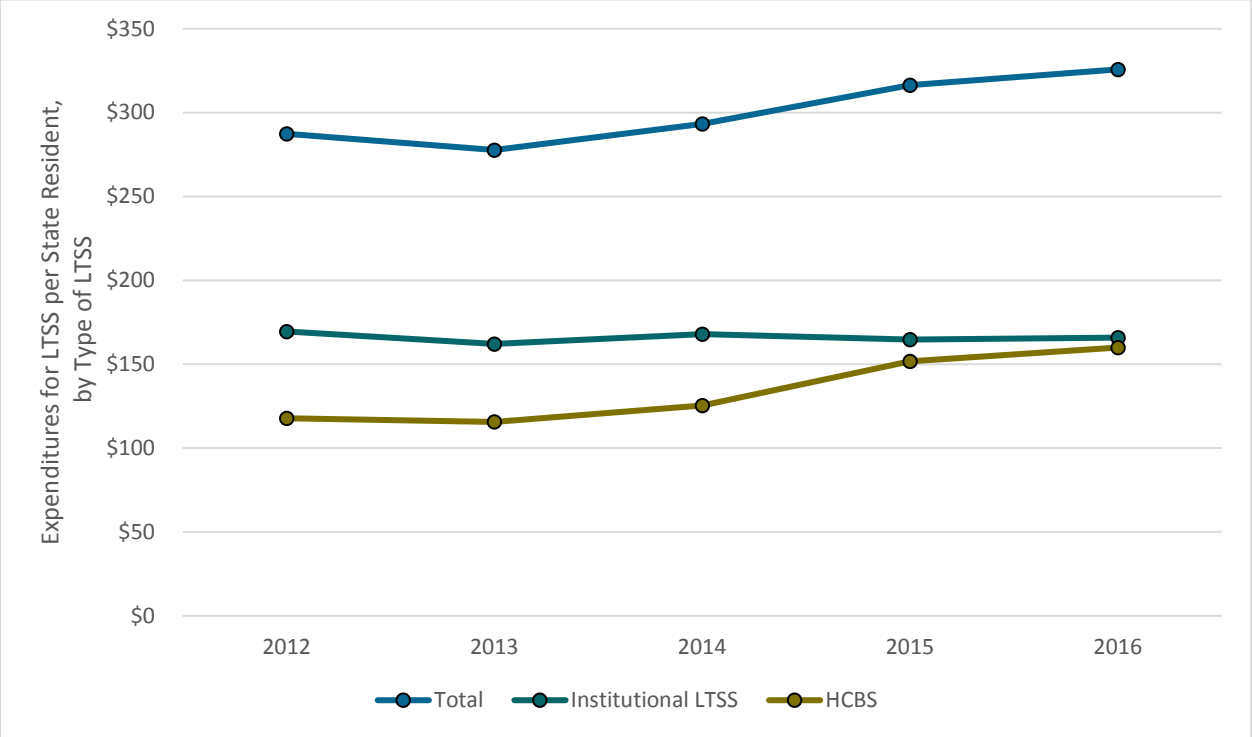
Key Takeaways: Colorado

Despite its being another state that was in the top half of states for percentage of LTSS spent on HCBS before the study period, Colorado's rate of progress was faster than that of most states. Colorado was creative with federal funding leveraged through the MFP grant—improving training for staff at nursing facilities to identify residents who desire a return to living in the community, contracting with Aging and Disability Resource Centers to provide options counseling, establishing a relationship with the statewide housing authority to improve access to affordable and accessible housing, and developing a way to easily identify available housing resources for those wanting to make the transition back to the community.

7. South Carolina

South Carolina is another state that has made progress toward rebalancing, increasing the percentage of LTSS expenditures going to HCBS by 8.1 percentage points from 2012 to 2016. Even so, it has not yet achieved HCBS spending that is higher than spending on institutional care. As shown in Figure 27, in 2016 HCBS spending and spending on institutional services were nearly identical, but they had not yet intersected; as of 2016, 49.1 percent of South Carolina's LTSS expenditures were for HCBS. As in other states, South Carolina experienced a steady increase in HCBS spending and a fairly constant rate of institutional spending.

Figure 27. South Carolina LTSS Spending per State Resident by Type of LTSS Program, 2012–2016



Abbreviations: HCBS, home and community-based services; LTSS, long-term services and supports.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

From 2012 to 2016, South Carolina's LTSS rebalancing was characterized by a flat rate of institutional LTSS expenditures (growing slightly from $801 million to $823 million) and an increase in HCBS expenditures (from $557 million to $794 million), as measured in raw dollars.

Table 9 shows the initiatives in which South Carolina participated during the study period. South Carolina did not elect to participate in Medicaid expansion[14] and has not added waivers or significantly increased capacity on its existing waivers. However, the state has implemented other program initiatives that have contributed to its improvement in rebalancing. These initiatives appear to focus on services for older adults and individuals with physical disabilities.

Table 9. Program Initiatives: South Carolina

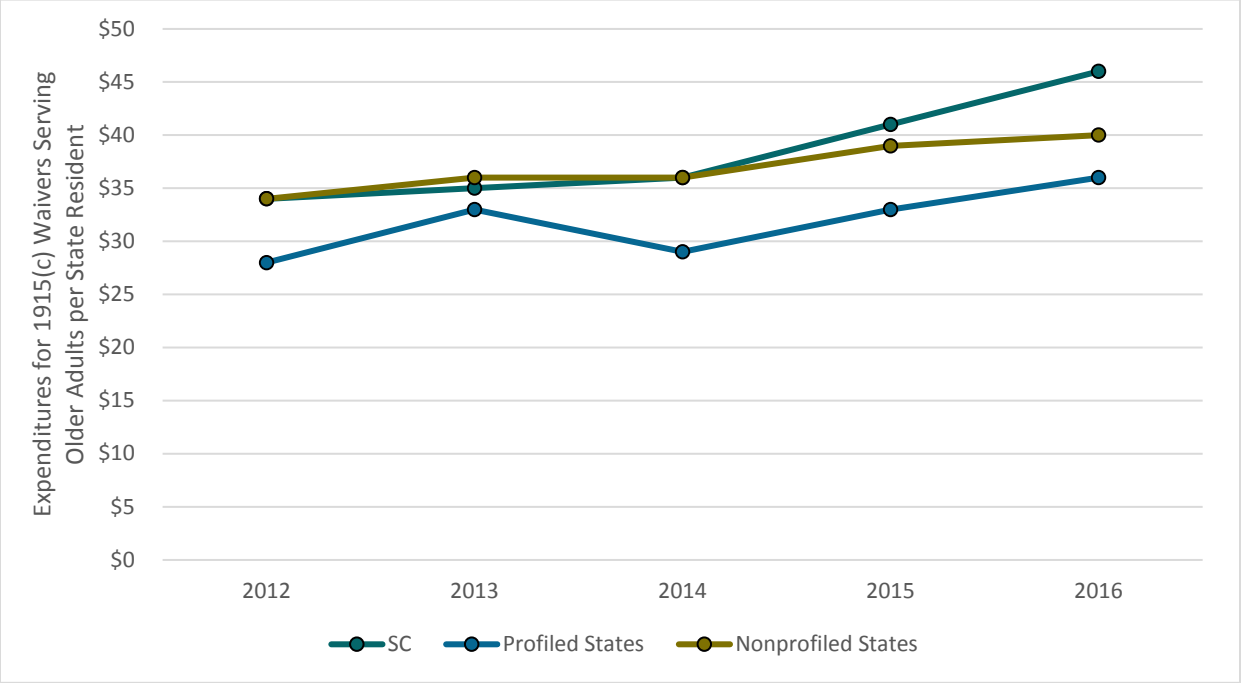
Program	Participation
Balancing Incentive Program	No
Money Follows the Person	Yes
Section 1915(i) state plan home and community-based services	No
State plan personal care services	No
Health homes related to long-term services and supports	No
Section 1915(c) waiver programs	Yes
Section 1115 demonstration related to home and community-based services	No
Managed long-term services and supports	Yes
Section 1915(j) self-directed personal care	No
Financial Alignment Demonstration	Yes
Section 1915(k) Community First Choice	No
Medicaid expansion	No

[a] Although South Carolina (as well as other profiled states) does not elect the personal care state plan option, personal care services may be provided through other benefits, such as EPSDT as required for children up to age 21 years, and other programs like section 1915(c) waiver programs for those who meet the level of care criteria as prescribed.

South Carolina received an MFP grant, initially awarded in 2011.[13] The state began transitioning participants in 2013, focusing its efforts on older adults and individuals with physical disabilities. By the end of 2016, it had completed 68 transitions—38 for older adults and 30 for individuals with physical disabilities.[13] South Carolina also developed and implemented a demonstration through the Financial Alignment Initiative, called Healthy Connections Prime, which initiated MLTSS in the state. The program began February 1, 2015, and enrolled older adults with a goal of improving coordination and quality of care for dually eligible members.[35] The state's Coordinated and Integrated Care Organizations were charged with coordinating a member's care, including LTSS. By the end of the quarter, 1,502 members were enrolled; by the end of 2016, 9,705 members were enrolled.[36]

These program initiatives contributed to South Carolina's success in increasing expenditures for HCBS targeting older adults and individuals with physical disabilities. The largest increase took place between 2014 and 2016 and exceeded per capita expenditure increases in nonprofiled states (see Figure 28). This trend coincides with the state's efforts with MFP and its MLTSS implementation.

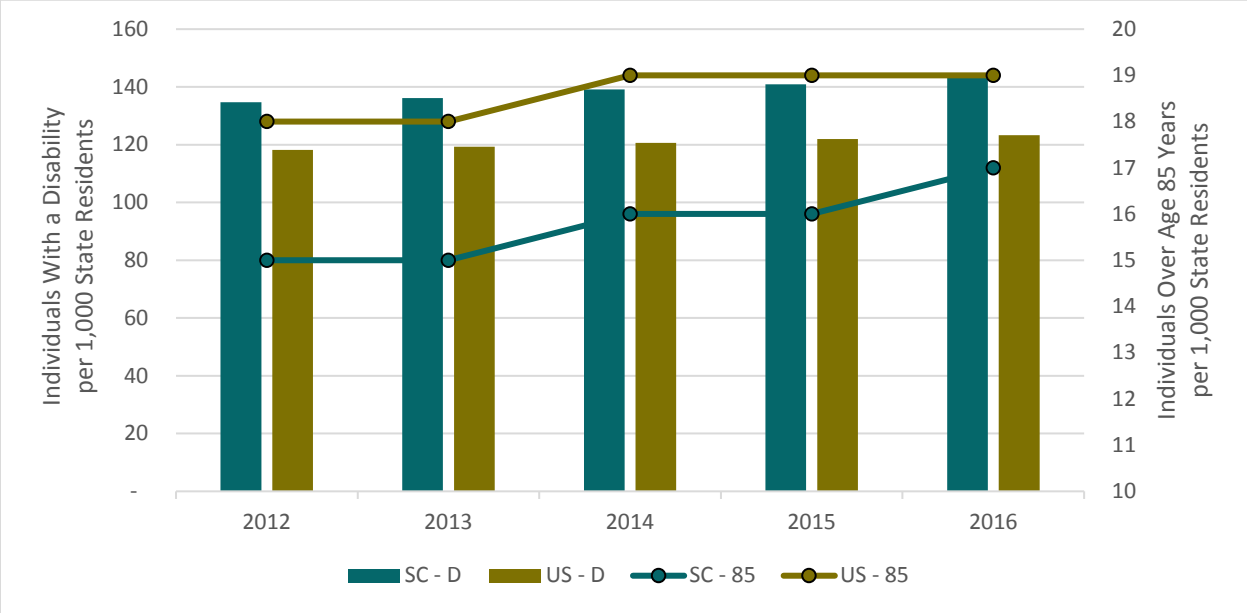
Figure 28. Expenditures for Section 1915(c) Waivers for Older Adults and People With Physical Disabilities in South Carolina and in Nonprofiled and Profiled States, 2012–2016



Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

Similar to Colorado, from 2012 to 2016 South Carolina had above-average increases in populations that typically use LTSS: those over the age of 85 years, which increased 3.2 percent on average annually, and individuals with a disability, which increased 1.5 percent on average annually (Figure 29). Like Colorado, South Carolina's share of individuals over the age of 85 years was below the national average, but unlike Colorado, the state's share of individuals with a disability already was higher than the national average.

Figure 29. Changes in South Carolina Populations of Interest, 2012–2016

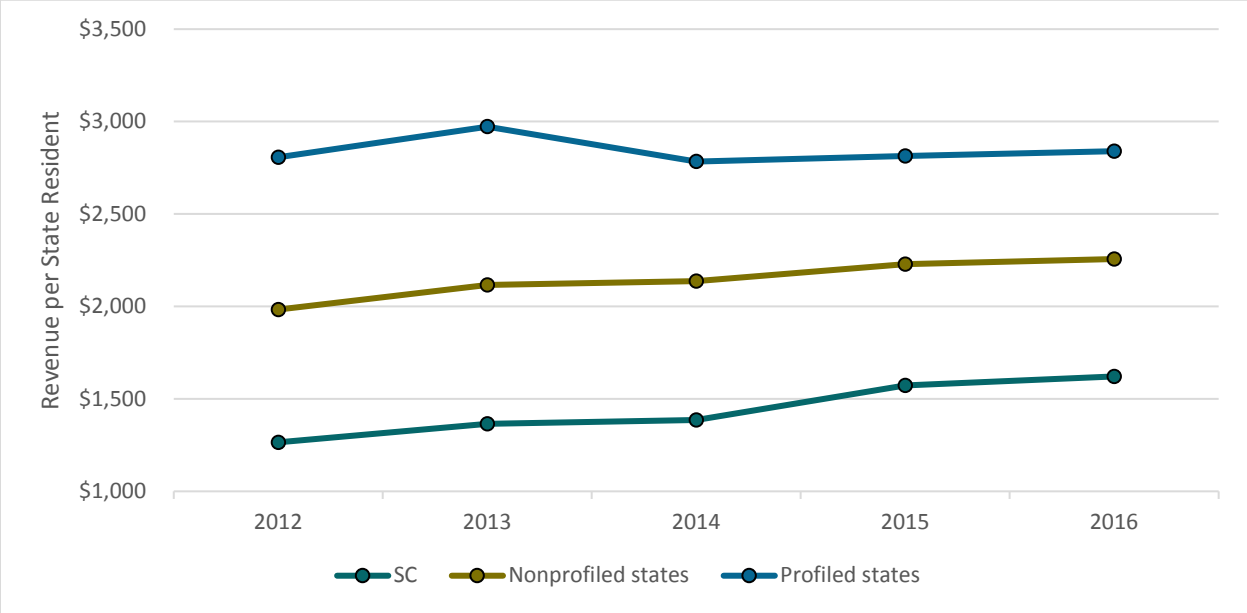


Abbreviation: D, disability.

Source: Analysis of data from U.S. Census Bureau. American Community Survey. 2018. https://www.census.gov/acs/www/data/data-tables-and-tools/

In addition to the challenges presented by an aging population and an above-average number of individuals with a disability, South Carolina also has below-average government revenue.[37] On the one hand, South Carolina has the second lowest GDP per state resident of any profiled state, ahead of Arkansas. On the other hand, the state is growing rapidly, with an annual average GDP growth per state resident of 3.7 percent from 2012 to 2016, the highest of any profiled state and above the national average growth of 2.9 percent. Additionally, the state's revenue per state resident has increased by $356 from 2012 to 2016, a rate of 6.4 percent annually (Figure 30).

Figure 30. Revenue per State Resident in South Carolina, 2012–2016



Source: Analysis of data from National Association of State Budget Officers. State expenditure reports 2012–2016. 2018. https://www.nasbo.org/reports-data/state-expenditure-report

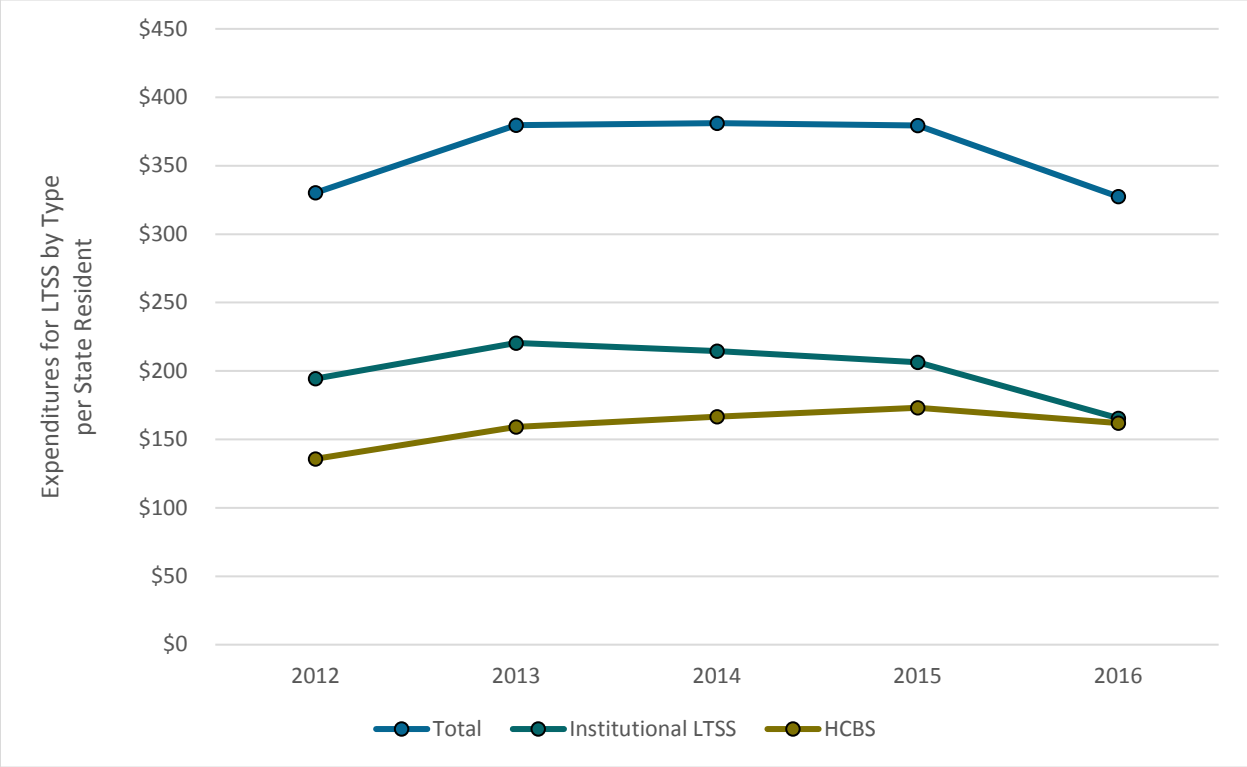
Key Takeaways: South Carolina

South Carolina is another example of a state that used more than one policy initiative to make meaningful progress in rebalancing care for older adults and individuals with a physical disability. The state leveraged both the community transition opportunities offered in MFP and the improved care coordination for dually eligible participants with its Financial Alignment Initiative demonstration.

8. Illinois

As with South Carolina, Illinois achieved an 8.1 percentage point increase in share of LTSS expenditures for HCBS from 2012 to 2016. Similarly, Illinois has not yet achieved rebalancing, although its institutional spending and HCBS spending were nearly identical in 2016, as shown in Figure 31. As of 2016, Illinois used 49.4 percent of LTSS spending for HCBS. Illinois had the fastest percentage decrease in institutional LTSS spending of any profiled state, experiencing a slight increase between 2012 and 2013, followed by a 25 percent decrease from 2013 through 2016. HCBS spending increased from 2012 through 2015 and declined slightly from 2015 to 2016.

Figure 31. Illinois LTSS Spending per State Resident by Type of LTSS Program, 2012–2016



Abbreviation: HCBS, home and community-based services; LTSS, long-term services and supports.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

From 2012 to 2016, LTSS rebalancing in Illinois was characterized by a decrease in institutional LTSS spending (from $2,546 million to $2,124 million) and an increase in HCBS spending (from $1,795 million to $2,078 million) as measured in raw dollars.

Table 10 indicates the initiatives in which Illinois participated during the study time frame.

Table 10. Program Initiatives: Illinois

Program	Participation
Balancing Incentive Program	Yes
Money Follows the Person	Yes
Section 1915(i) state plan home and community-based services	No
State plan personal care services	No
Health homes related to long-term services and supports	No
Section 1915(c) waiver programs	Yes
Section 1115 demonstration related to home and community-based services	No
Managed long-term services and supports	Yes
Section 1915(j) self-directed personal care	No
Financial Alignment Demonstration	Yes
Section 1915(k) Community First Choice	No
Medicaid expansion	Yes

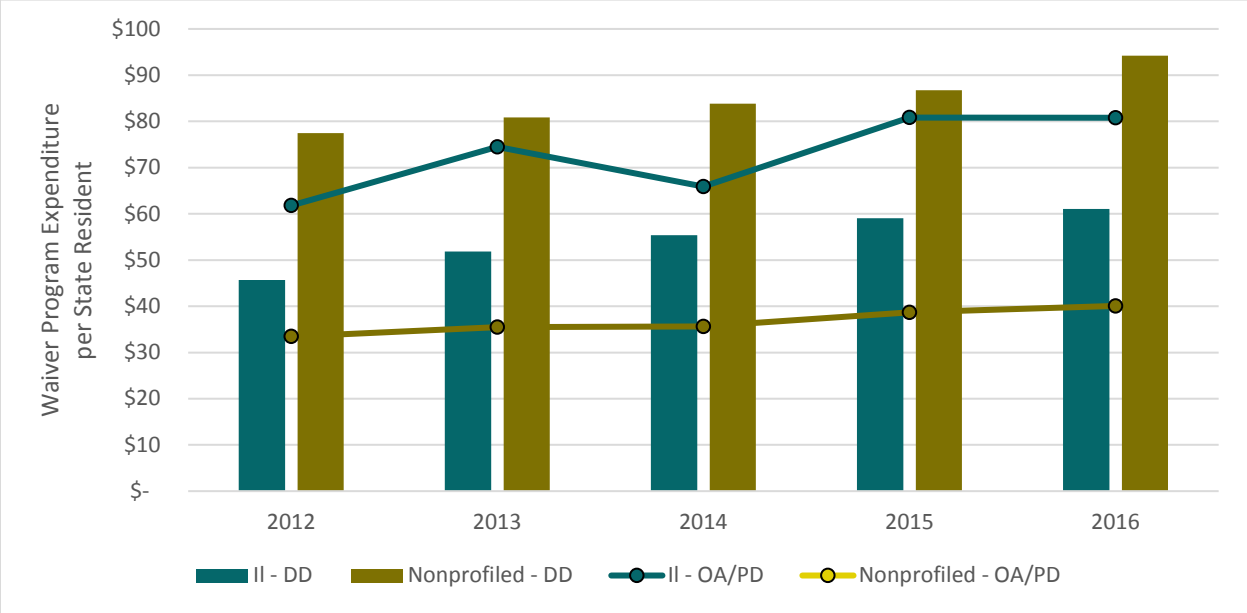
Illinois participated in Medicaid expansion and currently runs nine Section 1915(c) HCBS waiver programs; no waiver programs were added or terminated during the study period. Using various program initiatives, as described below, the state made progress in reducing its waiting list for HCBS by 42 percent over the study period, from 33,114 individuals on the list in 2011[14] to 19,163 on the list in 2016.[15] The state achieved this by increasing capacity for several waiver programs and improving access to HCBS through the use of MLTSS.

As a participant in BIP, initially awarded in July 2013, Illinois used the enhanced FMAP funds to increase waiver capacity on its Adults with Developmental Disabilities Waiver.[38] The state also improved nursing home diversions, funded employment first initiatives, and expanded services and supports teams to support individuals receiving waiver services.[38] These efforts helped Illinois rebalance its system—its benchmark grew from 27.8 percent spending on HCBS in 2009 to 45.7 percent in 2015.[11]

Illinois also received an MFP grant, initially awarded in 2007, and achieved 2,731 transitions through 2016.[13] It used grant funds to support housing for individuals served in the community by having a statewide housing coordinator identify housing units for MFP participants, thus increasing the number of Community Integrated Living Arrangements available for individuals with DD.[34] It also implemented a caseworker portal to allow transition coordinators to screen participants easily for two affordable housing resources.[34] In addition, the state promoted community transitions faster by implementing a bridge subsidy for participants.[34] Through this combination of initiatives, 696 older adults, 854 individuals with physical disabilities, 313 individuals with I/DD, and 868 individuals with severe mental illness successfully transitioned to the community.[13]

In part because of the combination of programs to assist in community transitions, Section 1915(c) waiver program expenditures on the three targeted populations—individuals with developmental disabilities, older adults, and individuals with physical disabilities—increased quickly (see Figure 32). Expenditures on individuals with DD increased 7.5 percent per state resident on average from 2012 to 2016, faster than the average of profiled and nonprofiled states. Similar growth was exhibited in expenditures for older adults and those with physical disabilities, although from a higher base, with a 6.9 percent average annual increase per state resident.

Figure 32. Illinois Waiver Program Expenditures on Individuals With Developmental Disabilities and Older Adults/Adults With Physical Disabilities, 2012–2016



Abbreviations: DD, developmental disability; OA/PD, older adult/physical disability.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

From 2011 through the end of the study period in 2016, Illinois implemented three MLTSS programs. The first was the Integrated Care Program, designed to improve care coordination for non-dually eligible members.[39] The second program was the state's demonstration developed for the Financial Alignment Initiative, called the Medicare-Medicaid Alignment Initiative (MMAI), for dually eligible members who were passively enrolled with the option to opt out.[40] Both of these programs improved care coordination, even for those members who did not meet institutional level of care criteria. The third program, called Managed Long-Term Services and Supports, was a mandatory managed care program for dually eligible members who opted out of MMAI.[41] The three programs covered approximately 189,000 individuals by the end of 2016.[36,g]

As other researchers have found, implementing MLTSS can have a compelling impact on decreasing use of institutional care in favor of HCBS.[42] MLTSS may be a contributing factor to the improvements in Illinois's rebalancing efforts, providing care coordination and care options other than those available in institutions for participants with LTSS needs. This increased care coordination and need for noninstitutional care options may have led the state to increase capacity within its Section 1915(c) HCBS waiver programs. Currently approved waiver applications for the Persons With Disabilities waiver show an increase in available waiver slots of 4,300 through the course of the waiver cycle effective from 2016

[g] ICP enrollment as reported publicly by the state: Healthcare and Family Services. Enrollment for Integrated Care Program (ICP). https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/ICPEnrollment.aspx; MLTSS enrollment as reported publicly by the state: Healthcare and Family Services. Enrollment for Managed Long Term Services and Supports (MLTSS). https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/MLTSSEnrollment.aspx

through 2021; the Persons Who Are Elderly waiver shows an increase in available waiver slots of 58,000 through the course of the waiver cycle effective from 2016 through 2021.[h]

During the study period, Illinois also was subject to several Olmstead lawsuits:

- *Williams v. Rauner (2005)*: As a result of this lawsuit and settlement agreement, Illinois agreed to its obligation to expand the current community-based services system to support individuals with severe mental illness currently residing in nursing facilities. The affected individuals were to be offered the choice of institutional care or community-based services in keeping with the aim of providing services in the least restrictive and most integrated setting possible.[43]
- *Colbert v. Rauner (2007)*: This lawsuit concerned individuals unnecessarily residing in nursing facilities. The Consent Decree filed in 2011 directed the state to support these class members by providing them with necessary supports and services to live in the community in the most integrated settings appropriate to their needs.[43]
- *Ligas v*. *Norwood (2005)*: This lawsuit concerned individuals with developmental disabilities who were placed in large intermediate care facilities for people with developmental disabilities. The Consent Decree filed in 2011 directed the state to offer each individual the opportunity for community-based services and placement.[43]

Key Takeaways: Illinois

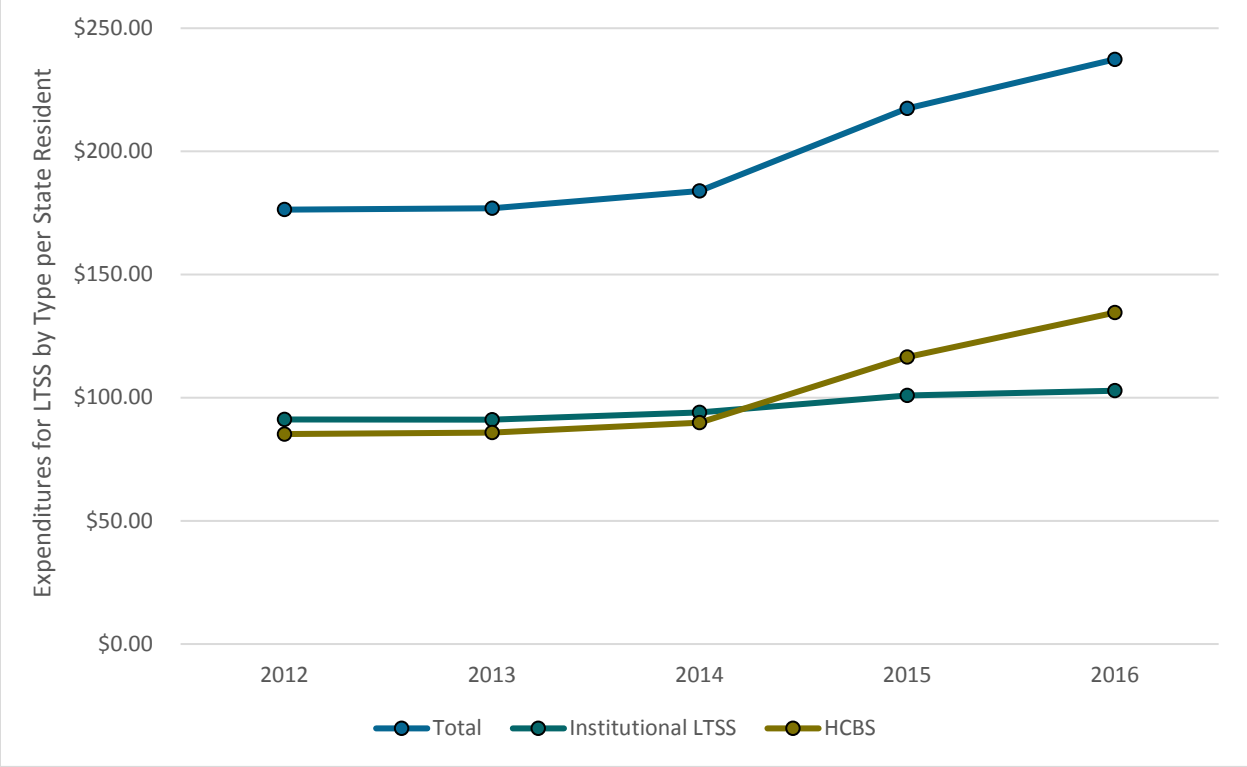
Illinois combined policy initiatives such as expanding capacity on HCBS waivers and improving access and care coordination through the use of MLTSS to support its rebalancing initiatives. The use of MLTSS may have been a contributing factor to the notable reduction in the number of individuals on its waiting list during the study period. Further, leveraging federal funding to simplify the process for identifying affordable housing for participants transitioning from institutional care to care in the community also may have played a role in the state's progress in rebalancing LTSS expenditures.

[h] Analysis of Section 1915(c) waiver applications, retrieved from www.medicaid.gov

9. Nevada

Nevada achieved a 7.9 percentage point increase in the percentage of LTSS spending for HCBS during the study period, with 56.7 percent of LTSS expenditures used for HCBS by 2016. As shown in Figure 33, Nevada's spending on institutional care and HCBS was similar from 2012 to 2014. As in other states, Nevada's institutional care remained flat through 2016, whereas HCBS spending increased sharply from 2014 to 2016, indicating a rebalancing of LTSS spending. Spending per resident was considerably lower in Nevada than in the other profiled states.

Figure 33. Nevada LTSS Spending per State Resident by Type of LTSS Program, 2012–2016



Abbreviations: HCBS, home and community-based services; LTSS, long-term services and supports.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

From 2012 to 2016, Nevada's LTSS rebalancing was characterized by an increase in HCBS expenditures (from $245 million to $395 million) and a slower rate of increase in institutional LTSS expenditures (from $257 million to $302 million), as measured in raw dollars.

The initiatives in which Nevada participated during the study period are shown in Table 11.

Table 11. Program Initiatives: Nevada

Program	Participation
Balancing Incentive Program	Yes
Money Follows the Person	Yes
Section 1915(i) state plan home and community-based services	Yes
State plan personal care services	Yes
Health homes related to long-term services and supports	No
Section 1915(c) waiver programs	Yes
Section 1115 demonstration related to home and community-based services	No
Managed long-term services and supports	No
Section 1915(j) self-directed personal care	No
Financial Alignment Demonstration	No
Section 1915(k) Community First Choice	No
Medicaid expansion	Yes

In general, Nevada spends considerably less on LTSS compared with some of the other profiled states. For example, Nevada spent just $134.53 per state resident on HCBS and $102.83 per state resident on institutional LTSS in 2016; in contrast, Massachusetts spent $727.94 per state resident on HCBS and $304.17 per state resident on institutional LTSS in 2016. Although Nevada participated in both BIP and MFP, the funding that it received was a fraction of that received by a state such as New York. For example, Nevada was awarded BIP funding of $7.7 million,[11] whereas New York was awarded $674.3 million.[11] Despite these differences in program spending, Nevada used its chosen program initiatives and policy levers to make steady progress and achieve rebalancing in its spending.

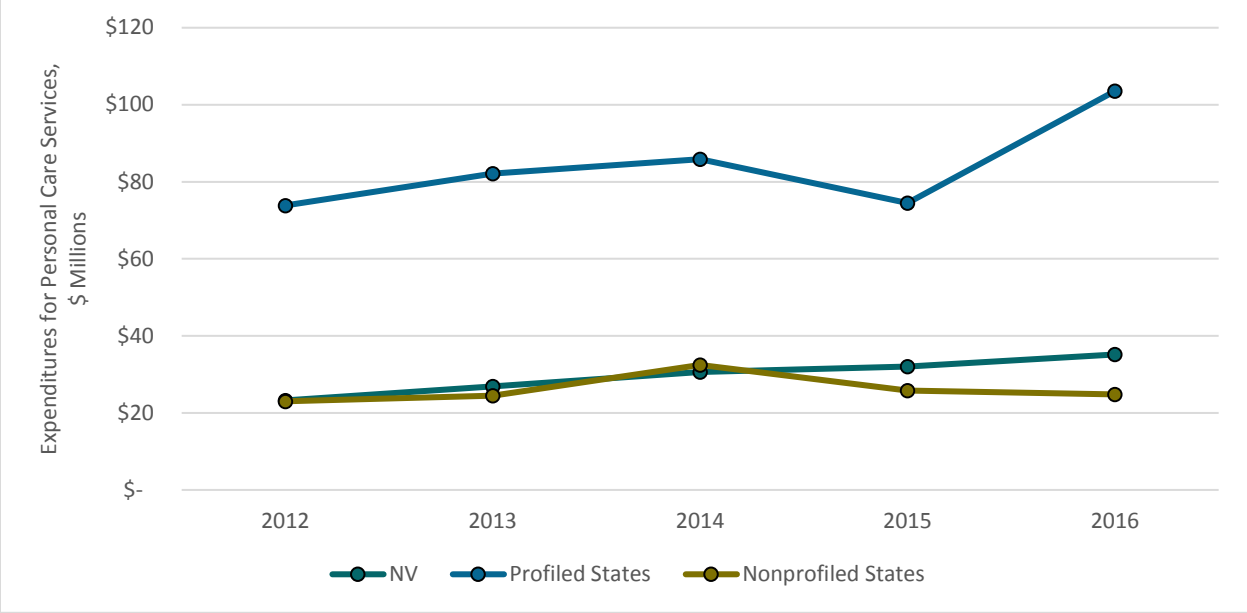
As with most other states nationally, Nevada received an MFP grant, with the initial award in April 2011. By the end of 2016, Nevada had transitioned 283 participants back to the community, including 96 older adults, 166 people with physical disabilities, and 21 participants with I/DD.[13]

Nevada began its participation in BIP later than other states, in April 2014. Its benchmark HCBS spending in 2009 was 41.6 percent, and it had increased to 47.9 percent by 2015.[11] Nevada used the enhanced FMAP to improve its LTSS system instead of increasing capacity as other states had done. For example, it implemented a media outreach campaign to advertise the availability of HCBS, automated the functional screening tools of case management system, and trained call center staff members to improve their performance answering questions.[44]

Further, Nevada supported the use of the section 1915(i) HCBS State Plan Option as early as 2007, serving participants who require assistance in performing activities of daily living, are at risk of harm and have need for supervision, and/or have functional deficits secondary to cognitive or behavioral impairments.[45] Participants using this option have access to day services such as adult day health care, habilitation services, or partial hospitalization for individuals with chronic mental illness.[45] The state's focus on participants who do not yet meet institutional level of care criteria may prevent or delay their needs from becoming greater and keep them in the community longer. This spending to help participants stay in the community may be reflected in the state's expenditure totals as LTSS rebalancing.

Nevada also saw an increase in spending focused on personal care services available through the state plan. In total, the state realized an average annual increase of 10.9 percent in personal care expenditures, as shown in Figure 34.

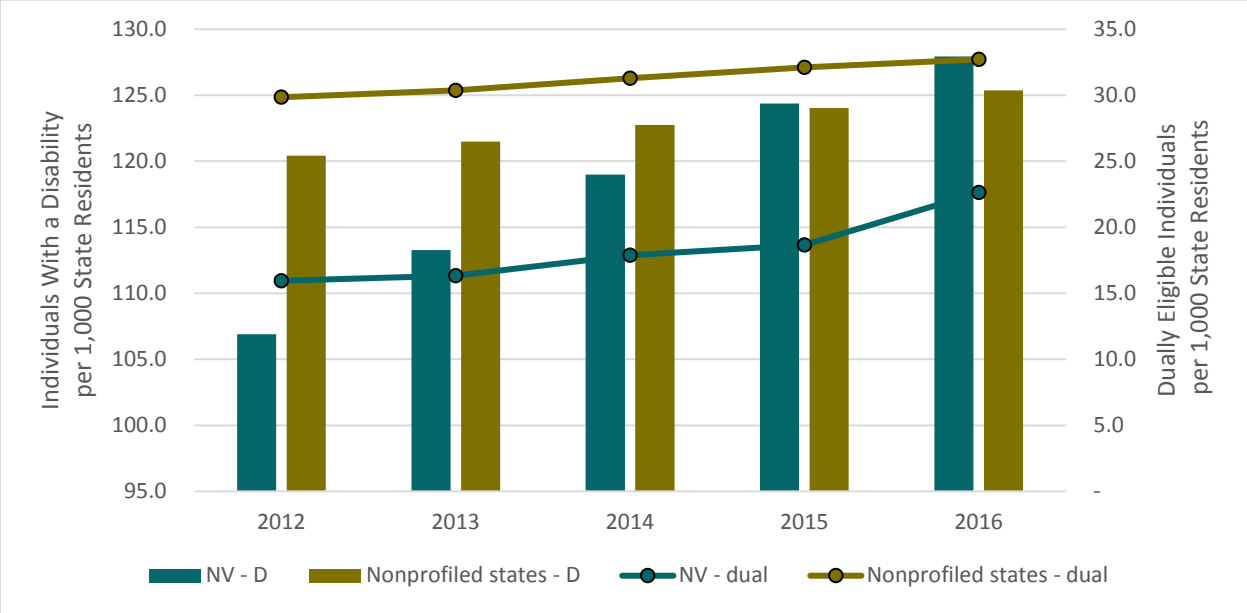
Figure 34. Personal Care Expenditures in Nevada and in Profiled and Nonprofiled States, 2012–2016



Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

Nevada has been popular a retirement destination in recent years. This may explain in part why the state has experienced rapid increases in the number of individuals with a disability, which has been growing at a rate of 4.6 percent annually, and the number of dually eligible individuals, which has been growing at a rate of 9.2 percent annually (Figure 35). Both of these rates are almost four times the national average.

Figure 35. Populations of Interest in Nevada and in Nonprofiled States, 2012–2016



Abbreviation: D, disability.

Source: Analysis of data from U. S. Census Bureau. American Community Survey. https://www.census.gov/acs/www/data/data-tables-and-tools/ and Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office. Monthly enrollment snapshots. 2018. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html

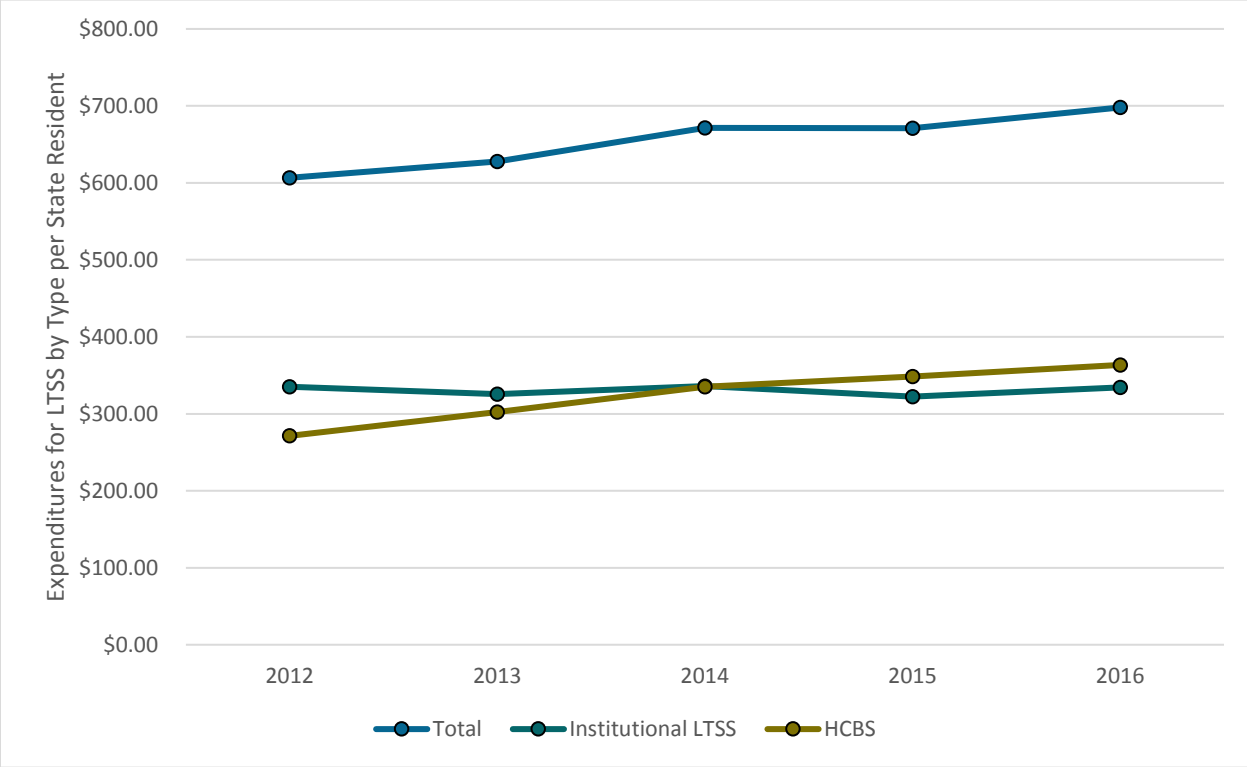
Key Takeaways: Nevada

Nevada appears to have focused on growing access to some state plan services and using the Section 1915(i) HCBS State Plan Option to support its efforts at rebalancing LTSS expenditures. Although Nevada received less enhanced federal funding than some other profiled states did, the policy levers it chose seem to have made an impact and helped Nevada achieve rebalancing.

10. Arkansas

The final state highlighted in this report is Arkansas, which achieved a 7.3 percentage point increase in HCBS expenditures as a share of LTSS spending during the study period. The state's progress was characterized by steady increases in HCBS spending, combined with mostly flat institutional spending (Figure 36). As of 2016, 52.1 percent of Arkansas' LTSS total spending went toward HCBS.

Figure 36. Arkansas LTSS Spending per State Resident by Type of LTSS Program, 2012–2016



Abbreviations: HCBS, home and community-based services; LTSS, long-term services and supports.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

Arkansas's efforts at rebalancing were characterized by a flat rate of institutional spending from 2012 to 2016 (slight increase from $990 million to $1,000 million) and an increased rate of HCBS spending during the same period (from $803 million to $1,086 million) in raw dollars.

Table 12 indicates the initiatives in which Arkansas participated during the study time frame.

Table 12. Program Initiatives: Arkansas

Program	Participation
Balancing Incentive Program	Yes
Money Follows the Person	Yes
Section 1915(i) state plan home and community-based services	No
State plan personal care services	Yes
Health homes related to long-term services and supports	No
Section 1915(c) waiver programs	Yes
Section 1115 demonstration related to home and community-based services	No
Managed long-term services and supports	No
Section 1915(j) self-directed personal care	Yes
Financial Alignment Demonstration	No
Section 1915(k) Community First Choice	No
Medicaid expansion	Yes[a]

[a] Arkansas elected to expand Medicaid through a Section 1115 demonstration waiver, which required adults eligible for the expansion to enroll in private health plans available through the Arkansas Marketplace. See Guyer J, Shine N, Musumeci M, Rudowitz R. *A Look at the Private Option in Arkansas.* Henry J. Kaiser Family Foundation; 2015. https://www.kff.org/report-section/a-look-at-the-private-option-in-arkansas-introduction/

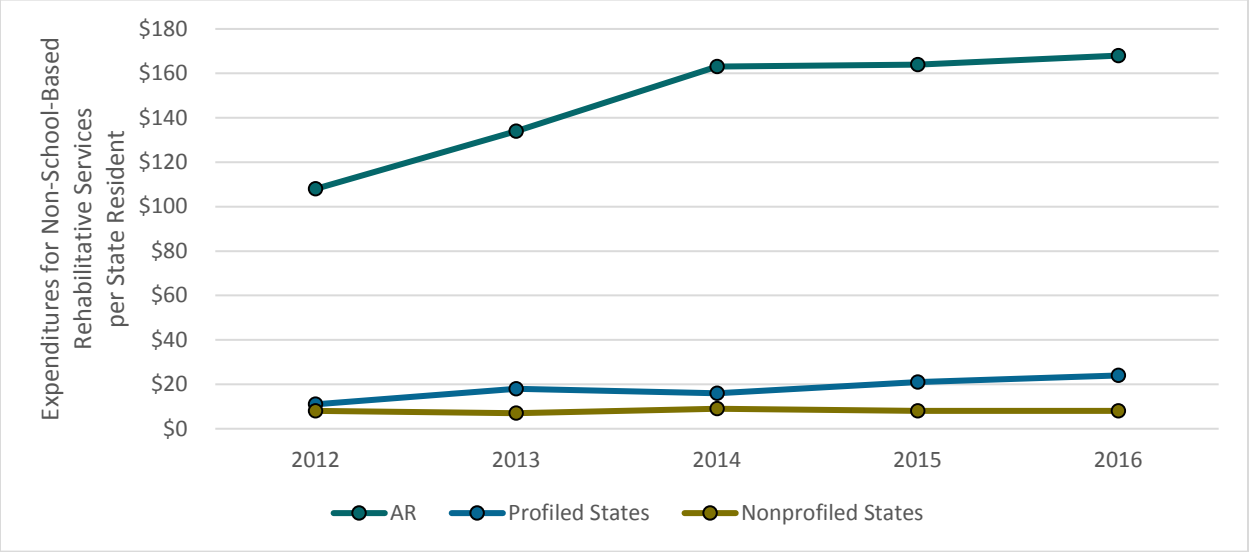
Arkansas's path to rebalancing began with the MFP grant, initially awarded in January 2007. The state had completed 899 transitions to the community by the end of 2016, with individuals with I/DD having the highest number of transitions (459), followed by people with physical disabilities (274) and older adults (165).[13]

Arkansas also participated in BIP, beginning the program in April 2013. Its benchmark for HCBS spending in 2009 was 29.8 percent, and it had nearly doubled this percentage by 2015 to 54.3 percent spending on HCBS.[11,i] The boosted FMAP funding offered through the program supported an enhanced information technology system for LTSS, improved rural access to these services, and provided new or enhanced HCBS offerings in the state.[46]

Although Medicaid expansion in Arkansas required most newly eligible adults to enroll in private health plans, Arkansas showed an increase in spending in one state plan service, specifically non-school-based rehabilitative services. Arkansas exhibited an 11.7 percent average annual increase in these services, as shown in Figure 37. Also, of all states (profiled or nonprofiled), Arkansas spent the most per state resident on these services in both 2015 and 2016.

[i] These values are slightly different from those used elsewhere, for example, Figure 36, and should not be directly compared with those values; this discrepancy is due to the differences in the methodologies used by BIP and by the Eiken et al. Annual LTSS Expenditures Reports to calculate the HCBS expenditures as a percentage of total LTSS expenditures.

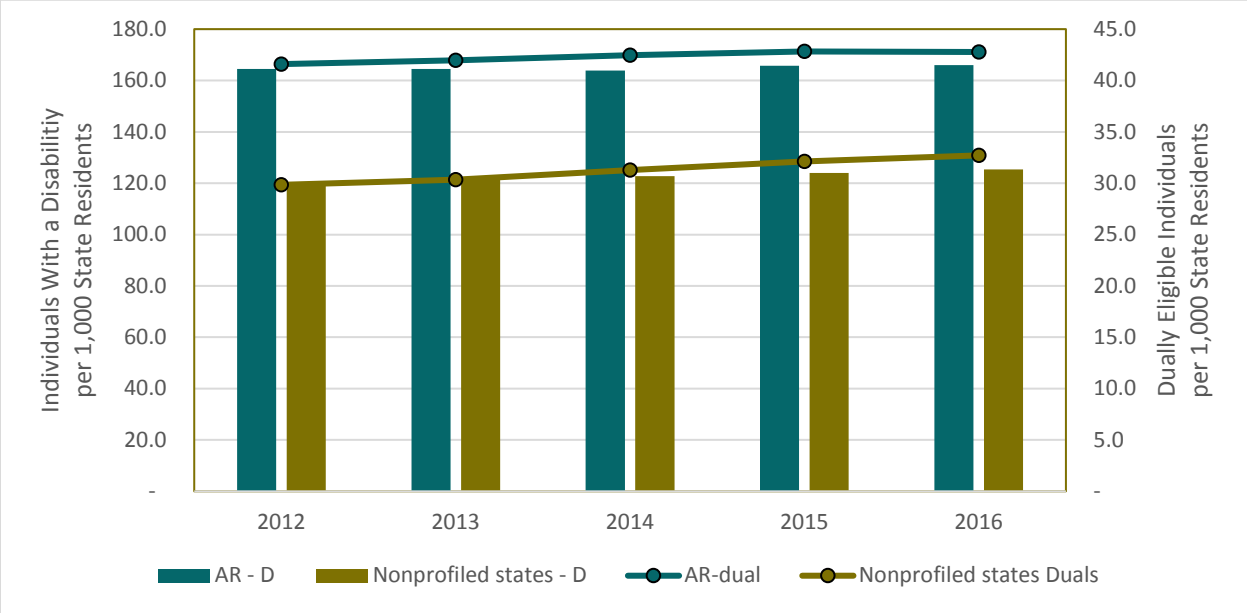
Figure 37. Rehabilitative Services Expenditures in Arkansas and in Profiled and Nonprofiled States, 2012–2016



Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

In contrast to many other profiled states, Arkansas experienced a very slow rate of growth in populations associated with LTSS (Figure 38). The number of individuals with a disability per state resident grew at an annual rate of 0.2 percent, which was the lowest of any profiled state and less than a quarter of the national average. Despite this low annual growth rate, Arkansas still had the third highest number of individuals with a disability per state resident in the nation. The number of dually eligible individuals per resident in the state grew at an annual rate of 0.7 percent, again from a high base. This annual growth rate was less than a third of the national average.

Figure 38. Populations of Interest in Arkansas and in Nonprofiled States, 2012–2016



Abbreviation: D, disability.

Source: Analysis of data from U. S. Census Bureau. American Community Survey. https://www.census.gov/acs/www/data/data-tables-and-tools/ and Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office. Monthly enrollment snapshots. 2018. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html

Key Takeaways: Arkansas

In its efforts to rebalance, the route taken by Arkansas was different from that taken by other states. Although like other states it expanded capacity and improved community transitions through federal programs that supported its initiatives, it also invested much more heavily in rehabilitative services than other states did.

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Appendix

Table A1. Medicaid HCBS Expenditures as a Share of LTSS Spending by State, Fiscal Year 2012–2016

State	%		Percentage Point Change	Rank
	2012	2016		
Mississippi	27	27	–0.4	40
Indiana	32	32	–0.2	38
Florida	35	34	–1.3	42
Louisiana	37	35	–1.4	43
New Jersey	27	39	11.7	5
Michigan	35	40	4.7	21
Hawaii	39	42	2.8	32
North Dakota	38	42	4.0	26
Alabama	41	43	1.8	37
Kentucky	37	43	6.0	18
West Virginia	48	45	–3.1	47
North Carolina	54	45	–9.3	49
Georgia	45	47	2.6	35
Oklahoma	45	47	2.5	36
South Dakota	45	48	2.7	34
New Hampshire	50	48	–2.1	46
Delaware	41	48	6.9	15
Pennsylvania	41	48	7.1	14
South Carolina	41	49	8.1	8
Illinois	41	49	8.0	10
Wyoming	50	50	–0.4	39
Iowa	43	51	7.4	12
Arkansas	45	52	7.3	13
Utah	48	53	4.3	25
Nebraska	46	53	6.3	16
Ohio	40	53	12.7	3
Connecticut	43	53	9.9	6
Tennessee	48	53	5.0	19
Maine	55	54	–1.1	41
Rhode Island	57	55	–1.6	44
Idaho	51	55	4.6	23
District of Columbia	58	56	–2.0	45
Maryland	53	56	3.6	28
United States	49	57	7.4	12
Kansas	52	57	4.7	21
Nevada	49	57	7.9	11

State	%		Percentage Point Change	Rank
	2012	2016		
Virginia	52	58	6.1	17
Montana	55	58	2.9	31
Texas	50	58	8.1	8
Missouri	44	58	14.9	1
New York	51	63	11.9	4
Alaska	69	64	–4.4	48
Colorado	58	66	8.5	7
Wisconsin	62	66	4.5	24
Washington	65	68	3.9	27
Vermont	68	70	2.8	32
Arizona	65	70	5.0	19
Massachusetts	56	71	14.1	2
Minnesota	73	76	3.1	29
New Mexico[a]	n/a	79	n/a	n/a
Oregon	78	81	2.9	30
California[b]	61	n/a	n/a	n/a

Abbreviations: HCBS, home and community-based services; LTSS, long-term services and supports; n/a, not available.

Note: States are presented in the same order as in Figure 1.

[a] New Mexico was excluded because of lack of data in 2012.

[b] California was excluded from this table because details about a high proportion of LTSS delivered through managed care were not available for California for Fiscal Year 2016.

Source: Analysis of data from Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf and Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf

Table A2. Total Institutional LTSS and HCBS Spending, $ Millions, Fiscal Year 2012–2016

State	2012		2013		2014		2015		2016	
	I-LTSS	HCBS	I-LTSS	HCBS	I-LTSS	HCBS	I-LTSS	HCBS	I-LTSS	HCBS
Alabama	999.5	691.4	972.1	708.4	1,001.7	709.8	1,022.4	743.1	1,032.7	769.9
Alaska	164.6	357.3	161.9	373.7	143.6	330.9	212.6	359.1	194.6	347.8
Arizona	553.7	1,045.3	498.5	1,074.8	485.4	1,152.9	506.9	1,170.5	517.4	1,229.5
Arkansas	989.8	802.5	964.6	895.8	998.6	994.4	957.2	1,038.0	999.6	1,086.3
California	5,293.5	8,378.1	5,437.9	9,754.5	5,596.7	10,045.7	4,484.2	9,668.0	3,874.8	11,006.8
Colorado	669.1	917.2	695.0	977.2	708.0	1,200.9	744.9	1,378.3	787.8	1,553.3
Connecticut	1,720.9	1,310.5	1,725.2	1,417.5	1,694.6	1,510.2	1,657.2	1,702.2	1,624.6	1,836.5
Delaware	265.3	183.4	297.1	194.9	298.4	217.5	307.8	250.5	293.1	268.6
District of Columbia	304.3	422.5	326.7	475.0	368.0	419.7	357.8	426.1	358.3	457.8
Florida	3,325.8	1,778.7	3,303.4	1,836.5	3,955.0	1,972.6	3,957.9	1,942.0	4,096.6	2,061.7
Georgia	1,313.5	1,057.0	1,445.2	1,198.6	1,276.8	1,160.7	1,349.8	1,209.6	1,380.6	1,234.3
Hawaii	290.8	183.6	289.2	189.6	271.2	194.1	297.0	200.6	305.8	217.0
Idaho	238.8	246.8	286.5	287.9	272.2	310.1	316.7	333.7	292.4	363.9
Illinois	2,546.1	1,795.2	2,960.2	2,112.5	2,783.5	2,149.7	2,658.9	2,222.1	2,124.4	2,077.7
Indiana	1,807.2	853.7	1,988.3	947.8	2,373.9	1,076.8	2,305.8	1,175.6	2,637.9	1,237.2
Iowa	890.2	673.5	995.3	943.7	1,027.3	1,023.0	1,028.2	1,107.9	1,055.5	1,076.4
Kansas	576.1	623.0	460.5	623.4	512.7	574.8	615.2	602.4	507.7	664.3
Kentucky	1,067.3	633.6	1,052.0	649.7	1,115.1	763.6	1,142.4	811.8	1,133.8	866.4
Louisiana	1,444.3	837.0	1,437.8	948.5	1,334.5	860.5	1,421.7	858.3	1,458.7	796.3
Maine	387.9	472.6	411.6	478.9	426.7	519.1	449.4	541.0	479.2	558.8
Maryland	1,303.3	1,444.2	1,292.5	1,478.1	1,298.0	1,651.7	1,352.5	1,743.3	1,361.8	1,748.8
Massachusetts	2,009.8	2,598.8	1,849.8	2,586.6	1,686.2	2,954.1	2,228.4	4,429.0	2,075.6	4,967.3
Michigan	1,857.2	1,013.8	1,880.3	1,037.2	1,948.0	1,045.0	1,934.6	1,305.5	1,897.7	1,266.7
Minnesota	1,074.0	2,847.2	1,030.4	2,879.4	1,046.2	3,113.1	1,054.1	3,468.2	1,174.3	3,661.2
Mississippi	1,096.5	413.4	1,123.2	420.4	1,096.5	438.3	1,099.3	523.5	1,074.2	398.2
Missouri	1,544.2	1,190.4	1,330.6	1,595.0	1,398.0	1,726.0	1,407.7	1,934.0	1,459.6	2,051.0
Montana	189.1	233.7	189.1	239.6	194.0	251.4	198.8	268.1	201.0	280.0
Nebraska	399.4	345.9	441.6	371.4	420.4	387.0	403.6	416.2	418.3	466.0
Nevada	257.3	245.1	261.6	248.9	268.5	269.7	285.9	332.8	302.2	395.4
New Hampshire	362.9	359.6	350.1	384.5	385.3	419.1	390.1	422.9	390.9	355.9
New Jersey	2,937.2	1,092.5	2,980.8	1,265.0	3,003.7	1,783.3	2,731.3	2,117.4	2,579.5	1,634.2
New Mexico	31.7	324.0	31.0	335.8	249.6	700.7	288.3	1,062.1	303.2	1,109.0
New York	11,773.6	12,161.5	10,450.5	12,448.5	9,817.3	12,856.8	10,308.8	12,576.6	9,865.7	16,588.5
North Carolina	1,921.6	2,295.6	1,500.9	1,932.1	1,368.5	1,755.0	1,343.7	1,709.8	2,022.0	1,659.0
North Dakota	304.1	184.5	312.0	194.3	338.9	230.8	337.8	247.0	351.8	252.3
Ohio	3,763.8	2,509.2	3,779.9	2,883.6	3,386.4	3,723.9	3,579.6	3,651.7	3,617.0	4,024.9
Oklahoma	679.9	550.7	745.6	577.2	771.0	594.7	766.1	631.3	722.5	648.4
Oregon	357.3	1,290.8	354.0	1,272.0	413.5	1,594.1	414.9	1,909.2	439.4	1,903.3
Pennsylvania	4,529.6	3,175.0	4,838.3	3,481.8	4,906.5	3,791.7	4,856.9	4,196.4	5,050.8	4,710.4
Rhode Island	338.0	446.4	345.8	480.7	361.1	497.6	374.0	500.3	380.6	470.4

State	2012		2013		2014		2015		2016	
	I-LTSS	HCBS	I-LTSS	HCBS	I-LTSS	HCBS	I-LTSS	HCBS	I-LTSS	HCBS
South Carolina	801.0	556.7	773.8	551.8	812.2	605.9	795.6	732.7	822.6	793.6
South Dakota	168.0	136.6	167.1	141.4	165.1	147.3	171.9	157.9	176.7	160.6
Tennessee	1,203.3	1,127.8	1,187.1	1,206.9	1,140.6	1,292.2	1,361.5	1,259.3	1,148.2	1,314.9
Texas	3,766.9	3,781.8	3,707.9	4,451.1	3,818.8	4,924.1	5,425.0	5,123.5	4,514.8	6,280.5
Utah	255.8	238.6	245.3	239.6	274.8	248.8	273.6	288.9	275.5	305.5
Vermont	118.9	246.9	117.9	254.3	123.1	270.9	123.3	278.7	123.8	293.3
Virginia	1,240.3	1,326.8	1,290.5	1,427.7	1,296.8	1,550.4	1,379.6	1,675.0	1,343.8	1,841.3
Washington	871.0	1,581.9	888.3	1,612.1	921.8	1,770.0	938.6	1,982.7	1,000.1	2,168.8
West Virginia	701.3	639.3	715.1	657.5	747.2	681.6	779.9	697.5	773.9	624.0
Wisconsin	1,126.9	1,822.9	1,159.5	1,993.7	1,113.5	2,115.6	1,105.2	2,285.4	1,107.9	2,182.4
Wyoming	130.4	131.9	135.0	133.2	134.0	132.8	136.5	131.4	142.0	141.3
United States	**71,962.7**	**69,576.5**	**71,184.4**	**74,870.1**	**71,549.2**	**80,710.7**	**73,641.2**	**85,799.1**	**72,272.7**	**94,407.7**

Abbreviations: I-LTSS, total institutional long-term services and supports; HCBS, total home and community-based services.

Source: Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2016.* Centers for Medicare & Medicaid Services; 2018. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf; Eiken S, Sredl K, Burwell B, et al. *Medicaid Expenditures for Long-Term Services and Supports in FY 2015.* Centers for Medicare & Medicaid Services; 2017. https://www.medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpendituresffy2015final.pdf.