# State Long-Term Services and Supports Scorecard
# What Distinguishes High- from Low-Ranking States?
# Overview of Three Case Studies

**Susan Reinhard, Enid Kassner, Leslie Hendrickson, and Robert Mollica**
**May 2012**

## Introduction

The *State Long-Term Services and Supports Scorecard* ranked states on 25 indicators that comprise the key dimensions of a high-performing system.[1] The *Scorecard* is designed to help states raise the performance of their long-term services and supports (LTSS) systems by targeting opportunities for improvement. While the *Scorecard* started a discussion about state LTSS performance, it did not explain *why* states ranked high, low, or somewhere in between. Therefore, the AARP Public Policy Institute, with support from The Commonwealth Fund and The SCAN Foundation, undertook a series of case studies to provide a deeper context for understanding state performance for the baseline *Scorecard*. This paper presents an overview of the findings from the case studies.

We studied three states to learn more about the factors that distinguish a high-ranking from a low-ranking state. We conducted site visits to the top-ranked state (Minnesota) and to a middle-ranked state (Idaho, ranked 19th) and a low-ranked state (Georgia, ranked 42nd). While three states were intentionally selected to examine the differences among them, the characteristics of one state do not necessarily pertain to those of other, similarly ranked states. For example, two states may have similar ranks, yet achieve them in quite different ways. Figure 1 illustrates the different dimension ranks achieved by North Dakota (ranked 18th overall) and Idaho (ranked 19th overall).

[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).

**Figure 1: Dimension Ranks for North Dakota and Idaho**

| State | Affordability and Access | Choice | Quality | Support for Caregivers |
|---|---|---|---|---|
| North Dakota | 29 | 41 | 2 | 16 |
| Idaho | 48 | 8 | 23 | 12 |

| Key | 1st Quartile | 2nd Quartile | 3rd Quartile | 4th Quartile |
|---|---|---|---|---|

Nevertheless, in the overview of the three case study states, it is apparent that significant factors differentiate a high-ranked state from a low-ranked one. These factors include state policy decisions and administrative structure, as well as features over which the private sector and consumers, rather than the state, have control. Such features include private pay rates for LTSS, the supply of home care workers, nursing home staff turnover, and measures of life satisfaction. Poverty and disability rates also can affect the challenges that states face. Notably, both Minnesota and Idaho have substantially lower than average rates of disability.

## Rankings at a Glance

Figure 2 illustrates the overall rankings of the three case study states, as well as their ranks on each dimension and indicator, by quartile of performance. The high, medium, and low performance of these states is clearly illustrated by the number of first quartile ranks for each: fifteen in Minnesota, eight in Idaho, and three in Georgia. Minnesota has only one indicator in the forth quartile. Georgia ranked significantly lower than Idaho, primarily because of its large number of third quartile rankings and scarcity of first quartile rankings.

**Figure 2: Case Study States: Dimension and Indicator Quartile Ranks[2]**

| Overall Rank | Minnesota | Idaho | Georgia |
|---|---|---|---|
| **Affordability and Access** | | | |
| Nursing Home Private Pay Affordability | | | |
| Home Care Private Pay Affordability | | | |
| LTC Insurance Policies in Effect | | | |
| Medicaid Coverage/Low-Income PWD | | | |
| Medicaid LTSS Coverage/Low-Income PWD | | | |
| ADRC Functionality | | | |
| **Choice of Setting and Provider** | | | |
| Medicaid Spending Balance | | | |
| Medicaid HCBS First | | | |
| Consumer Direction | | | |
| Tools and Programs for Consumer Choice | | | |
| Home Health and Personal Care Aides | | | |
| Assisted Living and Residential Care | | | |
| Percent in Nursing Homes w/Low Care Needs | | | |
| **Quality of Life and Care** | | | |
| PWD Getting Needed Support | | | |
| PWD Life Satisfaction | | | |
| Employment PWD age 18–64 | | | |
| NH Pressure Sores | | | |
| NH Physical Restraints | | | |
| NH Staff Turnover | | | |
| NH Hospital Admissions | | | |
| Home Health Pressure Sore Prevention | | | |
| Home Health Hospital Admissions | | | |
| **Support for Family Caregivers** | | | |
| Life Satisfaction | | | |
| Legal and System Supports for Caregivers | | | |
| Nurse Delegation of Health Maintenance Tasks | | | |

PWD = people with disabilities; HCBS = home and community-based services; NH = nursing home

| Key | 1st Quartile | 2nd Quartile | 3rd Quartile | 4th Quartile | No Data |
|---|---|---|---|---|---|

[2] Full descriptions of all data indicators can be found in appendix B-2 of the *LTSS Scorecard*.

## Highlights for Minnesota

Minnesota was selected because it ranked first overall in the nation. It has 11 indicators ranked among the top five states in the nation. It is the only state that achieved a first quartile rank across all four dimensions.

The following are notable features of Minnesota's LTSS system:

- There is a long history of collaboration between state officials and consumers and other stakeholders in the development of public policy and programs.

- Minnesota has a mature LTSS system with an array of Medicaid and state-funded home and community-based services (HCBS) that balances the majority of spending toward HCBS.

- A well-established statewide managed care program includes both acute care state plan services and LTSS. The capitation approach used with health plans creates an incentive to use HCBS rather than nursing homes.

- Individuals seeking admission to a nursing home or other LTSS receive an assessment and information about all service options. The state's Aging and Disability Resource Center (ADRC) helps consumers find the services for which they are eligible. These features help to account for the state's high ranking on both the *Affordability and Access* and *Choice of Setting and Provider* dimensions.

- Minnesota's performance-based incentive payment program has improved the quality of care and quality of life in nursing homes.

- Minnesota's current challenges are in the areas of home health and residential services: Home health is the single area in which all its low scores were clustered. Not only is home health affordability a challenge; home health quality measures lag, especially in comparison to other areas of performance in the state. State officials noted that the expansion of residential living alternatives resulted in individuals with low care needs that could be met in their home entering assisted living and "spending down" to Medicaid eligibility. The state has implemented preadmission counseling to inform applicants about in-home service options.

- Minnesota has submitted a §1115 waiver demonstration proposal to the Centers for Medicare & Medicaid Services that would raise the nursing home level-of-care criteria. The state is proposing to create a lower cost Essential Community Service package for people with lower needs, and seeks federal reimbursement for a state-funded HCBS program.

## Highlights for Idaho

With an overall rank of 19, Idaho scored higher than 32 other states.

- The biggest challenge this state faces is in the dimension of *Affordability and Access*. In particular, Idaho's lowest scores were in the functionality of its 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.

- 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 over where they receive services and who provides them. Ranked 8th in this dimension, Idaho excels in balancing the LTSS spending in its Medicaid program toward the 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 the 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 Idaho's nursing homes. Notably, it 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 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 provider. 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 both 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.

## Highlights for Georgia

Like many other southern states, Georgia ranked in the lowest quartile of state LTSS performance. Georgia had an overall rank of 42, meaning only 9 states scored lower on the overall ranking.

- The biggest challenge Georgia faces is allowing consumers to exercise more *Choice* and control over where they receive services and who provides them. The state does not have an agreement or vision among policymakers that HCBS services are preferable to institutional services. An expression of this is the state's involvement in federal court and Department of Justice settlements around the need to take people out of institutions. With long HCBS waiting lists and reliance on nursing homes to conduct Medicaid preadmission screening of people already in their facilities, it is a struggle for consumers to find alternatives.

- Georgia's biggest achievement is providing legal and system *Support for Family Caregivers*. Georgia has strong spousal impoverishment provisions in its HCBS regulations.

- Although the state ranks in the first quartile for *Affordability* of private-pay nursing home and home care costs, *Access* to LTSS for low-income people is thwarted by a lack of systems to divert people from institutional care by offering them choices outside of nursing homes, and timely information and help to get those services. The result is that in Georgia, two-thirds of new Medicaid LTSS users first receive services in institutions.

- Most *Quality of Life and Quality of Care* indicators signal a need for improvement, particularly in promoting employment opportunities for people with disabilities and reducing hospital admissions for long-stay nursing home residents.

## Major Policy Initiatives

A major finding of the *Scorecard* was the important role of Medicaid as a leading indicator for state performance. Most people who need LTSS receive the majority of the services they need from family caregivers. While some do so out of personal preference, others turn to family members because of the high cost of services. The *Scorecard* found that the cost of LTSS is unaffordable for middle-income families in every state. When LTSS needs intensify, or when there are no family caregivers who can fill this demanding role, people may exhaust their life savings paying for care. At that point, Medicaid becomes the primary source of payment. Thus, its role is significant in access to and affordability of care, in choice of setting and provider, in quality oversight—especially for HCBS—and in the support for family caregivers that it does or does not provide. In short, the Medicaid program touches all four dimensions on which states were ranked.

Medicaid Balancing

The *Scorecard* rankings accurately reflect the decades-long policy initiatives in both Minnesota and Idaho that were designed to shift the historical focus of the Medicaid program away from paying for nursing home services. What is striking about both Minnesota and Idaho is how broad and long-lasting these policy agreements are. The rankings of Minnesota and Idaho are the result of years of work by state policymakers, providers, and state staff. Recognizing that HCBS were both cost-effective and the clear choice of most consumers, these states developed Medicaid HCBS waivers and other mechanisms to help people remain in their own homes and in community-based settings. Their policy initiatives have yielded success: Both states scored high on the percentage of Medicaid LTSS dollars going to HCBS and on their ability to serve the large majority of users in HCBS when they first enter the Medicaid system.

In contrast, Georgia still devotes the great majority of its Medicaid LTSS spending to institutional care, and two-thirds of new Medicaid LTSS beneficiaries go into nursing homes. One factor that may influence the apparent policy difference in the use of nursing homes is the extent to which the nursing home industry influences state legislators.[3] In Idaho, interviewees noted that the state's "frontier" roots have created a culture that strongly values independence. As a result, nursing homes are viewed as a setting of last resort. Minnesota took an active role by enacting the nation's only "rate equalization" policy, which prohibits nursing homes from charging privately paying residents in shared rooms more than the Medicaid reimbursement rate. Such willingness to "take on" the nursing home industry is not apparent in Georgia, where the nursing home industry has successfully resisted policies and financing tools that promote HCBS. In fact, nursing homes are charged with conducting preadmission screening—a responsibility that is a conflict of interest.

Waiting Lists

More than a decade ago, Idaho made a deliberate policy decision that it would not maintain waiting lists for Medicaid HCBS. The state finds a way to serve eligible individuals in HCBS and thus, has excelled in balancing its service delivery. In contrast, Georgia has long waiting lists for HCBS. As of December 2011, more than 7,500 people were waiting for Medicaid waiver services.[4] When people cannot get HCBS they may enter a nursing home, ultimately leading to higher costs for the state.

Medicaid Managed Care

Minnesota was a leader in the adoption of managed care as a mechanism to deliver more integrated care. Its managed care system provides clear financial incentives to favor HCBS over nursing homes, yet the people who receive HCBS have a wide array of services that are tailored

[3] For example, the Georgia Nursing Home Association contributed $377,640 to 174 political candidates during 2004–2008, and people associated with nursing homes contributed $3.1 million from 2000 to 2011. See http://www.followthemoney.org/database/IndustryTotals.phtml?f=0&s=GA&b%5B%5D=H2200.

[4] All waivers (except the SOURCE program until January 2012) have waiting lists: On December 1, 2011, 1,536 people were waiting for the Community Care Services Program, 2,879 waiting for the New Options Waiver, and 3,208 waiting for services from the Comprehensive Supports Waiver.

to their individual needs. Idaho is in the process of adopting a managed care system for LTSS, and Georgia is exploring this possibility. Careful study of the program characteristics in Minnesota could help these and other states develop effective systems that reduce institutional use, protect consumers' choices, and provide an array of cost-effective health care and LTSS.

Aging and Disability Resource Centers

The three states studied could not be more different in the functioning of their ADRCs and single point of entry systems. Minnesota ranked first, Idaho ranked last, and Georgia was practically in the middle at 24th. ADRCs and single points of entry perform an important function in helping consumers of all disabilities and all income levels to learn about the resources that are available to meet their needs. In a highly functioning system like Minnesota's, the ADRC is a single source of a wide array of services, including information and referral, screening, both functional and financial eligibility determinations, and nursing home preadmission and transition services.

By contrast, at the time of *Scorecard* data collection, Idaho's ADRC consisted primarily of a website that contained limited information about available services. While the state intends to bring its Area Agencies on Aging into a more active role, at present many functions of a high-performing ADRC (such as coordinating services and arranging for eligibility determinations) are not available through Idaho's ADRC. This finding is a factor in Idaho's overall low score in the *Affordability and Access* dimension, on which the state ranked 48th. Thus, Idaho is a state of contrasts: Gaining access to the system may be more difficult than in other states, but, once consumers are in the system, the state does an effective job in offering them their choice of preferred setting. In Georgia, the functions of the ADRC are less robust than those performed in Minnesota. Both Idaho and Georgia could benefit from studying top-ranked ADRC operations and determining how their own could be improved.

Administrative Structure

Minnesota's system has an integrated administrative structure in which there is coordination among the agencies that administer health, LTSS, and aging services. In contrast, both Idaho and Georgia are characterized by systems in which there is no clear locus of responsibility for aging and disability policy and program development, financing, and accountability. Stakeholders in Idaho acknowledged that there is little overlap between the functions of the Aging and Medicaid departments. A complex state administrative structure in Georgia makes it difficult to achieve a unified, coordinated vision for improving its LTSS system.

Quality

The *Scorecard* findings in the area of quality are complex, with indicators that span life satisfaction as well as nursing home and home health quality. Regarding home health, while Minnesota's overall rank in this dimension is high, it scored in the third quartile on both measures of home health quality. Both Idaho and Georgia scored in the middle range on quality overall, but Georgia scored higher than Minnesota on both home health measures and Idaho had a mixed result, with one very high and one very low score on home health measures. Idaho also had low rates of hospital admissions among home health patients. Regarding nursing home

quality, both Idaho and Minnesota had top quartile ranks on two measures of nursing home quality, notably low rates of pressure sores in nursing homes, and low rates of hospital admissions from nursing homes. People interviewed for the case studies in Minnesota and Idaho noted the important role played by their state's quality improvement organization in helping to raise and maintain these standards. Providers interviewed pointed out examples of how their organizations also improved quality of care.

Residential Alternatives

All three states have undertaken initiatives to support the development of residential alternatives. These efforts are reflected in the *Scorecard*'s indicator on the number of assisted living and residential care units per 1,000 people age 65+. This is the only indicator on which all three states are ranked in the first or second quartile: Minnesota (1st), Idaho (3rd), and Georgia (22nd). Minnesota uses the term "housing with services" to describe assisted living. While Medicaid beneficiaries account for only 8 to 12 percent of assisted living residents, 35 percent of older adult waiver recipients live in assisted living, and they account for 65 percent of all waiver spending. Minnesota also has almost 5,000 adult foster care homes.

In Idaho, Medicaid pays for about 39 percent of the residents in assisted living—a far higher percentage than the national average, which is closer to 19 percent.[5] Idaho also has a large number of Certified Family Homes (sometimes called adult foster care homes in other states), each of which serves a small number of residents. While most serve people with intellectual disabilities, some do serve older people.

Georgia recently enacted assisted living legislation, with regulations promulgated in January 2012. It calls for a "meaningful distinction" in the level of care provided in assisted living: something intermediate between a nursing home and a personal care home.

Support for Family Caregivers

Although Georgia did not respond to the State Boards of Nursing survey that gathered data for the *Scorecard* on the number of nursing tasks that may be delegated to home care workers (from a list of 16 tasks), the state recently enacted regulations for "proxy caregivers" that will expand the scope of nurse delegation. In both Minnesota and Idaho, 13 of the 16 tasks may be delegated.

While the findings in the caregiver support dimension are mixed, one indicator stands out: The life satisfaction expressed by family caregivers is in the top quartile in both Minnesota (ranked 3rd) and Idaho (ranked 6th), whereas it is in the low fourth quartile in Georgia (ranked 47th). At first glance, this finding might appear puzzling, given that Georgia actually scored highest of the three states on the legal and system supports provided to family caregivers (ranked 7th). This finding may reflect a contention made in the *Scorecard* that perhaps "the most meaningful support for caregivers is a better overall system that makes LTSS more affordable, accessible,

[5] 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.

and higher quality, with more choices."[6] Clearly, these characteristics are more evident in Minnesota and Idaho than in Georgia, which may be a factor in the low life satisfaction among Georgia's caregivers.

## Future Potential for Progress

Future *Scorecards* will allow analysts to measure state progress over time. Minnesota already has taken steps to examine its challenges in the area of home health services. If it successfully addresses these challenges it will be hard for other states to match its performance, provided its current successes are maintained—even as it, like other states, faces budget challenges. Georgia is working to promote more consumer direction and support for family caregivers. But it has a long way to go to improve the balance of its Medicaid LTSS system away from institutions. The governor's budget for fiscal years 2012 and 2013 contains $4.7 million to restore a one-half of 1 percent cut to nursing homes, while appearing to leave waiting lists for waiver services intact.[7] This action appears to perpetuate the state's institutional bias. Idaho recognizes the challenge it faces in providing access to services through a more comprehensive ADRC, and articulated the hope of improving its function. Yet budget challenges may impair its efforts.

As an increasing number of states, including perhaps Idaho and Georgia, move into Medicaid managed care for LTSS, they would do well to follow the lead of Minnesota, which developed a more seamless, cost-effective, integrated system in consultation with consumers and other stakeholders.

The *Scorecard* clearly demonstrated that all states, even the highest performing one, have challenges as they strive to provide LTSS to older people and adults with disabilities. Yet even the lowest ranked states have areas of success on which they can build. By targeting the areas most in need of improvement, states can make steady progress toward higher performance.

---



*Support for this research was provided, in part, by The Commonwealth Fund and The SCAN Foundation.*

[6] Reinhard et al., *Raising Expectations*.
[7] See http://www.dch.georgia.gov/vgn/images/portal/cit_1210/8/33/180741920January_19_DCH%20Pres_to_Joint_Approp.pdf.