State Long-Term Services and Supports Scorecard
What Distinguishes High- from Low-Ranking States?
Case Study: Idaho

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Introduction

The *State Long-Term Services and Supports Scorecard* found wide variation in how states perform across the 25 indicators that comprise the key dimensions of a high-performing system.[1] The *Scorecard* is designed to help states improve the performance of their long-term services and supports (LTSS) systems by targeting opportunities for improvement. Looking to other states that performed better in specific areas can inform potential paths for improvement. Leading states do well on multiple indicators, but even states with a low ranking scored in the top quartile for at least one indicator. A series of case studies provides a deeper context for understanding how high-, medium-, and low-ranking states performed for the baseline *Scorecard*, and how they are already striving to improve LTSS for older people and adults with physical disabilities. This case study focuses on Idaho.

Highlights for Idaho

Idaho scored in the upper-middle range of overall LTSS performance. As shown in table 1, Idaho had an overall rank of 19, meaning 32 states scored lower than Idaho on the overall ranking. Appendix A provides a complete summary of Idaho's ranking on each of the 25 indicators that comprise the four dimensions and yield the overall ranking.

- The biggest challenge this state faces is in the dimension of *Affordability and Access*. Idaho's lowest scores were in the functionality of its Aging and Disability Resource Center (ADRC), on which it ranked lowest in the nation at the time of *Scorecard* release, and on the reach of its basic Medicaid program to low-income people with disabilities, on which it ranked 47th. As a result, consumers may face barriers in learning about or qualifying for services.

[1] S. Reinhard, E. Kassner, A. Houser, and R. Mollica, *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers* (Washington, DC: AARP Public Policy Institute, September 2011).

- The state's biggest achievement is in allowing consumers to exercise *Choice of Setting and Provider.* This dimension measures whether consumers have a robust array of choices for where they receive services and who provides them. Ranked8th highest among the states in this dimension, Idaho excels in "balancing" the LTSS spending in its Medicaid program toward the home and community-based services (HCBS) that most consumers prefer. The state offers a broad array of services to meet the individualized needs of beneficiaries. A key factor in reducing reliance on nursing homes is the state's decades-old decision to eliminate all waiting lists for Medicaid HCBS. This decision may account for the finding that few people with comparatively low care needs are found in the state's nursing homes. Notably, Idaho has not experienced the "woodwork" effect that concerns some states—that is, the demand for the more popular HCBS has not led to spending increases, because the cost of services is so much lower than the cost of nursing home care.

  During interviews, numerous individuals noted that the strongest push to get people out of institutions was among advocates for children with disabilities and for adults with physical disabilities. Yet, unlike other states that have not broadened their system transformation, Idaho seems to have experienced a "spillover" effect, conferring these systemic changes on the older population, as well.

- Idaho also ranked in the first quartile on *Support for Family Caregivers*. One factor in this high ranking is its score on laws that allow nurses to delegate health maintenance tasks to home care workers. From a list of 16 tasks on which the National Council of State Boards of Nursing surveyed its members, Idaho allows nurses to delegate 13, including administering oral medications, to a home care worker. This practice helps family caregivers by relieving them either of the responsibility to perform these tasks or of having to pay the higher cost of a nurse to perform them.

- The *Quality of Life and Quality of Care* dimension was in the midrange overall, with select areas of very high performance. In particular, Idaho has very low rates of hospital admissions from nursing homes and home health, and the incidence of pressure sores among nursing home residents is low. These are all significant indicators of high quality. However, staff turnover in nursing homes is among the highest in the nation, with a rate nearly two-thirds higher than the national average.

Table 1: Idaho's Ranking on the *Scorecard*

Idaho and the Scorecard Dimensions	Ranking where 1 = highest	Quartile Ranking where First Quartile is the highest
Overall Ranking	19	Second Quartile
Affordability and Access	48	Fourth Quartile
Choice of Setting and Provider	8	First Quartile
Quality of Life and Quality of Care	23	Second Quartile
Support for Family Caregivers	12	First Quartile

Idaho's success in providing services in the home and community-based settings that most consumers prefer is the result of more than a decade's deliberate efforts to "balance" its Medicaid spending. In December 2003, Idaho's then-governor, Dirk Kempthorne, served as chair of the National Governors Association. He launched a national initiative called A Lifetime of Health and Dignity, designed to encourage community-based care and support family caregivers.[2] Such efforts were already under way in his state.

Yet Idaho faces a challenge in integrating the provision of services from its Medicaid program with those offered through the Commission on Aging. There are few formal linkages between these departments, which function under separate government agencies. As a result, eligibility determinations are not coordinated. This lack of integration is reflected in the state's low rank on access to services. At the time *Scorecard* data were collected, the state's ADRC consisted primarily of a website that consumers could turn to for information. However, the state intends to make concerted progress by designating the Area Agencies on Aging (AAAs) to be the local ADRCs for their regions. The goal is to provide consumers with a physical location they can visit to obtain assistance and information.

The state also has received a Money Follows the Person grant and intends to identify and transition nursing home residents who are able to return to a home or community-based setting.

Background

The *Scorecard* is the first attempt to use a multidimensional approach to comprehensively measure state LTSS system performance overall and across diverse areas of performance. It describes the goals to aim for when considering both public policies and private sector actions that affect how a state organizes, finances, and delivers services and supports for people who need ongoing help with activities of daily living (ADLs), instrumental activities of daily living (IADLs), health maintenance tasks, service coordination, and supports to their family caregivers. The *Scorecard* examines state performance across four key dimensions of LTSS system performance: (1) *Affordability and Access*; (2) *Choice of Setting and Provider*; (3) *Quality of Life and Quality of Care*; and (4) *Support for Family Caregivers*.[3]

Idaho offers an important example of a state that ranked in the upper half overall, but with mixed results across dimensions. With targeted improvements, this is a state that could be poised to move into the top quartile of performance, by building on its successes in the areas of choice, quality, and support for family caregivers.

Located in the Northwest, Idaho is geographically large, occupying a land mass greater than all of New England. But with a total population of just 1.6 million,[4] its population density is among the lowest in the nation at 19 people per square mile, compared to a national average of 87.4.[5]

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[2] National Governor's Association, *A Lifetime of Health and Dignity*, http://www.nga.org/files/live/sites/NGA/files/pdf/KEMPTHORNEINITIATIVE.pdf

[3] Adequate state-level data were not available to assess states' performance on a fifth dimension, *Effective Transitions and Organization of Care.*

[4] U.S. Census Bureau, *State and County Quick Facts,* http://quickfacts.census.gov/qfd/states/16000.html.

[5] Ibid.

Some 12.4 percent of the population was age 65 or older in 2010, just slightly below the national average of 13.0 percent.[6] The median household income of $44,926 falls below the $50,221 national median income. It also is lower than most of its neighboring states (Washington, Oregon, Nevada, Utah, and Wyoming), with only Montana having lower median income.[7] The state is slightly below the national average of people age 18–64 with an ADL disability (1.7 percent compared with 1.8 percent), and significantly lower than the national average for older people with an ADL disability (6.9 percent compared with 8.8 percent).[8]

LTSS programs are administered in two agencies. The Department of Health and Welfare (DHW) administers Medicaid state plan and waiver services, as well as mental health, substance abuse, and services to people with developmental disabilities. It also oversees the Children's Health Insurance Program and health facility licensing. The Idaho Commission on Aging (ICOA) administers federally funded programs under the Older Americans Act (OAA) through a statewide network of six AAAs. The ICOA reports to the Executive Office of the Governor.

Methodology

To better understand the context for Idaho's current *Scorecard* ranking and the state's plans for improvement, the authors conducted a site visit in February 2012. In addition to document reviews, data collection included participant observations and interviews. One researcher observed a focus group comprised of assisted living providers.

Interviews with multiple stakeholders included the following:

- State officials in ICOA, DHW, and the Governor's office
- LTSS providers, including home care, assisted living, and nursing home sectors
- Consumer, nonprofit, and academic stakeholders, including staff from AARP Idaho, Friends in Action, and researchers at the Center for the Study of Aging at Boise State University

Through these methods, we focused on factors that affect Idaho's performance in each of the *Scorecard's* four dimensions, with priority attention to selected indicators in the top and bottom quartiles. We also explored current or planned activities that might lead to improvement.

Current Status and Future Potential for Progress

Affordability and Access

The dimension of *Affordability and Access* measures the extent to which individuals and their families can easily navigate their state's LTSS system, finding readily available, timely, and clear information to make decisions about LTSS. In a high-performing system, services are affordable for those with moderate and higher incomes, and a safety net is available for those

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[6] Ibid.
[7] AARP Public Policy Institute analysis of 2009 American Community Survey, Public Use Microdata Sample.
[8] All data are found in the *Scorecard* exhibits 15–17. http://www.longtermscorecard.org.

who cannot afford services. Eligibility is determined easily and quickly, and the costs of LTSS do not impoverish the spouse of the person needing LTSS.

This dimension poses the greatest challenge to Idaho, particularly on the measures of access to services. The state's low rank of 48 is pulled down by two very low scores: the reach of the state's Medicaid program to low-income people with disabilities (ranked 47th) and the functionality of the state's ADRC system (ranked last in the nation). Numerous stakeholders noted that the state does not place a high value on conducting outreach to inform people about services for which they might be eligible.

State officials and others interviewed cited two reasons why the state ranked low on general Medicaid coverage to low-income people with disabilities, but much higher on the reach of the state's Medicaid LTSS services to this population (ranked 17th). First, Medicaid eligibility for the aged, blind, and disabled population is restrictive: To qualify, individuals may have income no higher than the federal Supplemental Security Income (SSI) level ($698 per month for an individual in 2012). While Idaho uses a conservative Medicaid eligibility standard, it is not overly restrictive compared with other states.[9] However, Idaho is one of 17 states that do not have a "medically needy" program that allows access to Medicaid by people with high medical expenses.[10] Second, informants reported that the culture of Idaho values self-reliance, and attempting to maximize government benefits was not considered an Idaho tradition.

Once an individual has a level of disability sufficient to qualify for LTSS, the state's income eligibility criteria are substantially more generous. People may qualify for Medicaid nursing home or waiver services with incomes up to 300 percent of the SSI benefit rate. In a state like Idaho where incomes are comparatively low, a higher proportion of the population will be able to access LTSS services compared with other states in which income levels are higher.

Several factors explain the state's low rank on its ADRC system. Idaho piloted an ADRC in the northern part of the state in 2006, after receiving a federal grant; however, when the funds expired in 2008, the project was not continued. The state turned to a "virtual" ADRC system when it established a website designed to provide information about LTSS to the state's residents. Although the state intended to complement the web-based ADRC with staff in each of the state's AAAs who would be designated to perform ADRC functions, funding for such positions was never approved. The state does have a 211 Care Line that directs callers to the AAAs, but staff do not perform all the functions of more robust ADRCs, such as determining functional and financial eligibility for all available LTSS services. Moreover, state staff interviewed said they thought a virtual system made sense in a state with a large rural population. Thus, the information and referral website is called an ADRC, but does not provide all of the functions of a more fully functioning ADRC, such as planning and service coordination or eligibility tracking.

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[9] In 2009, for people who were aged, blind, or had a disability, the monthly income required to qualify for Medicaid in Idaho was $707. In terms of the federal poverty level (FPL), Idaho was one of nine states that used a Medicaid financial eligibility level equal to 76 to 99 percent of the FPL Twenty-four states used a lower standard equal to 75 percent of the FPL, and 18 states used a higher standard. See Kaiser Commission, *Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities* (Washington, DC, February 2010) http://www.kff.org/medicaid/upload/8048.pdf.

[10] Ibid, table 2.

In states with higher-ranked ADRCs, an individual can make one contact and arrange to be assessed for eligibility for the full range of services offered in the state—be they Medicaid, Older Americans Act, or state-funded. The ADRC may perform financial eligibility tests and arrange for functional eligibility determination, as well as provide counseling about alternatives to nursing homes and other services. Not only does Idaho lack these functions; given the comparatively low use of the Internet by people age 65 or older[11] (the population most likely to need LTSS), it is questionable whether a web-based system is an effective way to serve this population.

When interviewed, staff responsible for the ADRC program reported that they were planning to expand ADRC activities in the state's AAAs. The goal is to provide consumers with a physical location they can visit within their region to obtain assistance and information.

Stakeholders interviewed in Idaho repeatedly acknowledged that there is little overlap between the functions of the ICOA and the Medicaid department. One exception is the state's Money Follows the Person/ADRC supplemental grant, which features a collaborative relationship among Medicaid staff in the Department of Health and Welfare and Idaho Commission on Aging staff, as well as the State Independent Living Council. Moreover, there has been turnover in the leadership at the ICOA, and stakeholders expressed hope that services will improve under new leadership. The state could work on better interagency coordination to develop a more seamless system for consumers. Without better coordination between agencies, an individual may have to visit several different offices to determine the services for which he or she may qualify.

Choice of Setting and Provider

For well over a decade, the Idaho Medicaid program has emphasized the development of HCBS alternatives for people with disabilities. Multiple stakeholders described Idaho as a western "frontier" state in which independence is of paramount importance to its residents. This frontier culture is credited with the impetus for Idaho's movement toward balancing its Medicaid LTSS system toward HCBS. The state also recognized that the cost of providing HCBS was less than the cost of maintaining an individual in a nursing home and made a policy decision more than a decade ago that it would not maintain waiting lists for HCBS waiver services.

The state's refusal to place eligible individuals on a waiting list for HCBS is a significant public policy decision. State officials interviewed called this "the right policy to have." They said that it was not logical to have a system that would pay for more expensive nursing home services and *not* pay for HCBS. These policy choices are a major factor in Idaho's first quartile rankings in three key indicators of choice:

- Percentage of Medicaid and state-funded LTSS spending going to HCBS for older people and adults with physical disabilities (2009)—ranked 11th

[11] According to research by the Pew Internet Project, Internet use by people age 65+ in 2009 was just over half that of all people age 18+ (38 percent compared with 74 percent). http://www.pewinternet.org/Infographics/2010/Internet-acess-by-age-group-over-time.aspx.

- Percentage of new Medicaid LTSS users first receiving services in the community (2007)—ranked 8th
- Percentage of nursing home residents with low care needs (2007)—ranked 7th

As noted above, Idaho scored well on the percentage of new Medicaid users first receiving services in the community. Idaho Medicaid staff attributed this to efficient work by state field offices. The Division of Welfare processes all applications for Medicaid. Applications by people who may need LTSS are all processed by one field office in Lewiston. If a person appears to meet Medicaid's functional eligibility criteria for LTSS, the Lewiston office sends a form to one of the seven field offices run by the long-term care unit. A nurse reviewer from one of the offices then goes out and meets with the person to assess LTSS needs. This is an efficient process and results in two-thirds of all new Medicaid LTSS users getting HCBS as their first Medicaid service.

Some states have feared that making HCBS as readily available as nursing homes would result in a "woodwork" effect; that is, if people could obtain the more desirable HCBS, even those who would refuse nursing home placement would come forward to claim HCBS. But Idaho has been able to control its Medicaid LTSS spending, even as the older population has grown.[12] The nursing home population has declined[13] while the number of people served through HCBS has grown. In fact, the nursing home occupancy rate in Idaho, at 78 percent, is below the national average of 83 percent.[14] Data provided by DHW show the Medicaid HCBS cost per person (for both waiver and nonwaiver services among the aged and disabled population) in 2009 at $20,045 per year. By comparison, the annual Medicaid nursing home cost for this population is twice as high, $40,660.[15]

Another factor that has stymied attempts to balance Medicaid spending toward HCBS in other states is resistance by nursing home providers, who hold great influence over state legislators in some states. Stakeholders noted that opposition by nursing home providers was not a major factor impeding Idaho's movement away from institutional services. The basic decision to emphasize HCBS was made 15 years ago, and the industry fought it at that time but lost, said one person interviewed. One possible explanation for the relative satisfaction of nursing home providers in Idaho is that the Medicaid reimbursement rate for nursing homes is above the national average ($194 per day in Idaho, compared with $178 per day nationally), and fairly close to private-pay rates, which are near the average ($214 per day in Idaho, compared with $213 nationally).[16] The American Health Care Association publishes an annual report showing the shortfalls between nursing home costs and what nursing homes are paid by Medicaid. In 2008, Idaho was the only state whose homes were reported to have been paid more than their

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[12] Idaho's population age 65+ grew by 60 percent between 1990 and 2010. PPI calculation based on U.S. Census data from Lisa Hetzel and Annetta Smith, *The 65 Years and Over Population: 2000* (October 2001), and Lindsay M. Howden and Julie A. Meyer, *Age and Sex Composition: 2010* (May 2011).

[13] American Health Care Association, http://www.ahcancal.org/research_data/oscar_data/NursingFacilityPatientCharacteristics/Forms/AllItems.aspx.

[14] Comparative data on nursing facilities are available from the Research Department of the American Health Care Association. See data for December 2011, http://www.ahcancal.org/research_data/oscar_data/Pages/default.aspx.

[15] Information obtained from State of Idaho staff on February 9, 2012.

[16] AARP, *Across the States*, *2012* (Washington, DC, forthcoming).

average cost per day.[17] It is possible that higher reimbursement rates are needed because those who remain in the state's nursing homes are likely to have higher than average acuity levels.

Idaho also has a large supply of assisted living and residential care units (ranked 3rd). Idaho has encouraged two residential models. First, as of January 2012 there were about 348 assisted living facilities in Idaho, with 8,839 licensed beds.[18] These facilities range in size from 6 to 148 beds. Like other states that have strong residential programs (such as Oregon and Washington), Idaho has supported this industry by providing Medicaid reimbursement for eligible residents. In Idaho, about 39 percent of the people in assisted living residences are paid for by Medicaid.[19] This is nearly double the national rate of 19 percent.[20] Perhaps in recognition of the changing mode of service delivery, the Idaho nursing home and assisted living associations merged in 2007 to work together on issues of common concern, a trend that also is observed in other states.

As of January 2012, Idaho also has developed approximately 2,200 Certified Family Homes. A fraction of the homes are for older people and adults with a physical disability; most are for people with intellectual and/or developmental disabilities, who would otherwise be in intermediate care facilities for people with developmental disabilities. Some 80 percent of these homes consist of people providing services to family members. These Certified Family Homes provide a family-style living environment for adults who need some assistance with ADLs but do not require a more restrictive institutional setting. Usually there are one or two adult residents, each of whom has a care plan designed to meet his or her individual needs. The homes are licensed by the state; in January 2011, approximately 3,200 people were living in these homes.[21]

In addition to residential programs, Idaho currently provides LTSS to people using 1915(c) Medicaid waivers. Idaho has one waiver for people who are older than 65 years of age or who have physical disabilities, known as the AD (aging and disability) waiver. From October 1, 2008, to September 30, 2009, 8,863 unique individuals received services through this AD waiver.

Appendix B contains waiver statistics for the period referenced above. The statistics show that, among the two waivers, 28 services were offered to 11,379 people. While 8 services were used by more than 1,000 people each, the other 20 services were used by fewer than 1,000 people. Indeed, 13 services were used by fewer than 100 people each. What this implies is that Idaho has found a way of individualizing services for people with particular conditions. The breadth of services and the state's ability to target them is a notable strength of the HCBS program.

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[17] Eljay, LLC, *A Report on Shortfalls in Medicaid Funding for Nursing Home Care*, A Report Prepared for the American Health Care Association (Washington, DC, December 2010), table 1, http://www.ahcancal.org/research_data/funding/Pages/default.aspx

[18] Information obtained from Idaho staffs, January 2012. See also Idaho Department of Health and Welfare, *Facts Figures Trends 2010-2011* (Boise, January 2011), p. 26, http://www.healthandwelfare.idaho.gov/LinkClick.aspx?fileticket=6skMs2-Ksgk%3D&tabid=1127.

[19] Idaho Department of Health and Welfare, *Facts Figures Trends 2010-2011.*

[20] C. Caffrey, M. Sengupta, E. Park-Lee, A. Moss, E. Rosenoff, and L. Harris-Kojetin, *Residents Living in Residential Care Facilities: United States, 2010*, NCHS Data Brief No. 91 (April 2012), http://www.cdc.gov/nchs/data/databriefs/db91.pdf.

[21] Idaho Department of Health and Welfare, *Facts Figures Trends 2010-2011*, p. 27.

Another factor in Idaho's strong ranking on the choice dimension was noted in interviews. Numerous informants stated that advocacy among parents of children with intellectual disabilities is strong in the state and was a major force in moving away from an institutional model of service delivery. According to one individual, in a small state like Idaho, it is relatively easy for advocates to get the attention of their state legislators. However, in some states, strong advocacy to transform LTSS delivery for people with intellectual disabilities has not translated to system improvements for the older population. For example, in New Hampshire, a state that has virtually eliminated institutional services for people with intellectual disabilities, the *Scorecard* found that only 20.3 percent of the state's Medicaid LTSS spending for older people and adults with physical disabilities goes to HCBS. Thus, New Hampshire ranked 43rd on this indicator.[22] In Idaho, however, it appears that there was a "spillover" effect: These policy improvements were conferred on the older population as well, despite what appears to be limited advocacy on behalf of older people for LTSS issues.

Despite Idaho's many strengths, people interviewed did not cite a written vision or philosophy codified in statute or regulation that guides the state's mission in providing LTSS. The vision appears to be a shared understanding among state policymakers, developed through 15 years of work on LTSS programs. However, the Idaho Administrative Code describes Medicaid HCBS waiver services as follows:

> Idaho's elderly and physically disabled citizens should be able to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective home-like setting. When possible, services should be available in the consumer's own home and community regardless of their age, income, or ability and should encourage the involvement of natural supports, such as family, friends, neighbors, volunteers, church, and others.[23]

Idaho ranked in the fourth quartile (41) on the indicator "tools and programs to facilitate consumer choice." The state received this low score because it does not use "presumptive eligibility" to speed up access to HCBS; at the time the *Scorecard* was developed, it did not have a federal Money Follows the Person (MFP) grant to transition people out of nursing homes, and it did not provide "options counseling" to help people access alternatives to nursing homes. To improve, Idaho could consider using these tools. Since the *Scorecard*'s publication, Idaho has applied for and received an MFP grant, an indication that it hopes to continue moving toward greater choice for its LTSS population.

Idaho's MFP program has modest goals in terms of the number of people it anticipates transitioning from institutions: 325 people over the six-year period from 2011 through 2016.[24] In explaining why this goal is appropriate, state staff point out that acuity is high in Idaho nursing

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[22] It is worth noting that on March 2, 2012, the Centers for Medicare & Medicaid Services announced that New Hampshire was approved as the first state to receive federal funds to implement the Balancing Incentive Payment Program, an initiative that gives financial incentives to qualifying states to help them achieve better balance in their Medicaid LTSS program toward HCBS. See http://www.cms.gov/apps/media/press/release.asp?Counter=4296.

[23] Idaho Administrative Code IDAPA 16.03.10, Department of Health and Welfare Medicaid Enhanced Plan Benefits, http://adminrules.idaho.gov/rules/current/16/0310.pdf.

[24] Information obtained from state staff on February 9, 2012.

homes. They contend that, after years of emphasizing HCBS, Idaho already has diverted most people who, in other states, would be candidates for nursing home transition programs.

Quality of Life and Quality of Care

While Idaho scored right around the midpoint on the quality dimension (23rd), many of the indicators that comprise this dimension were either very high or very low, indicating areas of both success and challenge. Among Idaho's strengths were high rankings for having relatively low rates of hospital admissions from both nursing homes (ranked 8th) and home health (ranked 5th). Nursing home residents in Idaho also have a low incidence of pressure sores (ranked 9th)—an indicator of high-quality care.

Regarding hospital admission rates, two people interviewed pointed to the effective tools provided by Qualis, the quality improvement organization operating in Idaho and neighboring Washington, which also ranked in the first quartile on low rates of hospital admissions. Qualis was said to provide clear materials in a simple and easily understood format, helping both professionals and laypeople identify indicators that can lead to a hospital admission. An examination of the materials confirmed these comments. An emphasis on self-management of chronic disease also was noted. In addition, both state and industry staff interviewed said that the nursing home surveyors in Idaho are exceptionally vigilant, strictly enforcing federal requirements.

However, one area of low performance was the percentage of high-risk home health patients who have a plan of care to prevent pressure sores (ranked 44th). A home health provider suggested that this result could be due to changes in the way these questions were asked when the OASIS C survey was implemented. Training on OASIS C has not been offered in Idaho and, thus, staff members who have been trained on it had to travel out of state. It was suggested that providers in the more rural parts of the state may not have been trained in interpreting OASIS C questions.

Another quality indicator on which Idaho ranked low (45th) was on staff turnover in nursing homes. At an annual rate of 72 percent, Idaho's turnover rate was nearly two-thirds higher than the national median of 47 percent. Stakeholders varied in their thoughts about this high turnover rate. Some suggested that low wages and few benefits were a factor; others suggested that the zealousness of the survey process was demoralizing for workers. Informants also noted that the data were from 2008 and that turnover was likely to have decreased as the economy suffered, although this factor is likely to have affected most states.

Although continuity of care is often considered an important factor in quality, quality measures in Idaho's nursing homes do not appear to have suffered. One factor may be the generally high staffing levels. For example, Idaho nursing homes reported providing 4.30 hours of direct care per patient day compared with the national average of 3.66 hours; 0.56 hours a day of care by registered nurses compared with the national average of 0.44 hours; and 2.92 hours a day of care by aides compared with the national average of 2.42 hours.[25] Even though Idaho nursing home

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[25] Comparative data on nursing facilities are available from the Research Department of the American Health Care Association, http://www.ahcancal.org/research_data/oscar_data/Pages/default.aspx.

residents exhibit higher than average levels of ADL dependency (4.16 compared with a national average of 4.08), quality remains high.[26]

One reason cited for the high staff hours is that when the state has to make Medicaid cuts, it spares the direct-care staff who provide hands-on services to residents and instead cuts other parts of nursing home reimbursement. This is an understandable reimbursement policy, since it emphasizes direct care to residents and makes cuts in administration, operating expenses, or indirect care areas.

Support for Family Caregivers

Although Idaho ranked in the first quartile on the caregiving dimension, its score is composed of both high and low ranks. One high rank is on the state's policies for allowing nurses to delegate health maintenance tasks to home care workers. From a list of 16 tasks, nurses are allowed to delegate 13, including administering oral medications, to home care workers.[27] Idaho also ranked very high (6th) on the percentage of caregivers who say they usually or always get needed support. Some stakeholders regarded this finding with skepticism. They suggested that people are simply unaware that there might be programs to help them in their role as family caregivers. Many stakeholders noted that there is a pervasive view in the state that family members *should* be the ones to provide care, rather than turning to the government for help. They posit that low expectations could lead to this high rank. It also is possible that large families and strong social networks help provide support to family caregivers.

However, informants noted that there is a great need for programs and services to support family caregivers in Idaho. In fact, on the indicator "legal and system supports for family caregivers," Idaho ranked at the bottom of the third quartile (36th). While few states have enacted laws that protect caregivers from employment discrimination or mandate paid family or sick leave, 35 states scored higher than Idaho on other components of this indicator. For example, the level of financial protection that Idaho provides to the spouses of Medicaid beneficiaries who receive HCBS waiver services is limited. In addition, while the needs of caregivers are assessed, there are few services that help them. Moreover, it was suggested that the tool used to assess caregivers is the same assessment instrument used to determine Medicaid eligibility for the person who receives services and may not adequately identify the needs of caregivers.

While the state pays for caregiver respite services through both its Medicaid program and the National Family Caregiver Support Program administered through the ICOA, state officials in both agencies noted that few people take advantage of it. It is unclear whether this is because, as some suggested, families don't want a "stranger" coming into their loved one's home, or because the state does not actively promote these services. While state spending for respite services was not measured in the *Scorecard*, it is an area in which better coordination between Medicaid and ICOA services would enhance the ability of caregivers to learn about services that are available to help them.

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[26] Ibid.

[27] From the list of 16 tasks in the survey, nurses in Idaho may not delegate those that involve injections (via prefilled insulin or insulin pen, drawing up insulin for dosage measurement, or administering intramuscular injection medications).

Summary and Conclusions

Idaho's most notable policy achievement in the area of LTSS is its effectiveness in balancing services toward the HCBS that most consumers prefer. Its percentage of spending on Medicaid HCBS exceeds the national mean by nearly 50 percent (44 percent compared with 30 percent), and more than two-thirds of new Medicaid users (68 percent) receive services first in HCBS settings, compared with 50 percent nationally. Through advocacy by the parents of children with intellectual disabilities, the state has effectively ended its institutional bias by eliminating waiting lists for HCBS for people of all ages and disabilities. This is a direction that other states could learn from. It has not led to an unmanageable "woodwork effect" as many states fear. Rather, the substantially lower cost of HCBS compared to nursing homes allows Idaho to serve more people at lower cost.

However, the state has significant challenges in building a more seamless and accessible system for consumers of all income levels and types of disabilities. While a predominantly rural state with low population density may face difficult challenges in establishing an effective ADRC, others have done so. For example, South Dakota and Montana scored 16th and 25th, respectively, on their ADRC function. This is an area of challenge for Idaho, and one that state officials said they intend to address.

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Appendix A

Idaho's Ranking on Each of the 25 indicators

Dimension and Indicator	Year	State Rate	All States Median	Top 5 States Average	Best State Rate	Rank
Affordability and Access						**48**
Median annual cost for private-pay nursing home resident, as percentage of median household income, age 65	2010	231	224	171	166	30
Median annual cost for private-pay home care, as percentage of median household income, age 65	2010	87	89	69	55	18
Private long-term care insurance policies in effect per 1,000 population, age 40	2009	36	41	150	300	33
Percentage of low-income adults at or below 250% of poverty level with ADL disability and enrolled in Medicaid or other public health insurance, age 21	2008-09	44.3	49.9	62.2	63.6	47
Medicaid LTSS participant years per 100 adults with ADL disability in nursing homes or living in the community at or below 250% of poverty level, age 21	2007	40.3	36.1	63.4	74.6	17
Ability to access LTSS system through ADRC or other single entry point (composite indicator, rated on 0–12 scale)	2010	1	7.7	10.5	11	51

Dimension and Indicator	Year	State Rate	All States	Top 5 States	Best State Rate	Rank
			Median	Average		
Choice of Setting and Provider						**8**
Percentage of Medicaid and state-funded LTSS spending going to home- and community-based services for older people and adults with physical disabilities	2009	43.8	29.7	59.9	63.9	11
Percentage of new Medicaid LTSS users first receiving services in the community	2007	67.5	49.9	77.1	83.3	8
Number of people with disabilities directing own services, per 1,000 adults age 18	2010	7	8	69.4	142.7	30
Tools and programs to facilitate consumer choice (composite indicator, rated on 0–4 scale)	2010	1	2.75	3.79	4	41
Home health and personal care aides per 1,000 population age 65	2009	37	34	88	108	21
Assisted living and residential care units per 1,000 population age 65	2010	62	29	64	80	3
Percentage of nursing home residents with low care needs	2007	7.8	11.9	5.4	1.3	7

Dimension and Indicator	Year	State Rate	All States	Top 5 States	Best State Rate	Rank
			Median	Average		
Quality of Life and Quality of Care						**23**
Percentage of adults age 18 with disabilities living in the community who usually or always get needed support	2009	70.2	68.5	75.5	78.2	22
Percentage of adults age 18 with disabilities living in the community who are satisfied or very satisfied with life	2009	85.4	85	90.9	92.4	23
Rate of employment for adults with ADL disability relative to rate of employment for adults without ADL disability, ages 18–64	2008-2009	21.7	24.2	42.4	56.6	42
Percentage of high-risk nursing home residents with pressure sores	2008	8.7	11.1	7.2	6.6	9
Percentage of long-stay nursing home residents who were physically restrained	2008	3.5	3.3	1.3	0.9	27
Nursing home staffing turnover: ratio of employee terminations to average number of active employees	2008	72.4	46.9	27.2	18.7	45
Percentage of long-stay nursing home residents with hospital admission	2008	12.7	18.9	10.4	8.3	8
Percentage of home health episodes of care in which interventions to prevent pressure sores were included in care plan for at-risk patients	2010	85	90	95	97	44
Percentage of home health patients with hospital admission	2008	24.2	29	23.2	21.8	5

Dimension and Indicator	Year	State Rate	All States	Top 5 States	Best State Rate	Rank
			Median	Average		
Support for Family Caregivers						**12**
Percentage of caregivers who usually or always get needed support	2009	81.4	78.2	82.2	84	6
Legal and system supports for caregivers (composite indicator, rated on 0–12 scale)	2010	2.4	3.17	5.9	6.43	36
Number of health maintenance tasks able to be delegated to LTSS workers	2011	13	7.5	16	16	13

See *Scorecard* website for Idaho at
http://www.longtermscorecard.org/DataByState/State.aspx?state=ID.

Appendix B

Idaho Aged/Disabled and Developmental Disability Waivers Statistics

10/1/2008–9/30/2009 A&D + DD Waiver Statistics							
Service Name	**Waiver Where Service Offered**	**# of Participants**	**% of Participants**	**Costs**	**% of Costs**	**Cost per Person on Waivers**	**Cost Per User of Service**
Adult Day Care	**Both**	1,235	11%	$2,574,929	2%	$226.29	$2,085
Medical Equipment/Supplies	**Both**	168	1%	$94,547	0%	$8.31	$563
Transportation	**Both**	1,274	11%	$547,414	0%	$48.11	$430
Attendant Care	**A&D Only**	4,368	38%	$44,048,814	26%	$3,871.06	$10,084
Chore Services	**Both**	306	3%	$112,089	0%	$9.85	$366
Companion Services	**A&D Only**	106	1%	$253,116	0%	$22.24	$2,388
Consultation	**A&D Only**	2,368	21%	$65,094	0%	$5.72	$27
Homemaker	**A&D Only**	25	0%	$47,951	0%	$4.21	$1,918
Residential Habilitation	**Both**	2,316	20%	$69,841,638	42%	$6,137.77	$30,156
Day Habilitation	**A&D Only**	2	0%	$30,520	0%	$2.68	$15,260
Home-Delivered Meals	**Both**	2,481	22%	$3,330,382	2%	$292.68	$1,342
Environmental Access. Adaptations	**Both**	36	0%	$140,947	0%	$12.39	$3,915
In-Home Respite	**Both**	91	1%	$215,734	0%	$18.96	$2,371
Nursing Services	**Both**	3,315	29%	$1,568,816	1%	$137.87	$473
Case Mgmt.	**A&D Only**	1,133	10%	$637,649	0%	$56.04	$563
Personal Emergency Response System	**Both**	2,129	19%	$642,245	0%	$56.44	$302
Adult Residential Care	**A&D Only**	3,778	33%	$39,033,595	23%	$3,430.32	$10,332
Supported Employment	**Both but only used on DD**	294	3%	$1,630,751	1%	$143.31	$5,547

10/1/2008–9/30/2009 A&D + DD Waiver Statistics							
Service Name	**Waiver Where Service Offered**	**# of Participants**	**% of Participants**	**Costs**	**% of Costs**	**Cost per Person on Waivers**	**Cost Per User of Service**
Behavior Consultation/ Crisis Management	**DD Only**	151	1%	$516,384	0%	$45.38	$3,420
Community Support—Emotional Support	**DD Only**	18	0%	$114,341	0%	$10.05	$6,352
Community Support—Job Support	**DD Only**	22	0%	$68,840	0%	$6.05	$3,129
Community Support—Learning Support	**DD Only**	41	0%	$203,575	0%	$17.89	$4,965
Community Support—Personal Support	**DD Only**	78	1%	$1,384,901	1%	$121.71	$17,755
Community Support—Relationship Support	**DD Only**	38	0%	$103,849	0%	$9.13	$2,733
Community Support—Skilled Nursing Support		4	0%	$2,117	0%	$0.19	$529
Supports Brokerage	**DD Only**	81	1%	$49,734	0%	$4.37	$614
Community Support—Transportation	**DD Only**	37	0%	$61,085	0%	$5.37	$1,651
Community Support—Adaptive Equipment	**DD Only**	20	0%	$37,417	0%	$3.29	$1,871
Waiver Service Totals	**Combined**	11,379	100%	$167,358,474	100%	$14,708	$14,708