The Hilltop Institute

analysis to advance the health of vulnerable populations

Rebalancing Long-Term Services and Supports: Progress to Date and a Research Agenda for the Future

June 14, 2011

UMBC

AN HONORS UNIVERSITY IN MARYLAND

Suggested Citation: Woodcock, C., Stockwell, I., Tripp, A., & Milligan, C. (2011, June 14). *Rebalancing long-term services and supports: Progress to date and a research agenda for the future.* Baltimore, MD: The Hilltop Institute, UMBC.

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Acknowledgements

The Hilltop Institute would like to thank Deborah L. Rogal, Jessica Rosen, and others at AcademyHealth for the opportunity to present this report at the AcademyHealth Long-Term Care Interest Group Colloquium on June 14, 2011, in Seattle, Washington. In addition, Hilltop thanks the sponsors of this event: AARP Public Policy Institute, the Benjamin Rose Institute, Intercompany Long-Term Care Insurance Conference Association, Inc., Leading Age (formerly AAHSA), and the Society of Actuaries Long-Term Care Insurance Section.

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Introduction

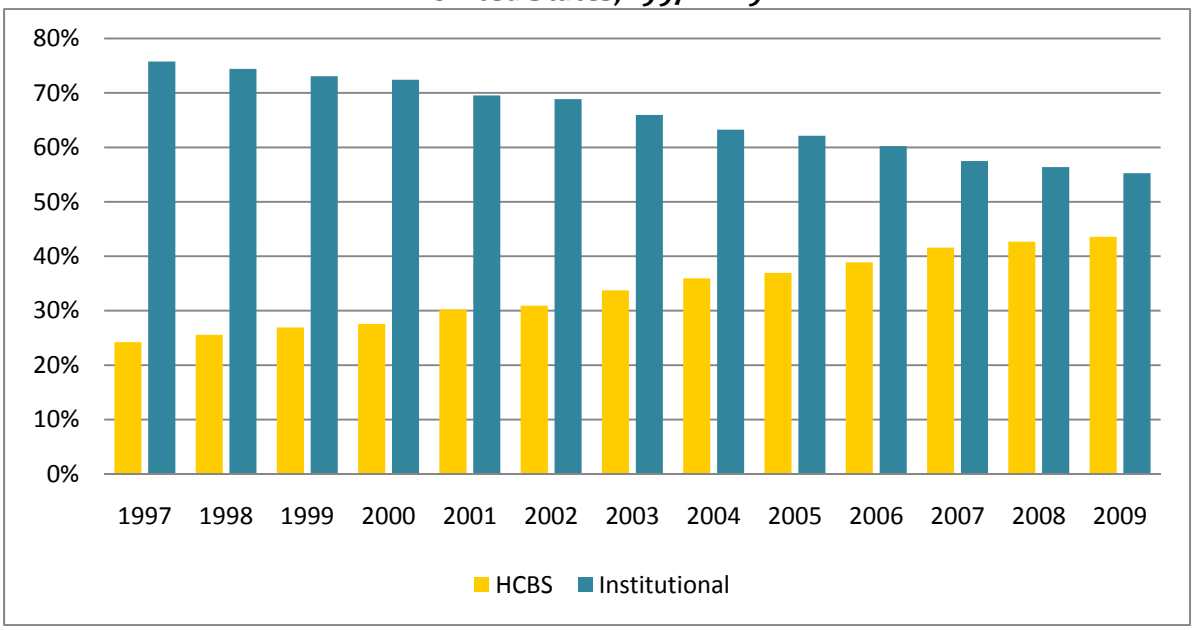
In a 2010 survey of adults aged 45 and older, 73 percent strongly agreed with the statement, "What I'd really like to do is stay in my current residence as long as possible" (AARP, 2010). Among individuals with intellectual and developmental disabilities, there is strong and consistent evidence that people who move to the community demonstrate improved adaptive behavior skills (Lakin, Larson, & Kim, 2011). Research on consumer preferences and wellbeing—together with the 1999 *Olmstead* decision in which the Supreme Court upheld an individual's right to receive services "in the most integrated setting appropriate" (Smith & Calandrio, 2001)—has motivated states to pursue "rebalancing" initiatives to move their long-term services and supports (LTSS) systems away from a dependency on institutional care and toward a system that embraces consumer choice and care in the home or community with the active engagement of the consumer's family and local support network. The federal government's most recent commitment to rebalancing is found in numerous provisions in the Affordable Care Act (ACA), where new authorities offer financial incentives to states to shift rebalancing efforts to the next level in order to continue to transform the LTSS system.

This report discusses progress in rebalancing Medicaid LTSS spending, how the ACA can support states' continued efforts to rebalance LTSS, and opportunities for future research to support continued system transformation.

Progress in Rebalancing

The most commonly cited measure for progress in rebalancing is the proportion of Medicaid expenditures for LTSS that was directed to institutional care versus home and community-based services (HCBS). Figure 1 shows spending for HCBS versus institutional care for these Medicaid eligibility groups: adults aged 65 and older, persons with physical disabilities, and persons with intellectual and developmental disabilities (ID/DD). From 1997 to 2009, HCBS spending increased at a compound annual growth rate of 11.41 percent, rising from $13.6 billion to $49.7 billion. The proportion of Medicaid LTSS spending for HCBS grew from 24.2 percent in 1997 to 43.6 percent in 2009. In contrast, institutional spending increased by a compound annual growth rate of just 3.33 percent, from $42.5 million to $63.0 million, and the proportion of Medicaid LTSS spending for institutional care declined from 75.8 percent to 56.4 percent.

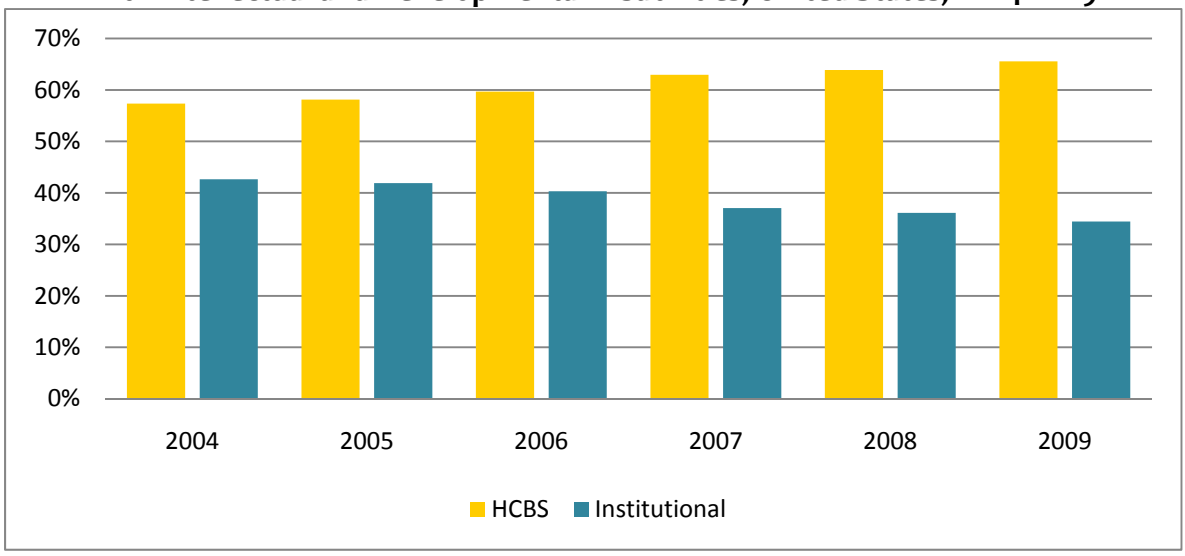
Figure 1. Percentage of Medicaid LTSS Spending for Institutional Care versus HCBS, United States, 1997-2009



Source: Thomson Reuters

Substantially greater progress has been made in rebalancing LTSS for persons with ID/DD. As shown in Figure 2, the percentage of Medicaid LTSS spending for HCBS for individuals with ID/DD reached 65.6 percent in 2009. Transitioning the ID/DD population to HCBS dates back to the deinstitutionalization movement that began in the 1970s. This movement has been supported by sustained advocacy efforts, as well as numerous court cases that required rebalancing. A recent study further documented the substantial progress in rebalancing this population. The authors found that the number of Medicaid participants with ID/DD increased 69.6 percent between 1998 and 2008, from 364,601 to 618,283. During this same period, residents of intermediate care facilities for the mentally retarded (ICFs/MR) decreased by 25 percent and Medicaid participants with ID/DD in HCBS more than doubled (Lakin, Scott, Larson, & Salmi, 2010).

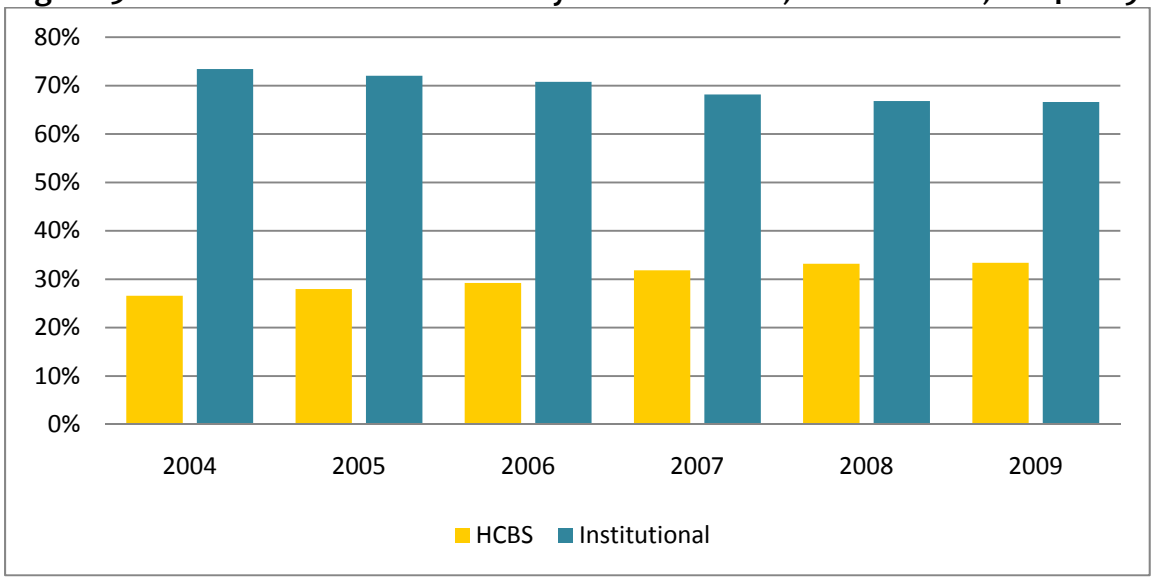
Figure 2. Percentage of Medicaid LTSS Spending for HCBS for Persons with Intellectual and Developmental Disabilities, United States, 2004-2009



Source: Thomson Reuters

Figure 3 shows the breakdown of Medicaid LTSS spending for adults aged 65 and older and persons with physical disabilities. From 2004 to 2009, the percentage of spending for HCBS for these populations increased by only about 7 percentage points, from 26.6 percent to 33.8 percent, which is about half that the percentage for persons with ID/DD (65.6 percent).

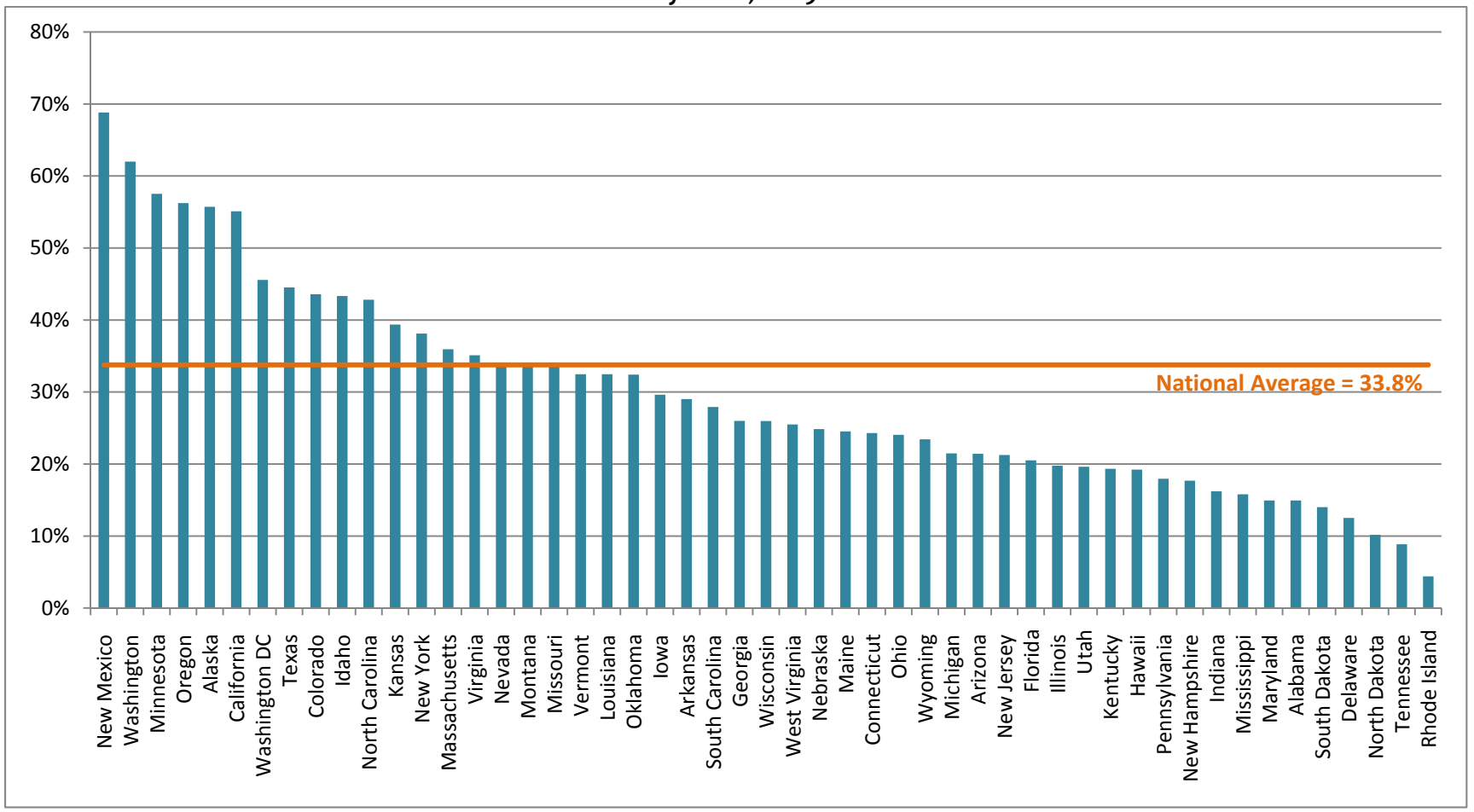
Figure 3. Percentage of Medicaid LTSS Spending for HCBS for Adults Aged 65 and Older and Persons with Physical Disabilities, United States, 2004-2009



Source: Thomson Reuters

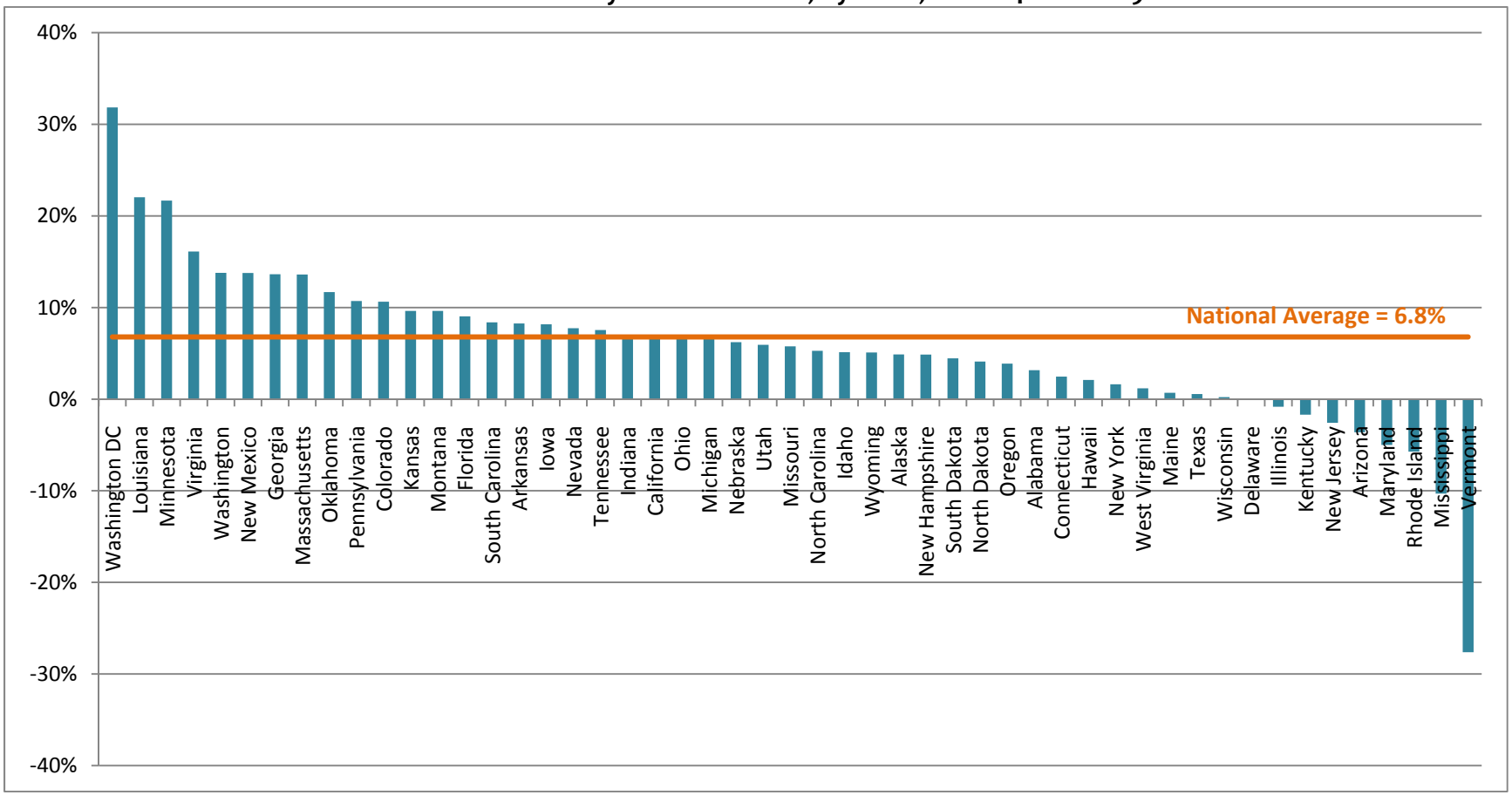
While overall progress in rebalancing LTSS for older adults and persons with physical disabilities has lagged significantly behind rebalancing for individuals with ID/DD, states vary in their position along the rebalancing curve (Figure 4). Sixteen states and the District of Columbia exceeded the 2009 national average of 33.8 percent of spending for HCBS for older adults and persons with physical disabilities, while 34 states fell below the national average. Another way to compare the progress of individual states is to examine the change in the percentage of LTSS spending for HCBS for older adults and persons with physical disabilities from 2004 to 2009 (Figure 5). Thirty-one states had spending growth that was below the average increase of 6.8 percentage points and nine of these states had a *decrease* in the percentage of LTSS spending for HCBS over the six-year period.

Figure 4. Percentage of Medicaid LTSS Spending for HCBS for Adults Aged 65 and Older and Persons with Physical Disabilities, by State, 2009



Source: Thomson Reuters

Figure 5. Change in the Percentage of Medicaid LTSS Spending for HCBS for Adults Aged 65 and Older and Persons with Physical Disabilities, by State, FY 2004 – FY 2009



Source: Thomson Reuters

Influences on the Rebalancing Equation

Medicaid's "institutional bias" is a serious impediment to rebalancing. Nursing facility care is a mandatory Medicaid state plan benefit and therefore an entitlement, so any Medicaid beneficiary who meets a state's financial and clinical eligibility requirements may take advantage of this benefit. In contrast, Medicaid beneficiaries are not entitled to HCBS waivers. States may choose to offer 1915(c) HCBS waivers and restrict the number of participants. States may also reduce HCBS waiver benefits during times of budgetary stress. A beneficiary's right to institutional care but not the comprehensive set of services and supports in an HCBS waiver is referred to as Medicaid's "institutional bias" and can work against states' efforts to rebalance LTSS.

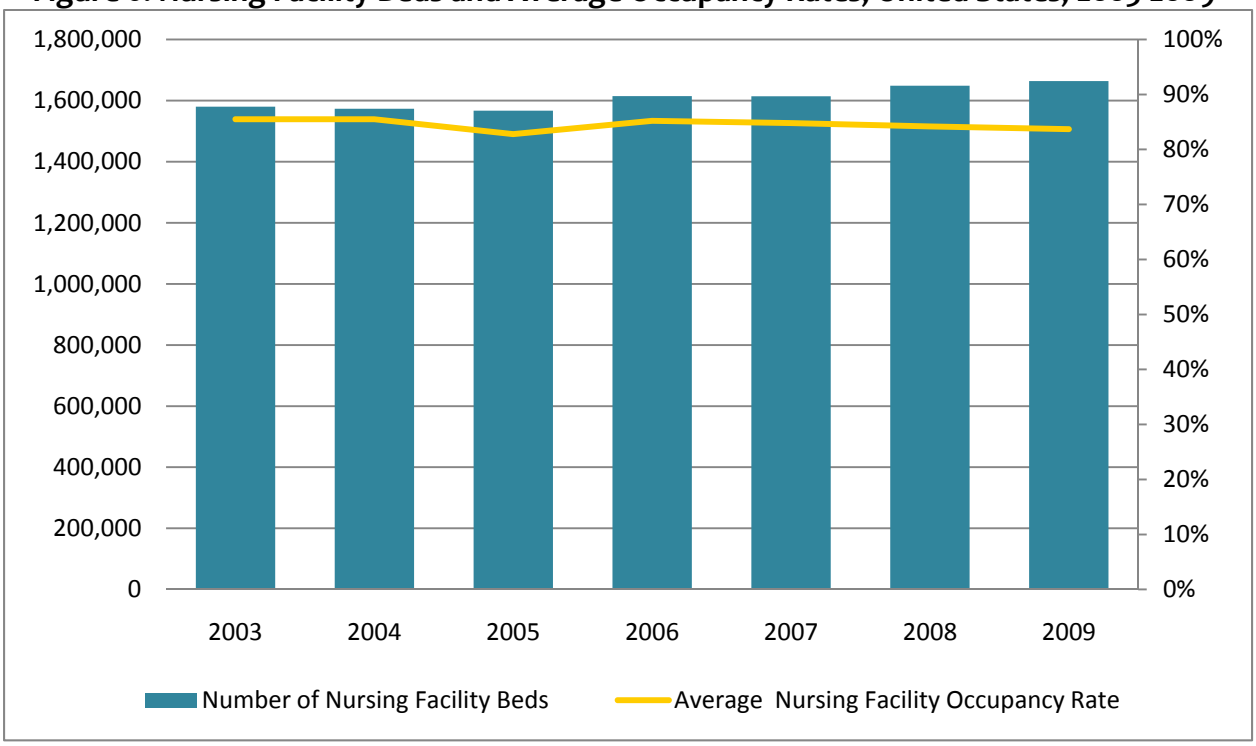
Institutional bias is present in other ways as well. Typically, individuals with incomes up to three times the Supplemental Security Income (SSI) payment amount who are assessed to need an institutional level of care are eligible for Medicaid nursing facility care, but this same level of income is too high for them to qualify for community-based Medicaid services. Current law allows Medicaid reimbursement for room and board in nursing facilities as a component of the institutional service, but room and board is not reimbursable in the community. Nursing facility residents who wish to transition to the community often cannot afford to do so if they have to pay room and board out of pocket or from the relatively small amount of resources in an SSI payment. For those residing in the community, room and board cannot be counted as a medical expense when an individual who incurs large medical expenses is seeking to "spend down" to Medicaid eligibility.[1]

Nursing facility payment methodology contributes to institutional bias. Cross-state comparisons of Medicaid nursing facility rates must be made with caution because the methodology for calculating rates is different in every state. In any one state, rates can vary by level of care, geographic region, and acuity. One study reports average per diem rates of $83.72 in 1995 and $160.66 in 2007—a compound annual increase of 5.58 percent (Harrington, Granda, Carrillo, Chang, & Woleslagle, 2008). Annual increases in Medicaid nursing facility rates are typically tied to inflation indices. Oftentimes, increases are written into state regulations and implemented automatically unless special legislation is passed. The result is a steady trajectory of rate increases, which in turn fuels spending increases on the institutional side of the state's rebalancing equation. Annual increases in payment rates for community-based services are less likely to be written into state regulations, resulting in inequities in provider rate increases and slower rates of spending growth on the HCBS side of the rebalancing equation.

[1] Thirty-five states and the District of Columbia allow persons with large medical expenses to deduct these expenses from their income in order to "spend down" to meet Medicaid financial eligibility requirements (AARP, 2010).

"Back-filling" of nursing facility beds may thwart efforts to rebalance. While there is no conclusive evidence on the relationship between declining occupancy rates and nursing facility efforts to fill empty beds, many states—with the encouragement of the Centers for Medicare and Medicaid Services (CMS)—have sought to reduce the number of nursing facility beds as part of their rebalancing strategies.[2] Forty-two states and the District of Columbia operate certificate-of-need programs and/or have adopted moratoria on new bed growth (Harrington et al., 2008). Nevertheless, since 2005 there has been a slight but steady increase in the number of nursing facility beds in the United States. In addition, the average occupancy rate has been declining since 2006 (Figure 6). Some data report an increase in the number of rehabilitation beds for short-term nursing facility stays,[3] but the relationship to declining lengths of hospital stays and the overall supply of nursing facility beds is not clear.

Figure 6. Nursing Facility Beds and Average Occupancy Rates, United States, 2003-2009

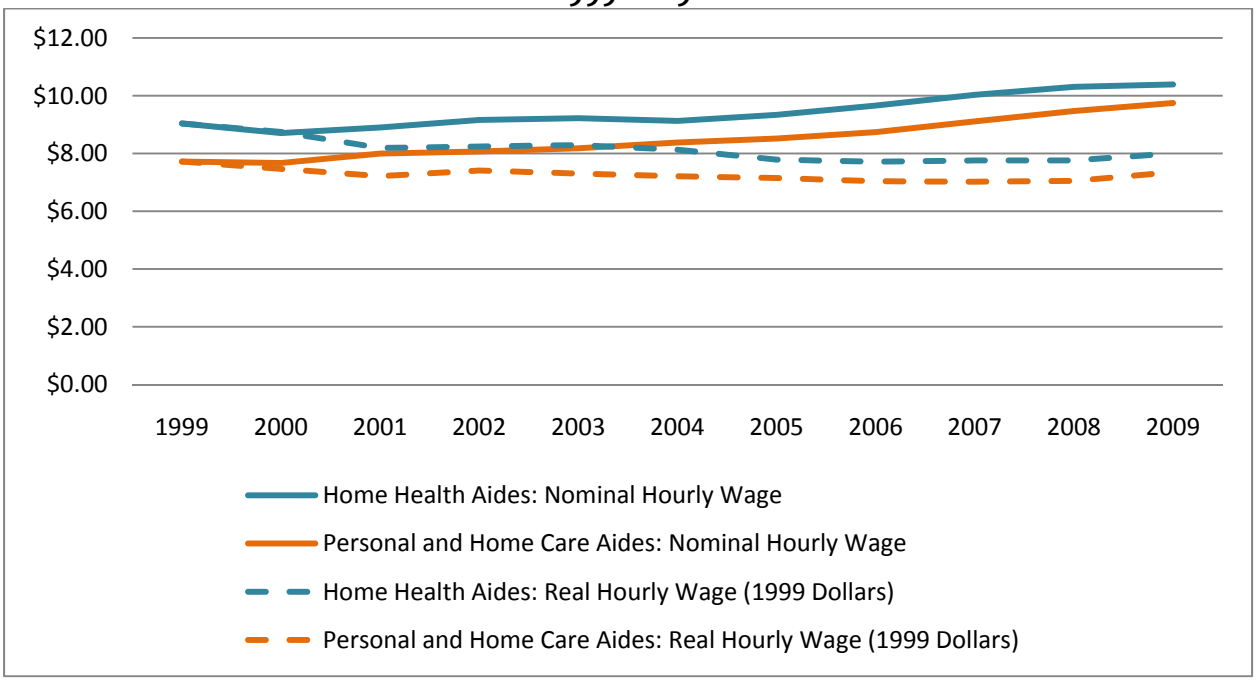


Source: Kaiser Family Foundation, statehealthfacts.org

[2] In an August 17, 2004, letter to state Medicaid directors, CMS states, "We encourage states to reduce nursing facility beds to assist a state in rebalancing its long-term care service system, but this is not a requirement."
[3] One study reports an 8.45 percent increase in the number of rehabilitation beds from 2004 to 2009 (Harrington et. al., 2010).

Ill-advised payment policies negatively affect the availability and quality of direct care workers. Wage growth for "personal and home care aides"—also called homemakers, caregivers, companions, and personal attendants—has been stagnant over the last decade (Figure 7). The same is true for "home health aides," who work under the direct supervision of a medical professional (usually a nurse) and are typically employed by certified home health or hospice agencies and, in some cases, nursing facilities.[4] The average hourly wage paid by nursing facilities for home health aides is slightly higher than the average hourly wage paid by agencies serving non-institutionalized individuals; in 2008, nursing facilities paid $10.20, home health care services paid $9.70, and community care facilities paid $9.44. Consequently, nursing facilities are likely to attract the more skilled and experienced workers in the home health aide workforce—potentially another factor contributing to the imbalance between institutional and HCBS spending. One strategy states have successfully used to increase earnings for direct care workers is the Medicaid wage pass-through program. In these programs, states channel additional funding directly to lower-skilled workers and have enabled workers to earn as much as 12 percent more per hour than in states without such programs (Baughman & Smith, 2010).

Figure 7. Median Hourly Wages for Personal and Home Care Aides and Home Health Aides, 1999-2009



Source: U.S. Bureau of Labor Statistics

[4] Home health aides should not be confused with "nursing aides"—also called certified nursing assistants (CNAs)—who have more training, typically work in hospitals and nursing facilities, and earn somewhat higher wages.

Assisted living has emerged as a new housing option. Finding housing for nursing facility residents who want to move to the community is one of the biggest challenges states face. Over the past two decades, assisted living has emerged as a new LTSS housing option and an important tool in states' rebalancing efforts. The assisted living sector has experienced rapid growth, largely without government financing or regulation and in areas of the country with higher educational attainment, income, and housing wealth. Nationally, there were 22.9 assisted living beds per 1,000 older adults in 2007 (Stevenson & Grabowski, 2010). Although assisted living facilities are potentially an important resource for Medicaid beneficiaries, many view large assisted living facilities as institutional settings.[5] The extent to which state Medicaid programs include supportive services provided in assisted living facilities as a covered benefit varies.[6] Trend data on assisted living utilization by Medicaid participants is not available.

Rebalancing does not always translate into immediate cost savings. Rebalancing is a slow process and a long-term investment. For the most part, past studies on the cost-effectiveness of Medicaid waiver programs, consumer-directed care, and capitated programs that blend acute care and LTSS have been inconclusive (Grabowski, 2006). However, a recent study of persons eligible for both Medicare and Medicaid (dual eligibles) in Maryland found that HCBS waivers are only cost-effective at the individual level when a nursing facility placement is actually avoided (Tucker & Johnson, 2010). Another study examined Medicaid spending on HCBS and found that expanding Medicaid HCBS typically results in a short-term increase in spending, followed by a decline in institutional spending and long-term cost savings (Kaye, LaPlante, & Harrington, 2009). In addition, this study found that states with limited non-institutional services experienced greater spending growth than states with more expansive non-institutional LTSS, and that states will achieve savings in Medicaid institutional costs only if the number of nursing facility residents is reduced over time (Kaye et al., 2009).

As the LTSS system evolves, nursing facility care is likely to be transformed but will continue to be a needed service. While most people would prefer to receive LTSS in their homes or in the community, nursing facilities serve a vital role: providing rehabilitative services and skilled nursing care to very sick and frail individuals. As states continue to pursue rebalancing, nursing facility services are likely to be reconfigured to meet the needs of a changing population and to reflect the emerging "culture change" movement, which emphasizes care that is responsive to individual lifestyles, needs, and preferences.[7] Because there will likely always be a role for

[5] The federal Money Follows the Person demonstration prohibits participants from transitioning to residences with more than four unrelated individuals. This disqualifies transitions to most assisted living facilities for the one-year enhanced Medicaid match and has been a disincentive for states to promote assisted living facilities for Medicaid beneficiaries.

[6] For example, waivers in some but not all states cover the cost of personal care and supportive services provided in assisted living facilities. However, federal financial participation is not available for room and board charges.

[7] For more information on the culture change movement, see this report from the National Conference of State Legislatures at http://www.ncsl.org/default.aspx?tabid=14483.

institutional care, states may eventually reach a threshold where further gains in rebalancing will be increasingly difficult to achieve.

Current rebalancing measures only examine LTSS expenditures, not the total cost of caring for a Medicaid beneficiary requiring LTSS. As a result, savings in acute care costs achieved through effective utilization of LTSS are not captured. Dual eligibles—the 8.9 million Americans enrolled in both Medicare and Medicaid—complicate such calculations because of the separate Medicare and Medicaid funding streams. Yet, aligning financial incentives and eliminating cost-shifting across the two programs has the potential for significant cost-savings. For example, unnecessary Medicare-financed hospitalizations can be avoided when a dual eligible receives competent care during a Medicaid-financed long-term nursing facility stay. Similarly, in the community setting, high-quality Medicaid HCBS can potentially keep an individual healthier and help prevent avoidable hospitalizations, resulting in savings in Medicare acute care costs.

Strategies to Promote Rebalancing

States have used a variety of federal funding authorities and policy options to limit institutionalization and promote greater use of HCBS. States' commitment to rebalancing has continued despite the budget crises that most are experiencing. In fiscal year (FY) 2010, 32 states reported actions taken to expand LTSS, although 18 reported implementing program restrictions. In FY 2011, once again 32 states reported planned LTSS expansions, but only 10 anticipated program restrictions (Smith, Gifford, Ellis, Rudowitz, & Snyder, 2010). Strategies used by states are discussed below.

LTSS in the Medicaid State Plan. All states are required to offer home health as a state plan benefit. In 2007, 813,848 individuals received home health, at a total cost of $4.9 billion (Kaiser Family Foundation, 2011). Also in 2007, 31 states and the District of Columbia provided state plan personal care—an optional state plan benefit—to 826,251 individuals, at a total cost of $9.5 billion (Kaiser Family Foundation, 2011). A 1915(i) state plan amendment is the newest option for states to offer HCBS under the Medicaid state plan. First authorized under the Deficit Reduction Act of 2005 (DRA), five states have adopted 1915(i) state plan amendments. To encourage additional states to participate, the ACA amended the option to permit states to target individuals with selected conditions. However, the benefit must now be offered statewide and there can be no ceiling on the number of recipients.

1915(c) HCBS Waivers. The Secretary of the U.S. Department of Health and Human Services (DHHS) may waive Medicaid provisions under the Social Security Act so that states can provide LTSS to Medicaid beneficiaries in community settings. In 2007, 48 states and the District of Columbia operated 270 HCBS waivers, serving 1.2 million individuals at a total cost of $27.2 billion (Kaiser Family Foundation, 2011). Table 1 shows participants, expenditures, and waiting

lists for waivers serving adults aged 65 and older, persons with physical disabilities, and persons with ID/DD.[8]

Table 1. Medicaid HCBS Waiver Participants, Expenditures, and Waiting Lists, by Type of Waiver, United States*

	Aged	Aged and Disabled	Physically Disabled	ID/DD
Participants	133,983	447,878	70,017	471,033
Expenditures	$1,185,296	$4,412,081	$1,148,864	$19,758,745
Waiting Lists**	6,262	101,301	7,960	221,898

*Data for participants and expenditures are for 2007. Waiting list data are for 2009.
**As reported by states. Many states do not screen individuals for Medicaid and waiver eligibility before placing them on a waiting list, nor are waiting lists always culled on a regular basis to remove individuals receiving other services or individuals who are deceased. In addition, individuals often place their names on the waiting lists for multiple waivers. As a result, the number of eligible individuals on waiting lists is often significantly overstated.

Source: Kaiser Family Foundation, statehealthfacts.org.

Waiver Consolidation. Some states have consolidated several 1915(c) waiver programs serving similar populations into one 1915(c) waiver in order to achieve operational efficiencies and streamline benefit offerings. A proposed rule issued by CMS on April 14, 2011, would allow states to target multiple populations in a single waiver. This is sure to prompt further waiver consolidations. Other states, such as Vermont and Rhode Island, have turned to "omnibus" Section 1115 demonstration waivers to consolidate all of their prior waiver programs. New Jersey is also pursuing a Section 1115 waiver.

Integrated Care. Eight states[9] operate programs in which they contract with health plans to provide LTSS to Medicaid beneficiaries for a per-member-per-month capitation payment.[10] Reflecting individual states' goals and preferences, the programs vary in scope and scale and operate under different waiver authorities. Some include LTSS only, while others include primary and acute care in addition to LTSS. In 2008, an estimated 353,300 individuals participated in these programs (The Hilltop Institute, 2009).[11] In April 2011, CMS awarded design contracts to 15 states[12] for the development of new integrated care programs.

Consumer Direction. Many states now have LTSS programs that enable Medicaid participants and/or their representatives to choose from among a variety of services and providers and

[8] States also operate waivers serving children and individuals with mental health conditions, HIV/AIDS, and traumatic brain injury/spinal cord injury (TBI/SCI).
[9] Arizona, Massachusetts, Minnesota, New Mexico, New York, Tennessee, Texas, and Wisconsin.
[10] In addition, there is the Program of All-inclusive Care for the Elderly (PACE), which integrates Medicare and Medicaid funding streams and includes programs in 30 states.
[11] This estimate excludes the Tennessee program, CHOICES, which was launched in 2010.
[12] California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin.

manage a service budget. State programs vary greatly, with each state tending to adopt its own unique approach. This is evidenced by a 2006 survey that queried states about 17 different consumer-directed approaches (Greene, 2007). Three states—Arkansas, Florida, and New Jersey—participated in the original Cash & Counseling demonstration; by 2007, 25 states reported having Cash & Counseling programs. Kaiser Family Foundation (2011) reports that as of January 2006, all but two states offer "individual budget" models of LTSS.

Money Follows the Person (MFP). Forty-two states and the District of Columbia now participate in this federal demonstration that provides financial incentives for states to transition Medicaid beneficiaries from institutional settings and supports infrastructure building to facilitate rebalancing efforts. As of 2011, MFP grant awards totaled $2.0 billion (Kaiser Family Foundation, 2011). As of June 2010, the 30 states implementing programs in 2007 reported a total of 8,517 MFP transitions from nursing facilities (90 percent of total transitions), ICFs/MR (9 percent), and mental institutions (1 percent) (Lipson & Williams, 2011).

Nursing Home Diversion Programs. Programs such as the Community Living Program sponsored by the U.S. Administration on Aging (AoA) aim to prevent functional decline in order to divert individuals from entering nursing facilities and prevent spend-down to Medicaid eligibility. AoA awarded grants to 12 states in 2007, 14 states in 2008, and 16 states in 2009. Federal funding totaled $23.3 million. At this time, there is no program report or evaluation available (U.S. Department of Health and Human Services, Administration on Aging, 2011).

Aging and Disability Resource Centers (ADRCs). A joint initiative of CMS and AoA, ADRCs are intended to integrate aging and disability services and provide a single point of entry into the LTSS system. Through "options counseling," individuals are informed about the full range of LTSS options available to them. ADRCs are in various stages of development in 47 states and the District of Columbia, and program models differ widely from state to state. Almost $111 million in joint AoA/CMS funding has been awarded to the states for ADRC development since 2003. As of October 2010, 325 ADRC sites were in operation in 45 states and territories (O'Shaughnessy, 2010). A program evaluation is currently in the planning stages.

The Challenges Ahead

Many challenges remain as states assess their progress in rebalancing and chart a course for the future. Meeting the needs of aging baby boomers and supporting the rights of persons with disabilities to enjoy life in the community will require nothing less than bold, transformative change. Some of the key challenges are discussed below.

Forming partnerships and setting common goals. Systemic change will require active and committed partnerships on the part of state legislators, advocates, industry leaders, and federal and state agencies to establish rebalancing goals, devise new strategies for providing community-based LTSS, and monitor quality and performance.

Addressing institutional bias. Rule and regulatory realignment that gives individuals the same rights to community-based care as to institutional care is crucial if states are to comply with *Olmstead v. L.C. and E.W*. and provide services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities" (Smith & Calandrio, 2001).

Anticipating new users. The availability of new HCBS options is likely to encourage more people to seek Medicaid HCBS. In what has been referred to as "the moral hazard problem," Medicaid HCBS may substitute for informal services previously provided by family and friends (Grabowski et al., 2010). For example, implementation of a new consumer-directed program in which Medicaid participants can hire family members as personal attendants may encourage new families to come forward with the goal of reimbursing their previously unpaid informal caregivers. While this may provide needed income to the family, states are at risk of using limited resources to replace informal caregiving with paid caregiving with no net increase in the number of people served. Monetizing informal caregiving and offering other programs that motivate unenrolled individuals to seek and use publicly funded LTSS can potentially lead to significant budget overruns.

Devising new service delivery and financing models. Sustainable evidence-based LTSS delivery models that emphasize coordination of services, linkages with medical care and chronic disease management, and delaying or preventing a descent into functional decline will be key, as well as new financing models that incentivize providers to rethink current service delivery and reconfigure service offerings to emphasize community-based, cost-effective LTSS and coordination with acute care and behavioral health.

Coordinating care and financing for dual eligibles. Better understanding provider behavior and integrating Medicare and Medicaid funding streams will be crucial to delivering cost-effective LTSS to the burgeoning population of almost 9 million dual eligibles.

Integrating behavioral health services into LTSS. The percentage of Medicaid participants with mental health and substance abuse disorders has been estimated to be as high as 48 percent (Adelmann, 2003). Integrating behavioral health services into LTSS delivery and financing models will be a priority in order to better serve individuals in the community.

Investing in information technology (IT). To support transformative change, it is imperative that states invest in IT systems that will facilitate "following the individual" across care systems and disparate databases, support development of new payment methodologies, and enhance performance monitoring and continuous quality improvement.

Creatively leveraging the new authorities in the ACA. States have an unprecedented opportunity to realize system transformation through creative use of the new authorities in the ACA and collaborating with CMS to bring about regulatory realignment.

ACA Provisions that Promote Rebalancing

Community First Choice Option

Section 2401 of the ACA authorizes—effective October 1, 2011—Community First Choice (CFC), a new Medicaid state plan option for providing community-based attendant services to Medicaid participants. States adopting this optional state plan benefit will receive a 6 percent increase in the Federal Medical Assistance Percentage (FMAP) for these services *indefinitely*. States must offer CFC statewide. Services must include not only attendant care for assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), but also backup systems such as personal emergency response systems and voluntary training for participants on how to hire and manage attendants. States have the option of covering certain transition costs and items that increase independence or substitute for human assistance.

The states most likely to adopt CFC are those with beneficiaries already receiving personal care or attendant care under the state plan or in a waiver that can be transferred to CFC with minimal or no increase in overall eligibility or spending for personal/attendant care. The maintenance of effort requirement—that the state's share of Medicaid expenditures for personal care attendant services must remain at the same level or be greater than expenditures during the year prior to implementation of CFC—will deter states from adopting CFC if current personal care costs are at an unsustainable level. Alternatively, states may delay adopting CFC until personal care costs can be reduced through rate cuts, caps in allowable hours, or some other means. Another consideration for states is the requirement for a standardized assessment process and data collection to support quality assurance and reporting.

State Balancing Incentive Payments Program

The State Balancing Incentive Payments (SBIP) program in §10202 of the ACA goes into effect October 1, 2011. States meeting certain rebalancing targets will receive an increased FMAP during a four-year period (October 1, 2011, to September 30, 2015). States spending less than 25 percent of LTSS expenditures for community-based services will receive a 5 percent increase in FMAP and be expected to reach a target of 25 percent of expenditures for community-based services by October 1, 2015. States with 25 to 50 percent of LTSS expenditures for community-based services will receive a 2 percent increase in FMAP and be required to reach 50 percent of expenditures for community-based services by October 1, 2015. The legislation is silent on sanctions for states who do not meet the rebalancing targets.

Eligibility for the SBIP program will depend on CMS's method for calculating the percentage of Medicaid LTSS expenditures for community-based services, including whether adults aged 65 and older and persons with disabilities will be combined with individuals with developmental disabilities for benchmarking purposes, or whether the two populations will be benchmarked separately. Rebalancing strategies for the two populations differ, so it would make sense to

permit states to separate the populations. States that are presently closer to the rebalancing targets of 25 percent and 50 percent are more likely to meet those targets by 2015. In 2005, 37 percent of total Medicaid spending for LTSS in the United States was for HCBS (see Figure 1 on page 2). By 2009, the percentage had increased to 43.6 percent, an increase of 6.6 percentage points over four years. States that would need to increase their percentage of HCBS by more than 5 to 8 percentage points to reach the ACA target should carefully consider whether attaining the target is realistic.

In considering the SBIP program, states will take into account any sanctions for not achieving rebalancing targets and the maintenance of effort requirement, which does not permit states to impose more restrictive eligibility standards, methodologies, or procedures for non-institutional LTSS than what were in effect on December 31, 2010. States are also required to have a core standard assessment tool, an established single-point-of-entry for accessing LTSS, and "conflict-free case management" in which case managers act without self interest and receive no financial reward from the providers of the services they recommend (Reinhard, Kassner, & House, 2011).

Health Homes

Section 2703 of the ACA permits states to provide a "health home" to Medicaid beneficiaries with at least two chronic conditions under a new state plan option. The health home provider will be responsible for coordinating all of the individual's care, including physical health, mental health, and substance abuse prevention and treatment services. This new option became available to states on January 1, 2011. The FMAP for health home services will be 90 percent for the first two years that the state plan amendment is in effect. Recognizing that a new service such as this will require planning and development of a new payment methodology, the federal government is encouraging requests from states to spend up to $500,000 in Medicaid funding at the state's regular FMAP to finance planning activities.

The ACA defines chronic conditions to include asthma, diabetes, heart disease, a mental health condition, a substance use disorder, or a body mass index of over 25. States can target populations based on the number of chronic conditions, a specified combination of chronic conditions, or the severity of the chronic conditions. Six core health home services specified in the ACA are reimbursed at the 90 percent FMAP. All other services provided to the specified population are reimbursed at the state's regular FMAP.

States with existing health home programs based on rigorously tested models are most likely to take advantage of this program. The challenge will be engaging providers, bringing the programs to scale, and sustaining them over the long term. In addition, states with experience in coordinating care for dual eligibles will have an advantage,[13] as will states with experience with

[13] States may not exclude dual eligibles from health homes because participation cannot be limited by eligibility category. See §2703 of the ACA.

managed care and capitated rate setting. Particularly intriguing will be states that experiment with health homes within managed care models where health plans take responsibility for establishing the health homes, or states that expand the health home concept to include coordination of medical services with LTSS.

Money Follows the Person (MFP)

Section 2403 of the ACA extends the MFP demonstration to 2016, with appropriations totaling $2.25 billion for FYs 2012-2016. Thirteen new states were approved as MFP demonstration sites in February 2011, bringing the total number of MFP sites to 42 states and the District of Columbia. MFP is intended to strengthen the ability of states to transition individuals from institutions, eliminate barriers that prevent Medicaid beneficiaries form receiving LTSS in the setting of their choice, ensure the availability of quality community-based services, and assist states in rebalancing. States receive an enhanced FMAP (referred to as MFP "savings") for one year for qualifying HCBS for individuals who meet MFP eligibility requirements and transition to a qualifying residence in the community.

Many view MFP as just a nursing home transition program. However, with financial incentives for IT and infrastructure development, and the availability of funding for specialized staff and training, states should consider positioning MFP as the focal point of rebalancing efforts and using MFP funding to strategically invest in the state's LTSS system.

1915(i) State Plan Amendment

The DRA amended §1915 of the Social Security Act by adding subsection (i) to enable states to offer HCBS as a state plan benefit. However, only five states adopted the 1915(i) state plan benefit, so §2402 of the ACA makes further amendments in an attempt to encourage more states to consider this option. States may now include individuals with incomes up to 300 percent of the SSI Federal Benefit Rate who would be eligible for an HCBS waiver. In addition, states can target benefits to individuals with selected conditions. For example, states could target Medicaid beneficiaries with specified mental health conditions. However, states must now offer the benefit statewide, and there can be no ceiling on the number of individuals receiving the benefit. The changes to 1915(i) became effective October 1, 2010. CMS issued guidance on August 6, 2010, in a letter to state Medicaid directors.

While no additional FMAP is offered to states adopting the 1915(i), a number of states are considering it as a way to target individuals with serious mental health conditions for specialized services and supports that will enable them to remain in the community. The 2011 MFP demonstration grants that were authorized by the ACA gave preference to states targeting individuals aged under 21 and over 65 with mental illness for transitioning from institutions. States may want to consider a 1915(i) state plan amendment to serve these MFP participants.

Community Living Assistance Services and Supports (CLASS)

CLASS is a federally administered, voluntary insurance program that will be available to all Americans and financed through contributions from participating individuals. Individuals will pay premiums through payroll deductions in exchange for a cash benefit in the event of disability. Employees of employers who agree to participate in premium withholding will automatically be enrolled in the program, but may opt out at any time. Individuals employed by non-participating employers will be able to make premium payments under alternative arrangements.

An individual can qualify for a cash benefit if he or she has paid premiums for a minimum of five years, has a disability expected to last for at least 90 days, and meets functional and/or cognitive eligibility criteria established by the DHHS Secretary. The average benefit is expected to begin at about $50 per day, adjusted for inflation in future years. Cash benefits may be used to purchase nonmedical services and supports that enable the beneficiary to maintain independence at home or in a community-based setting. For Medicaid beneficiaries, a portion of the benefit is to be applied to the individual's institutional care or community-based LTSS. Regulations are expected from DHHS in November 2012; actual start-up could come as soon as 2013.

While the specifics of program administration and shared responsibility between the states and the federal government are yet to be worked out, states are likely to have a significant role in program administration—particularly in the areas of protection and advocacy, and potentially in eligibility assessment and advice and assistance counseling. More importantly, states must encourage consumers and employers to participate in CLASS and to take an active role in expanding the direct care workforce to support CLASS beneficiaries because CLASS benefits could potentially reduce reliance on the state's safety net.

In recent months, the long-term fiscal sustainability of CLASS has been questioned. By some estimates, federal distributions in the out-years will far exceed federal collections. In the upcoming deficit-reduction discussions that will be taking place in The White House and Congress, amendments to CLASS are likely to be proposed to address fiscal solvency.

Promoting Integrated Care for Dual Eligibles

The Medicare-Medicaid Coordination Office (MMCO) authorized by §2602 of the ACA is now in operation.[14] Closely aligned with the Center for Medicare and Medicaid Innovation (CMMI), MMCO is charged with improving the coordination between the federal government and the states to improve access to services for dual eligibles. The roles of MMCO are to a) provide states with analytical tools to evaluate service utilization and costs for dual eligibles; b) identify

[14] Originally called the Federal Coordinated Health Care Office (FCHCO) in the ACA, the name was changed to the Medicare-Medicaid Coordination Office (MMCO) in May 2011.

administrative, regulatory, and legislative policies that would improve the integration of Medicare and Medicaid services; and c) encourage state innovation through technical assistance and demonstrations.

In April 2011, CMMI announced awards for design contracts to 15 states[15] to develop innovative service delivery and payment models for integrating Medicare and Medicaid benefits for dual eligibles. Many of these states will be looking to the federal government to relax or waive federal rules that work against integrating Medicare and Medicaid benefits. MMCO is planning additional demonstrations for the near future.

In May 2011, MMCO announced a process for giving states access to Medicare for dual eligibles so that states can examine the cross-payer effects on service utilization and costs. Section 2601 of the ACA permits states with concurrent 1915(b)(c) Medicaid waivers serving dual eligibles to request that the waivers be synchronized so that they are on the same five-year renewal schedule. States are also considering consolidating waiver programs for dual eligibles into 1115 demonstration waivers. CMS has expressed willingness to consider such requests.

A Research Agenda for the Coming Decade

Assess the experience with the new authorities in the ACA. The ACA mandates evaluations of CFC and health homes, as well as annual monitoring of CLASS. MFP is being evaluated as required by the DRA. Other programs in the ACA should be evaluated as well (e.g., SBIP, the 1915(i) state plan option, and demonstrations sponsored by CMMI).

It would be instructive to assess overall take-up of the new ACA authorities, the extent to which states are implementing multiple initiatives simultaneously, and creative ways in which states build synergy and leverage rebalancing efforts. Examining factors influencing states' rebalancing decisions (e.g., demographics, fiscal conditions, political culture, and industry structure) and ultimate outcomes (e.g., access to HCBS, avoidable institutionalizations, and cost-effectiveness) could provide important lessons for both federal and state policy. It would also be informative to examine whether states are taking advantage of ACA provisions aimed at simplifying Medicaid program management (e.g., allowing states to synchronize concurrent waivers serving dual eligibles) and how administrative management might be further streamlined.

CLASS should be examined to determine how it will change consumer perceptions related to the need to prepare financially for functional decline during old age. How will sales of long-term care insurance be affected? What will be the impact on utilization of Medicaid LTSS? How can consumers be educated so that they understand that CLASS is merely one component of a balanced long-term care portfolio?

[15] California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin.

Section 5302 of the ACA provides institutions of higher education with incentives to train more direct care workers. To what extent are educational institutions partnering with state and local agencies to develop employment opportunities for these workers? How are these training programs affecting the direct care workforce and the quality of services provided in the home and community? Have training programs been coupled with other initiatives to increase the supply of direct care workers, such as the establishment of associations and public authorities that provide outreach, advocacy, training, and, in some cases, benefits and payroll services?

Evaluate innovative models for LTSS delivery. New evidence-based models for integrating behavioral health services into the LTSS system need to be developed and evaluated so that individuals with serious mental health conditions and problems with substance abuse can manage their conditions and successfully reside in the community. Similarly, new health home models should be developed and evaluated for individuals with co-morbidities and chronic conditions that engage primary care providers, link medical care and LTSS, and address the divide that exists between Medicare and Medicaid financing. There is a need for research on how to bring these models to scale in order to broaden their reach across populations and beyond circumscribed demonstration sites or geographic areas. Different financing arrangements and provider incentives should be developed and assessed, such as risk-based Medicaid managed care, integrated Medicare-Medicaid financing, pay-for-performance (P4P) incentives, and Accountable Care Organizations. It will also be important to examine the effectiveness of different models for care coordination across settings and providers. Finally, new initiatives are needed to support informal caregivers and provide subsidized housing so that people have a place to go when they leave an institution.

Test new models for integrating care for dual eligibles. There is a need for research to better understand the pathways to dual eligibility, the challenges dual eligibles encounter in accessing and coordinating services and supports across the medical and LTSS systems, and the incentives driving Medicare and Medicaid provider behavior. States want to better understand how dual eligibles make decisions about which Medicare and Medicaid plans to join, as well as the extent to which Medicare Advantage Special Needs Plans (SNPs)—which the ACA reauthorized through 2014—are available to consumers and meet consumer needs. Many states would like to have technical assistance on obtaining and linking Medicare and Medicaid data for dual eligibles at the individual level to facilitate program monitoring and evaluation. New models for integrating and financing Medicare and Medicaid benefits need to be developed and tested, and lessons learned should be shared with the states. Investigations into federal rules and regulations that might be waived or realigned to eliminate barriers to Medicare-Medicaid integration—while protecting consumer choice and program integrity—will be important to informing the debate on the most promising integrated care models.

Develop and evaluate LTSS delivery models that recognize the diverse needs of diverse populations. The populations needing LTSS vary, ranging from frail, older adults to younger adults with brain injuries or other physical disabilities to individuals with co-morbid conditions

such as serious mental illness coupled with heart disease, diabetes, and/or chronic obstructive pulmonary disease (COPD). More research is needed on the preferences of different populations (e.g., type of housing, level of community integration, involvement of family), the kinds of supports most suited to their needs (e.g., supports that enable younger people with disabilities to work or older people to age with dignity), the affordability of different models, and the challenges encountered in monitoring the quality of services delivered to dispersed, diverse populations.

Conduct research on more effectively assessing consumer needs for LTSS. A number of provisions in the ACA require states to have core standard assessment tools in place. More research is needed on such tools, including how to measure functional and health status, identify unmet needs, and develop consumer-centered care plans that address unmet needs and take into account natural supports. In order to better understand needs, perceptions of access to and availability of services, and how the LTSS system could work better, surveys and focus groups of consumers and families would be useful as well.

Examine how rebalancing is transforming care settings and service utilization. As states consider policies to incentivize provider behavior, research on the impact of state policies aimed at restricting nursing facility growth, expanding community-based services, and increasing the direct care workforce will be informative. It will be important to monitor how the nursing facility industry adapts to the shift toward community-based care by examining trends in bed supply, occupancy rates, patient demographics and acuity, payer mix, and service specialization and diversification. The emerging role of assisted living facilities should be examined, including the extent to which assisted living facilities are substituting for nursing facilities; the demographic characteristics, functional and health status, and service utilization patterns of assisted living residents; and trends in the supply of assisted living facilities, occupancy rates, and payer mix. Research on consumer satisfaction with and perceptions of assisted living (i.e., is assisted living community living or institutionalization?) would be informative.

With today's geographically dispersed families and the ability of consumers to employ relatives and friends as personal attendants, further research on the extent to which paid caregivers are replacing unpaid caregivers and the impact on LTSS costs and consumer satisfaction is needed.

If a state restricts access to a particular service because of budgetary constraints or to re-channel service utilization for some reason—for example, a state Medicaid program places an hourly cap on personal care services—is there a substitution effect? Studies are needed in order to tease out whether consumers use more adult day care in place of personal care, for example, or substitute personal care with more expensive services such as home health aide services, skilled nursing services, or nursing facility care.

Develop metrics to measure progress in rebalancing. A common methodology to measure rebalancing progress within and across states is needed. Several efforts are already underway to develop performance measures,[16] but there is not yet consensus on the "right" measures. Proposed measures must be rigorously tested and states must develop data collection processes and IT capability to report on the measures.

Final Thoughts

Even though the economy is showing signs of recovery, most states will continue to confront severe budget deficits over the next few years. Despite this, states voice an unwavering commitment to rebalancing their LTSS systems and ensuring that services are available to all who need them. However, states must find ways to allocate staff time and resources to LTSS transformation while concurrently implementing major health reform required by the ACA, ranging from Medicaid expansions to health insurance exchanges. LTSS provisions in the ACA offer an unprecedented opportunity for states to leverage their efforts by building on existing initiatives, experimenting with new designs, and creating new infrastructure. At the same time, aggressively pursuing a rigorous research agenda to guide and support state innovation is paramount to success.

[16] Measurement development includes:

1) The CMS-sponsored National Balancing Indicator Project. To date, 18 qualitative and quantitative indicators along 8 domains have been developed to measure states' progress in rebalancing and developing a person-driven LTSS system.
2) AARP, with support from the SCAN Foundation and the Commonwealth Fund, is developing an LTSS performance scorecard for states with a number of indicators across five domains aimed at measuring a high-performing LTSS system.
3) The Agency for Healthcare Research and Quality (AHRQ) is sponsoring the HCBS Measure Scan Project, which is focusing on potentially preventable hospitalizations among the Medicaid HCBS population.
4) Twenty-five states are participating in the National Core Indicators project sponsored by the National Association of State Directors of Developmental Disabilities Services (NASDDDS) to inform policy and priority setting for the population with ID/DD.
5) The Hilltop Institute has developed rebalancing metrics as part of Maryland's MFP program that could be adopted more broadly by other MFP states.

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