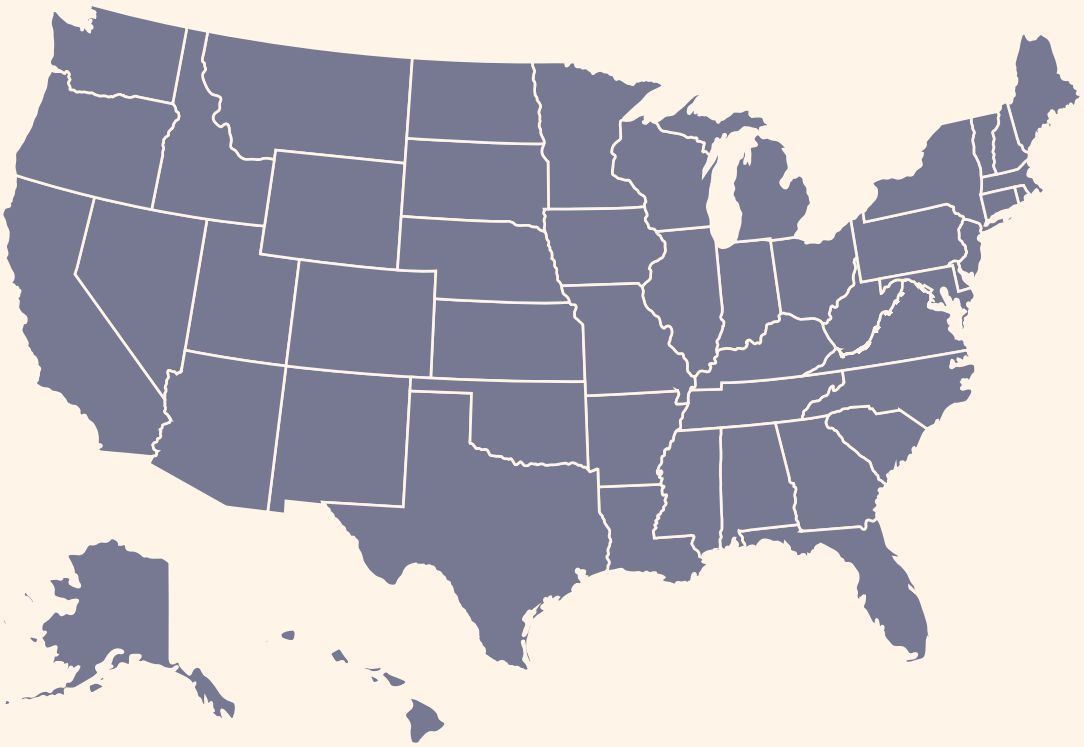
Long-Term Services and Supports State Scorecard

2020 Edition | Reference Edition

ADVANCING ACTION

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



AARP Public Policy Institute

longtermscorecard.org

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AARP Foundation

The Commonwealth Fund

THE scan FOUNDATION

AARP Foundation's mission is to serve vulnerable people ages 50+ by creating and advancing effective solutions that help them secure the essentials. AARP Foundation helps millions of older Americans who struggle to meet their basic need for nutritious food, safe and affordable housing, adequate income, and much-needed personal connections.

The Commonwealth Fund, among the first private foundations started by a woman philanthropist—Anna M. Harkness—was established in 1918 with the broad charge to enhance the common good. The mission of The Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, and people of color. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy.

The SCAN Foundation is an independent public charity devoted to advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit http://www.TheSCANFoundation.org.

Preface

From the Authors: The *Scorecard's* Release in a 2020 Context

Advancing Action: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers is the fourth edition in a series that began in 2011.

This report is a compilation of state data and analysis that is based on a vision of a high-performing system of long-term services and supports (LTSS). By using reliable, consistent, available data, it is designed to spark conversations that can result in actionable solutions at the local, state, and national levels—solutions that help older adults, people with physical disabilities, and their family caregivers live their best lives possible. Making that happen is the responsibility of both the public and private sectors, with advocates playing crucial roles. And consumers' choices and actions ultimately affect a state's LTSS system as well.

The *2020 Scorecard* in Context of a Pandemic

Clearly, context matters. As we release this *Scorecard*, the nation is in the midst of a coronavirus pandemic (COVID-19) that is highly contagious and has particular severity for older people, those with multiple health conditions, and the direct care workers and family caregivers who support them. At the time of this writing, COVID-19 is perhaps the single greatest global concern, affecting every sector of life, including the economy, social interaction, health care, and—directly related to this *Scorecard*—LTSS system performance. Yet as a result of the sudden arrival and ongoing impact of the virus, it is outside the scope of this edition of the *Scorecard.* The most current available data, collected for this *Scorecard*, generally cover the period 2016–2019. These data were collected and analyzed in 2019, and so the *Scorecard* paints a picture of comprehensive LTSS system performance before the outbreak began. LTSS system performance in the areas of affordability and access, choice of setting and provider, quality of life and quality of care, support for family caregivers, and effective transitions remain both highly variable between states and critically important.

Scorecard Findings and COVID-19: Setting Expectations

It is important to consider certain elements of the *Scorecard* as it relates to the current pandemic.

First, the *Scorecard* does not contain any measures that are directly relevant to COVID-19 preparedness, impact, or response. This is not merely because the *Scorecard* data predate the emergence of the virus. Currently available COVID-19 measures are not complete or consistently comparable across states, LTSS settings, and source of payment. If it were possible to include COVID-19 preparedness or response measures in the *Scorecard*, they would be included in the Quality of Life and Quality of Care dimension. We have long called for better and more comparable data on LTSS users, services, outcomes, and especially quality—even considering the quality dimension to be incomplete in the last two *Scorecards*. The recent outbreak shines a stronger light on why more and better data are needed.

Second, the prevalence of COVID-19 cases, deaths, and other adverse outcomes in LTSS settings depends not only on LTSS system performance but also on a number of public health and societal factors, and the rate of community spread. Where there is significant community spread of COVID-19, there will be a significant impact on the LTSS system. That does not mean, however, that LTSS providers, policy makers, and other stakeholders are helpless in affecting the spread and lethality of COVID-19. Their role is crucial, even if the impact cannot be adequately measured at this time.

Third, the COVID-19 pandemic has put a national spotlight on one particular LTSS setting: nursing homes. With good reason, both the public and policy makers are concerned about the disproportionate impact on vulnerable individuals with underlying health conditions living in congregate care settings. However, most people receiving LTSS are not in nursing homes. LTSS users and providers in other settings are also highly vulnerable, and should similarly get special attention and public scrutiny. As states begin to rethink congregate care settings after COVID-19, other sources of LTSS, including home- and community-based services (HCBS) and family caregiving, may increase in importance.

The *Scorecard's* Appeal: Reimagining Policy Solutions

The pandemic has drawn attention to LTSS challenges, especially in residential settings. We will need to learn from COVID-19 experiences, but it is the data in the *Scorecard* that will provide the foundation for understanding LTSS system reform today and tomorrow. State LTSS systems may look very different in a post-pandemic world, in ways that we cannot yet know. The *Scorecard* offers policy ideas and best practices that can help states achieve high performance as they rebuild and reimagine their LTSS systems going forward.

Some of the policies tracked in the *Scorecard* are particularly critical as the nation moves to relief and recovery post-COVID. For example, having paid sick leave and being able to use it for family caregiving becomes even more important, so that individuals can tend to their own health and the health of their family members without the risk of losing a paycheck. Similarly, states with policies enabling them to fully utilize their health care workforce offer consumers greater access to health care services and preventative screenings that can help individuals live healthy independent lives. Policies that promote direct patient access to nurse practitioners, working to the full extent of their education and training, also expands the health care workforce capacity to manage a future health crisis.

Lessons Learned and Policy Efforts Linked to *Scorecard* Findings

A fundamental shift to more consumer options for HCBS will be both essential to keep consumers safe and a financial necessity for states struggling with post-COVID budget deficits. Once the public health emergency is over, states will likely face enormous budget shortfalls and an arduous economic recovery. This will put new pressure on policy makers to offer consumers choices that keep them safe at home and, from the budget-conscious policy-maker perspective, at a fraction of the cost of institutional care.

Independent living options also require a robust health care and LTSS workforce. Several states took emergency action to expand health care access by enabling nurse practitioners to work to the full extent of their education and training during the pandemic. States that temporarily provided direct patient access to nurse practitioners will need to consider permanent policy solutions that ensure patients receive care when and where they need it. Additional emergency actions, such as creating centralized referral and information services or toll-free hotlines, can become the basis of a robust "No Wrong Door" system that helps individuals and family caregivers navigate LTSS options, including nursing home alternatives, regardless of where they first seek help.

Information Informs Improvement

Emergencies can illuminate the vulnerabilities in local, state, and national systems, for people of all ages. They can also present a renewed interest in data, trends, and best practices that can inform evidence-based decisions. This in turn can spark reflection and reassessment of long-standing policies and create the opportunity for an intentional redesign of a high-performing LTSS system.

Good data and accurate measurements are the foundation for meaningful improvement. The deadly consequences of COVID-19 in nursing homes add new urgency and demand for relevant and reliable data on infection, quality, and preparedness. These and other data are essential to inform evidence-based solutions and raise the level of LTSS system performance. The *Scorecard* remains committed to capturing the best available, reliable data on LTSS quality, including relevant and appropriate infection measures arising from the COVID-19 pandemic.

Historically we have envisioned the *LTSS Scorecards*, including this latest edition, as a tool to identify opportunities and catalyze improvement of state LTSS systems to meet growing future demand for long-term services and supports. Now more than ever, the *2020 Scorecard* calls for advancing action to improve the lives of older adults, people with disabilities, and family caregivers.

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ADVANCING ACTION

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

Purpose

The *2020 Long-Term Services and Supports (LTSS) State Scorecard* aims to empower state and federal policy makers, the private sector, and consumers with information they need to do the following:

- Effectively assess their state's performance across multiple dimensions and indicators.
- Learn from other states.
- Improve the lives of older adults, people with disabilities, and their families.

The *Scorecard* is guided by the belief that, in order to meaningfully manage and improve performance, one must measure it. Unlike many other rankings that focus on a particular aspect of LTSS system performance, the *Scorecard* compares state LTSS systems across multiple dimensions of performance, reflecting the importance and interconnectedness each has on the overall LTSS system. The goal is to spark conversations, galvanize broad-based coalitions, and focus stakeholders' attention on the factors that most directly impact consumers and their families.

About the *Scorecard*

LTSS affects everyone. LTSS includes a continuum of services provided in the home and community or an institutional setting. These supports help older people and adults with physical disabilities manage tasks that would be difficult or impossible to perform on their own, such as personal care (e.g., bathing, dressing, and toileting); complex care (e.g., medication administration, wound care); home care (e.g., help with housekeeping and meal preparation), and transportation. Although older people are more likely to need LTSS, people of all ages rely on the LTSS system. In 2018, more than half (56 percent) of American adults who needed LTSS were ages 65 or older, while 44 percent were ages 18 to 64.[1] The LTSS system can also be a source of support for approximately 41 million family caregivers who help family and close friends with daily tasks.[2] In 2017, collectively about $235 million was spent on formal (paid) LTSS across all settings.[3]

As the country ages and adults with physical disabilities seek more options to remain independent, the need for LTSS will continue to grow. States have the opportunity to act now in strengthening LTSS systems and identifying new ways to maximize the use of limited resources to account for these demographic shifts.

The *Scorecard* offers accurate, reliable, and comparable data that can serve as the basis for evidence-based solutions so that older people and adults with disabilities in all states can exercise choice and control over their lives, thereby maximizing their independence and well-being. High-performing LTSS systems also ensure that family caregivers have the support they need when caring for close relatives and friends.

1 Edem Hado and Harriet Komisar, "Long-Term Services and Supports," Fact Sheet, AARP Public Policy Institute, Washington, DC, August 2019, https://www.aarp.org/content/dam/aarp/ppi/2019/08/long-term-services-and-supports.doi.10.26419-2Fppi.00079.001.pdf.

2 Susan C. Reinhard et al., *Valuing the Invaluable: 2019 Update: Charting a Path Forward* (Washington, DC: AARP Public Policy Institute, November 2019), https://www.aarp.org/content/dam/aarp/ppi/2019/11/valuing-the-invaluable-2019-update-charting-a-path-forward.doi.10.26419-2Fppi.00082.001.pdf.

3 Hado and Komisar (2019).

Furthermore, the *Scorecard* strives to present a complete and comprehensive assessment of LTSS system performance across five key characteristics; but the *Scorecard* can only be as complete and comprehensive as the data that are available to measure performance, and data availability continues to fall short of where it ought to be. From the beginning of the *Scorecard* project, a key finding has been that better data are needed to assess state LTSS system performance. In the first *Scorecard*, released in September 2011, six specific data gaps were identified, and others have subsequently been noted.

In the decade since that initial assessment, there have been some successes in addressing these gaps, particularly in the area of effective transitions, and measures of subsidized housing and transportation policies. However, there have been some retreats in data quality and availability as well: quality of life in the community, staffing turnover, and basic Medicaid LTSS participant and spending data. In the last *Scorecard*, continued erosion of data availability to measure quality of life and quality of care resulted in the dimension being considered "incomplete." That continues to be the case in this *Scorecard*, and better data are still needed, such as prevention of infection in all LTSS settings (e.g., nursing homes, assisted living, adult day care, and home care).

EXHIBIT 1 Framework for Assessing LTSS System Performance

HIGH-PERFORMING LTSS SYSTEM

Five dimensions of LTSS performance, constructed from 26 individual indicators.

AFFORDABILITY AND ACCESS

1. Nursing Home Cost
2. Home Care Cost
3. Long-Term Care Insurance
4. Low-Income PWD with Medicaid
5. PWD with Medicaid LTSS
6. ADRC/NWD Functions

CHOICE OF SETTING AND PROVIDER

1. Medicaid LTSS Balance: Spending
2. Medicaid LTSS Balance: Users
3. Self-Direction
4. Home Health Aide Supply
5. Assisted Living Supply
6. Adult Day Services Supply
7. Subsidized Housing Opportunities

QUALITY OF LIFE AND QUALITY OF CARE

1. PWD Rate of Employment
2. Nursing Home Residents with Pressure Sores
3. Nursing Home Antipsychotic Use
4. HCBS Quality Benchmarking

SUPPORT FOR FAMILY CAREGIVERS*

1. Supporting Working Family Caregivers
2. Person- and Family-Centered Care
3. Nurse Delegation and Scope of Practice
4. Transportation Policies

EFFECTIVE TRANSITIONS

1. Nursing Home Residents with Low Care Needs
2. Home Health Hospital Admissions
3. Nursing Home Hospital Admissions
4. Burdensome Transitions
5. Successful Discharge to Community

ADRC/NWD - Aging and Disability Resource Center/No Wrong Door
HCBS - Home- and Community-Based Services
LTSS - Long-Term Services and Supports
PWD - People with Disabilities
*Support for Family Caregivers Dimension evaluated across 12 individual policies, which are grouped into four broad categories.

Source: Long-Term Services and Supports State Scorecard, 2020.

The Vision

By definition, a vision is aspirational. Guided by the *Scorecard* National Advisory Panel, our vision of LTSS system performance is composed of five characteristics that are approximated in the *Scorecard* by dimensions for which LTSS performance can be measured where data are available. Each dimension is constructed from individual indicators that are interpretable and show variation across states (see Exhibit 1). Achieving this vision takes concerted action, as well as data to measure the extent to which states reach the vision.

1. **Affordability and Access**
   Consumers are able to easily find, pay for, and receive the services they need in the setting they choose. Medicaid public safety nets are sufficient to provide peace of mind and security to those who cannot afford services.
2. **Choice of Setting and Provider**
   Consumers are at the center of care and have the choice of setting and control over their services and who provides them.
3. **Quality of Life and Quality of Care**
   Consumers are treated with dignity and respect. Their personal preferences and aspirations are honored whenever possible. The services they receive are effective and quality is measured and compared both within and across states for continuous improvement.
4. **Support for Family Caregivers**
   Family caregivers are recognized as the backbone of the LTSS system. Caregivers' own needs are identified and supported.
5. **Effective Transitions**
   Consumers experience seamless coordination across LTSS and health care systems with minimal disruption and unnecessary hospitalizations.

How Different Stakeholders Can Use the *Scorecard*

State Agencies/Policy Makers

The *Scorecard* is a useful tool to benchmark and compare LTSS performance across states and identify innovative and promising practices. Here are some ways state agencies and policy makers can use the *Scorecard* to advance action:

- **Ensure effective implementation.** State agencies play a critical role in implementing policy decisions in their state. Areas of weakness identified by the *Scorecard* may signal the need for additional quality oversight or monitoring. In the absence of sufficient data to guide decisions, policy makers should seek more data as part of any plan of action.
- **Influence policy debates.** Agency officials and program managers can look within their own state data to understand what the *Scorecard* is measuring and how those measurements reflect performance against other states. State agency officials can refer to *Scorecard* findings to inform policy decisions, evaluate funding proposals, and shape public debate.
- **Discover promising practices.** The *Scorecard* highlights a handful of states that stand out in performance. Examples of innovative solutions are documented in Promising Practices and Emerging Innovations reports available at http://www.longtermscorecard.org. Policy makers may choose to adopt successful strategies from other states to improve their LTSS system.
- **Engage the public and private sectors**. Consider sharing the information about state rankings with community partners, advocates, the private sector, and other stakeholders to assess what is or is not working. The *Scorecard* measurements can help guide those conversations and drive consensus on action steps.

Advocates

The *Scorecard* can serve as a road map to improve the lives of individuals who use LTSS and increase efficiencies in state LTSS systems. Here are some ways that advocates can use the *Scorecard* to advance action:

- **Seek robust quality data and public reporting.** In order to ensure consumers are well-informed and prepared to advocate for themselves and their family members, they must have access to reliable and current LTSS data for both institutional and community settings. Where public reporting and data collection is inconsistent, advocates should seek more data and transparency.
- **Identify opportunities**. Advocates can consider how recent initiatives and strategies have impacted state performance across various indicators over time. If there are links between recent policy or budget decisions and improvements in performance, advocates may choose to celebrate that progress. Advocates can apply the information available in the *Scorecard* to tackle needs and leverage opportunities locally.
- **Evaluate legislative and budget proposals against *Scorecard* measurements.** *Scorecard* data, charts, state fact sheets, and state comparisons can provide advocates with an evidence-based rationale to support policy changes and enactment of model legislation. Advocates may wish to refer to *Scorecard* findings when delivering public testimony before legislative committees or making presentations to relevant stakeholders.
- **Draw comparisons to similar states**. Advocates may wish to adopt successful strategies from high-performing states and seed those ideas with key policy makers and legislators. When looking for other state examples, it may be useful to start with neighboring states or those with similar population size or demographics.
- **Spark conversation**. The *Scorecard* can be a useful resource to build bridges with other organizations and spark conversation with the public so that those and other stakeholders can understand state results, assess common priorities, and identify opportunities for action.
- **Capture the attention of key influencers**. Advocates may wish to leverage the *Scorecard* to draw attention to the findings and implications for local residents. Advocates can help identify points of intersection between state policy priorities and the *Scorecard* findings. Additionally, advocates can help contextualize the data by sharing personal stories and experiences with policy makers.

Family Caregivers

The *Scorecard* provides family caregivers with a high-level scan of policies in place to assist and support them. Availability of these supports varies considerably across states.

- **Find available resources.** The *Scorecard* may alert family caregivers about a new resource or an underutilized benefit in their own state. For example, a family caregiver may learn that their state or locality guarantees family caregivers workplace protections against discrimination or flexible leave to help balance work and family responsibilities.

Tools to Use

Find full results and more on the *LTSS State Scorecard* website. Go to http://www.longtermscorecard.org for the following:

1. **State Data and Fact Sheets**
   Get state-specific data, compare state performance and/or rankings, and download fact sheets for each state.
2. **Maps, Graphics, and Tools**
   Explore the data with easy-to-use maps and tools. Visualize the findings in each dimension.
3. **Videos**
   See the impact of the *Scorecard* and programs for people with LTSS needs.
4. **Promising Practices and Other Resources**
   Download, read, and share papers that provide concrete examples of programs and policies from states that have performed well in a specific area. Learn which LTSS innovations states are developing, piloting, or testing.

Fourth Edition of the *Scorecard*

This *2020 Long-Term Services and Supports State Scorecard* is the fourth edition in an ongoing series. The previous *Scorecards* were published in 2011, 2014, and 2017. The *2020 Scorecard* ranks all 50 states and the District of Columbia on a set of 26 indicators across 5 dimensions. Ten indicators in the *2020 Scorecard* differ from the previous edition: 2 indicators are entirely new; 2 indicators are replaced with similar constructs; and 6 have revised definitions, owing to changes in data sources or data availability.

New Indicators (2):

- Adult day services total licensed capacity per 10,000 population ages 65 and older
- Home- and community-based services (HCBS) quality cross-state benchmarking capability

Replaced Indicators (2):

- Estimated percentage of Medicaid aged/disabled LTSS users receiving HCBS
- Percentage of short-stay residents who were successfully discharged to the community

Revised Indicators (6):

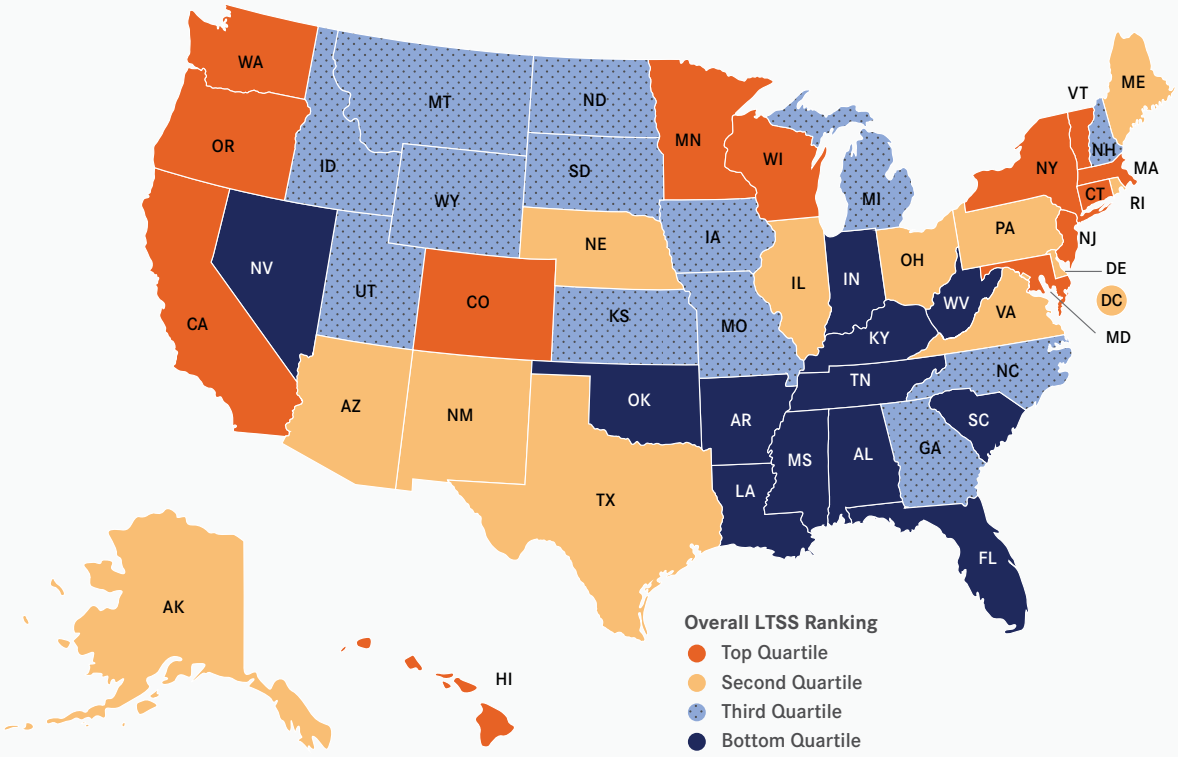
- Private long-term care insurance policies in effect per 1,000 population ages 40+
- Estimated Medicaid LTSS users per 100 population with ADL disability
- Percentage of high-risk nursing home residents with pressure sores
- Percentage of nursing home residents with low care needs
- Percentage of home health patients with a hospital admission
- Percentage of nursing home residents with one or more potentially burdensome transitions at end of life

State Rankings

How Does Your State Rank?

Exhibit 2 shows overall state LTSS system performance by quartile across all 50 states and the District of Columbia.[4] Exhibit 3 presents all states in order of overall LTSS system performance and shows performance across all five key dimensions. High-performing state LTSS systems tend to perform well across all dimensions, while low-performing states have room for improvement in many areas. Complete results for every dimension and indicator are available in the Appendices.

EXHIBIT 2 *2020 State Scorecard* Summary of LTSS System Performance Across Dimensions—National Heat Map of All States and the District of Columbia



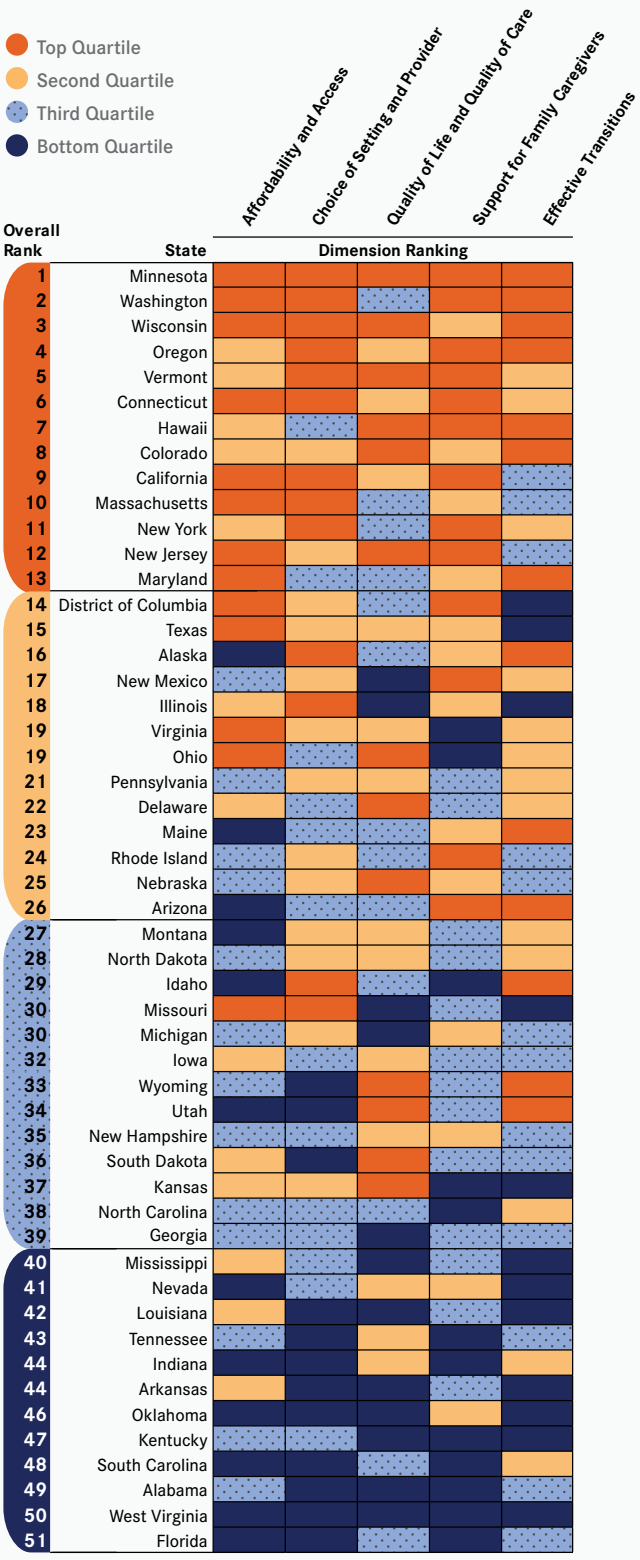
Note: Rankings are not entirely comparable to previous *Scorecard* rankings. Changes in rank may not reflect changes in performance. Measures may be different and improved performance can result in a lower rank if other states experienced greater improvement.

Source: Long-Term Services and Supports State Scorecard, 2020.

4 The District of Columbia is ranked alongside all 50 states and hereafter will be categorized in the *Scorecard* as 1 of 51 states.

EXHIBIT 3

2020 State Scorecard Summary of LTSS System Performance Across Dimensions—Matrix Heat Map of All States and the District of Columbia



Source: Long-Term Services and Supports State Scorecard, 2020.

A Note On Methodology

The scoring and ranking methodology in this *Scorecard* is based on the same methodology used in previous *LTSS State Scorecards.* As in the *2017 Scorecard*, the Quality of Life and Quality of Care dimension is given half the weight of the other dimensions in determining the overall rank, and the Support for Family Caregivers dimension is calculated as a single composite.

Dimensions and Indicators: The *Scorecard* measures LTSS system performance using 26 indicators (or policy categories) across 5 dimensions:

- Affordability and Access (6 indicators)
- Choice of Setting and Provider (7 indicators)
- Quality of Life and Quality of Care (4 indicators)
- Support for Family Caregivers (12 policy areas, grouped into 4 broad categories)
- Effective Transitions (5 indicators)

Indicators had to be clear, important, and meaningful, and have comparable data available at the state level. These 26 indicators were selected because they represent the best available measures at the state level. While no single indicator can fully capture LTSS system performance, taken together they provide a useful measure of how state LTSS systems compare across a range of important dimensions.

Ranking Methodology: The *Scorecard* ranks the states from highest to lowest performance on each indicator in the Affordability and Access, Choice of Setting and Provider, Quality of Life and Quality of Care, and Effective Transitions dimensions. Within each of these four dimensions, individual indicator ranks are averaged and those averages are then re-ranked for dimension-level ranks. The Support for Family Caregivers dimension is a single composite across all 12 policy areas, and dimension rank is based on the total composite score. The dimension ranks are then averaged (with the Quality dimension given half weight) and re-ranked to compute the overall ranking of LTSS system performance. In the case of missing data or ties in rank, minor adjustments are made to values used in calculating the average. See Exhibit B2 in Appendix B for more detail.

Measuring Change In Performance Over Time

One of the main goals of this report is to assess how state LTSS systems improved or declined between the *2017 Scorecard* and the *2020 Scorecard*. However, state ranks at the dimension and overall levels should not be compared directly between the current *Scorecard* and prior *Scorecards*. There are significant changes in the methodology and indicator sets, so changes in rank may not reflect actual changes in relative performance.

Change in performance can be measured directly at the indicator level. Baseline year data (typically three years prior to the most current data) are available for 21 of the 26 indicators in the *Scorecard*. For these 21 indicators, the *Scorecard* reports both current and baseline data, and identifies meaningful change (either positive or negative). Note that the period of time covered by the data varies by indicator. Some measures have a significant data lag, so the change measured in the *2020 Scorecard* may have occurred prior to the publication of the *2017 Scorecard*.

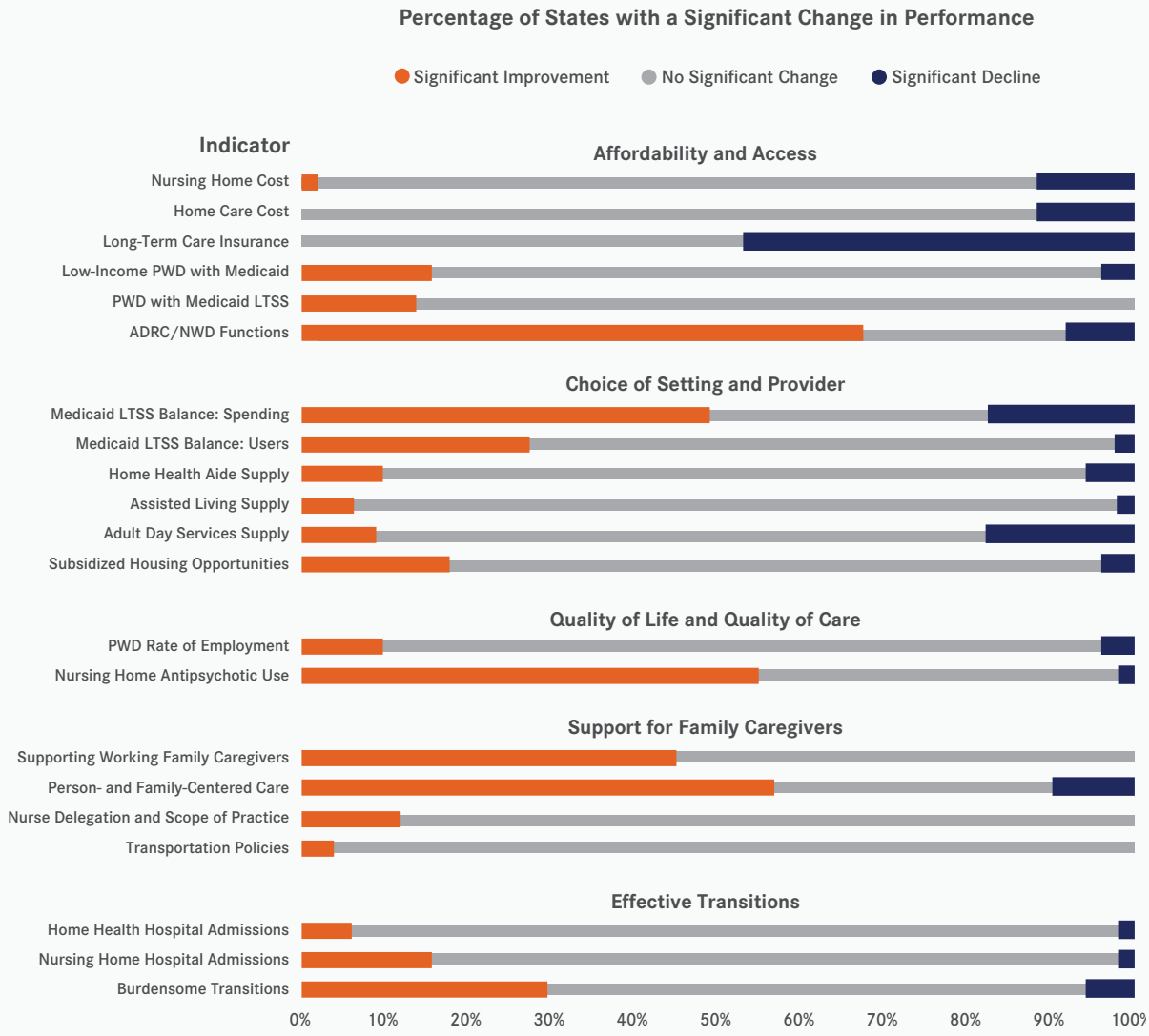
To aid in the interpretation of indicator-level change, appendix data tables show current and baseline values for each trended indicator, and also indicate the magnitude of changes with a green check mark for a substantial improvement, a red X for a substantial decline, and a black, two-headed arrow for little or no change. For most measures, a threshold of 10 or 20 percent or more was used. More detail about how change over time is measured, including thresholds for each trended indicator, may be found in Exhibit B3 in Appendix B.

Major Findings

States Made Modest Progress, but the Status Quo Dominates

State performance remained largely flat across most of the indicators. As demonstrated by the gray bars in Exhibit 4, among the 21 indicators for which performance could be measured over time, at least 60 percent of states (more than 30 states) showed little or no change for 15 indicators. With only incremental improvement across indicators at a time when demographic trends portend a rapid increase in LTSS demand, the *Scorecard* results suggest that many states may not be well prepared to offer affordable, accessible LTSS choices for individuals in the future.

EXHIBIT 4 Change in State Performance by Indicator: Percentage of States



Improvement or decline means a significant change (usually +/- 10% or equivalent) since a reference data year (usually three years prior). For some measures, a revised baseline is used, as the indicator definition or data source may have changed since the last *Scorecard*.
ADRC/NWD = Aging and Disability Resource Center/No Wrong Door.
PWD = People with Disabilities.

Source: Long-Term Services and Supports State Scorecard, 2020.

On some elements of LTSS system performance, however, some states did pick up the pace of change. Specifically, at least 40 percent of states (more than 20 states) showed significant improvement in performance in five indicators:

- Aging and Disability Resource Center (ADRC)/No Wrong Door (NWD) Functions
- Medicaid LTSS Balance: Spending
- Nursing Home Antipsychotic Use
- Supporting Working Family Caregivers
- Person- and Family-Centered Care

The Long-Term Care Insurance indicator was the only measure with 20 or more states showing a significant decline in performance.

"State performance remained largely flat across most of the indicators."

Even the Highest-Performing States Have Room for Improvement

Minnesota and Washington have been ranked either 1 or 2 in every edition of the *Scorecard*. In this fourth edition, Minnesota ranked 1, followed by Washington, Wisconsin, Oregon, and Vermont.

The four editions of the *Scorecard* each used slightly different methodologies and indicator sets, based primarily on data availability. Therefore, ranks are not directly comparable between years, but the results across all four *Scorecard* editions nevertheless indicate that Minnesota and Washington are consistently on top.

The leading states tend to do well across multiple dimensions; however, all states can improve on one or more of the five dimensions of performance. Only Minnesota scored in the top quartile across all five dimensions. In no case did a state score in the top 10 across all dimensions.

Exhibit 5 highlights that the top-performing states still have an opportunity to improve in specific indicators.

EXHIBIT 5 Top Five States and Improvements Needed

Rank	State	Improvement Needed
1	Minnesota	#11 in Effective Transitions
2	Washington	#27 in Quality of Life and Quality of Care
3	Wisconsin	#17 in Support for Family Caregivers
4	Oregon	#24 in Affordability and Access #23 in Quality of Life and Quality of Care
5	Vermont	#23 in Affordability and Access #16 in Effective Transitions

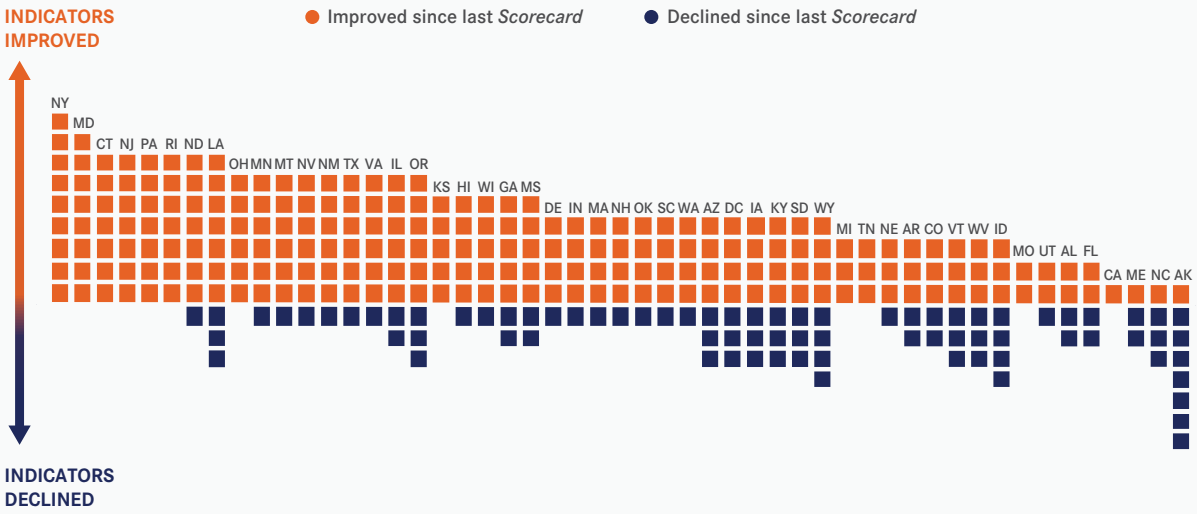
Source: Long-Term Services and Supports State Scorecard, 2020.

States with the Greatest Number of Improved Indicators

As shown in Exhibit 6, one-third of states (17) improved significantly in six or more of the 21 indicators for which trend data are available in this *Scorecard*. These states ranged from six in the top quartile of performance to two states that ranked in the bottom quartile, demonstrating that states at all levels of LTSS system performance can show significant improvement based on the specific elements of this *Scorecard*.

Among the 17 states having the greatest number of indicators with significant improvement, seven states showed significant improvement in six or more indicators and a decline in none. The other 10 states declined significantly in one or more indicators.

EXHIBIT 6 Number of Indicators Improved and Declined by State



Notes: Each block represents one significantly changed indicator.
States are arranged in order of greatest to least number of indicators showing improvement. Improvement or decline means a significant change (usually +/- 10% or equivalent) since a reference data year (usually three years prior). For some measures, a revised baseline is used, as the indicator definition or data source may have changed since the last *Scorecard*.

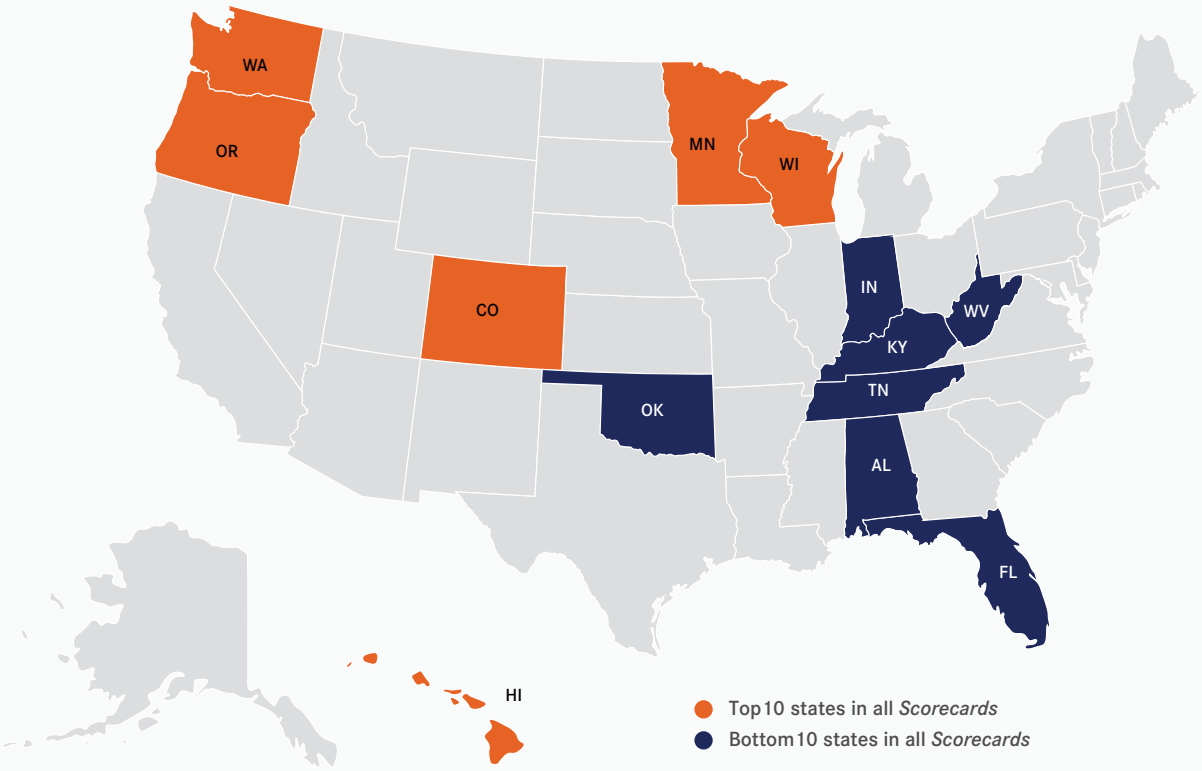
Source: Long-Term Services and Supports State Scorecard, 2020.

"The leading states tend to do well across multiple dimensions; however, all states can improve on one or more of the five dimensions of performance."

Top- and Bottom-Ranked States Have Remained Consistent

Although the indicator set has been different for each *Scorecard*, and ranks are not directly comparable, the same states have generally ranked near the top and near the bottom over the past decade. As shown in Exhibit 7, six states have consistently ranked in the top 10 and seven states have consistently ranked in the bottom 10 across all four editions of the *Scorecard*.

EXHIBIT 7 Top- and Bottom-Ranked States in Overall System Performance Across All Four *LTSS State Scorecards*



Source: Long-Term Services and Supports State Scorecard, 2020.

States Showed the Most Progress in Five Areas

ADRC/NWD Functions. In many states and communities, LTSS is fragmented and administered across multiple agencies and providers. The process of navigating a complex LTSS system can put unnecessary strain on those who need services and their families. To help address this, all states have created ADRCs that function as a single point of access or an NWD system to help streamline access to LTSS for older adults and people with disabilities.

ADRCs can serve as the gateway for helping individuals of all ages, abilities, and income levels and their families find and access LTSS, including light housekeeping, transportation, and respite care. An NWD system can provide counseling on options for individuals and families to help them make informed decisions based on individual circumstances.

However, the function and capabilities of ADRCs differ significantly among states, and so do their level of support for consumers and family caregivers. High-performing ADRCs can help individuals determine their LTSS needs, understand the full range of options available to them,

and connect individuals to the services that are right for them. Nine of the top 10 states have fully operational NWD systems that conduct nursing facility preadmission screenings. The prescreening function helps expedite HCBS eligibility and avoid nursing home placement for those who wish to receive services in the community.

Of the 21 indicators for which performance could be measured over time, the ADRC/NWD indicator had the greatest number of states showing improvement. Thirty-three states demonstrated meaningful improvement, 13 of which improved by 11 percent or more (Alabama, Arizona, District of Columbia, Georgia, Hawaii, Indiana, Kentucky, Mississippi, New York, Oregon, South Dakota, Tennessee, and Wisconsin). The states with the most improvement focused on expanding training for person-centered counseling, implementing Lifespan respite grants,[5] and strengthening their public outreach.

Medicaid LTSS Balance: Spending. Most adults ages 50 and older prefer to remain in their homes and communities for as long as possible.[6] Appropriate Medicaid balance between nursing homes and HCBS helps ensure this. Half the states improved their spending to reflect consumer demand for more care support in their homes, and communities and nearly a quarter spend a majority on HCBS.

However, improvement was uneven across states. The spread between high- and low-performing states is widening as a result of both stronger performance among high-performing states and regression in some of the lowest-performing states.

Of the 13 states in the top quartile, eight saw significant improvement and only one saw a significant decline. By comparison, of the 12 states in the bottom quartile, four saw significant improvement but five saw significant decline.

Inappropriate Use of Antipsychotic Medication in Nursing Homes. For the second *Scorecard* in a row, most of the states experienced a significant decrease in the inappropriate use of antipsychotic medications in nursing homes. While this is a potentially promising trend, more research is needed to understand how improved performance was accomplished. Stakeholders should consider whether the change coincides with a higher rate of diagnosis for schizophrenia among the population ages 65 and older, the impact of staff training and staffing ratios, and how occupancy rates and resident population mix may impact this measure.

Supporting Working Family Caregivers. The *Scorecard* also found significant progress in the enactment of public policies that support working family caregivers. More states and localities are recognizing the competing pressures on family caregivers and offering flexibility to use accrued sick time for family caregiving responsibilities. States are also enacting paid family leave programs to ensure that family caregivers do not risk losing their paycheck when close family members need help. Since the last *Scorecard*, the number of states with paid family leave programs tripled from three states to nine states.

Person- and Family-Centered Care. Most states (29) improved significantly on this indicator, which measures performance on three types of policies: (a) state policies on financial protection for spouses of Medicaid beneficiaries who receive HCBS; (b) assessment of family caregivers' own needs; and (c) enactment of the Caregiver Advise, Record, Enable (CARE) Act. The biggest factor driving improvement was the number of states conducting assessments of family caregivers for

5 Lifespan respite care programs are coordinated systems of accessible, community-based respite care services for family caregivers of children and adults of all ages with special needs. In 2006, Congress passed the Lifespan Respite Care Act, which authorized competitive grants to ADRCs in collaboration with public or private nonprofit state respite coalition organizations to make quality respite available and accessible to family caregivers regardless of age or disability. Lifespan respite care programs reduce duplication of effort and assist in the development of respite care infrastructures at the state and local levels. As of 2017, competitive grants of up to $200,000 each were awarded to eligible agencies in 37 states and the District of Columbia.

6 Joanne Binette and Kerri Vasold, "2018 Home and Community Preferences: A National Survey of Adults Ages 18-Plus," AARP Research, Washington, DC, July 2019, https://www.aarp.org/research/topics/community/info-2018/2018-home-community-preference.html.

their own health needs and well-being. Twenty-four states saw significant improvement in this area, bringing the total number of states conducting family caregiver assessments to 41.

States also continue to make strong progress in enacting the CARE Act. Nine additional states have enacted the CARE Act since 2016, bringing the total to 41 states.[7]

Specific provisions of the CARE Act vary by state, but generally require hospitals to do the following:*

ADVISE all patients of their opportunity to identify a family caregiver.

RECORD the family caregiver's name and contact information in the health record with the patient's permission.

ENABLE family caregivers by providing as much notice as possible about the discharge timing, consult with them on the discharge plan, discuss with them the family caregiver's role in carrying out the discharge plan, and instruct them on any medical or nursing tasks family caregivers will handle at home.

*Susan C. Reinhard and Elaine Ryan, "The CARE Act Implementation: Progress and Promise," AARP Public Policy Institute, Washington, DC, March 2019.

States Showed a Significant Decline in Long-Term Care Insurance Policies

Everyone faces a risk, but not a certainty, of needing LTSS. A 2015 study using microsimulation modeling estimated that about 52 percent of people turning age 65 would develop needs that require LTSS.[8] Long-term care insurance (LTCI) can provide a valuable benefit for those who have it. Most LTCI covers nursing home, assisted living, and in-home care services. Having LTCI also gives people more control over the care they receive and in the setting of their choice, as well as services to maintain independence. In 2018, LTCI carriers paid $10.3 billion in claims benefits, up from $6.6 billion in 2012 (a 56 percent increase).[9]

Despite the benefits and likelihood that more than half of Americans will need LTSS at some point in their lives, relatively few adults ages 40 and older purchase LTCI, and that number is steadily declining. The *Scorecard* found a decrease of 430,448 policies (6 percent) between 2015 and 2018.

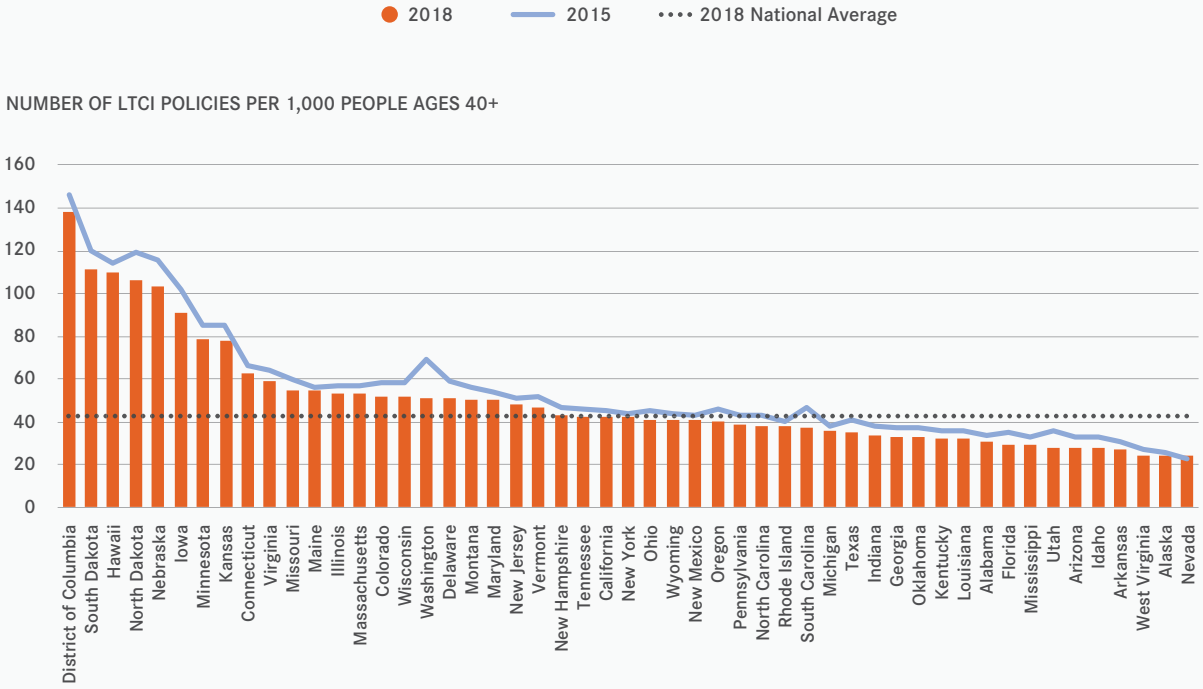
Exhibit 8 shows a comparison by state of the number of active, private LTCI policies in effect in 2015 versus 2018 for people ages 40 and older. The average coverage rate in 2018 for the top five states (District of Columbia, Hawaii, Nebraska, North Dakota, and South Dakota) is 114 LTCI policies per 1,000, compared with 123 policies in 2015—a 7.3 percent decline. In contrast, the average coverage rate in 2018 for the bottom five performing states (Alaska, Arkansas, Idaho, Nevada, and West Virginia) is 25 policies per 1,000 people, compared with 28 policies in 2015—a 10.7 percent decline. The national average in 2018 is just 43 policies per 1,000 people ages 40 and older, compared with 47 policies in 2015—an 8.5 percent decline.

7 Puerto Rico and the US Virgin Islands have also enacted the CARE Act.

8 Melissa Favreault and Judith Dey, "Long-Term Services and Supports for Older Americans: Risks and Financing Research Brief," US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Washington, DC, 2015, https://aspe.hhs.gov/basic-report/long-term-services-and-supports-older-americans-risks-and-financing-research-brief.

9 "Long Term Care Insurance Industry Paid $10.3 Billion in Claims in 2018," Facts, Statistics and Relevant Information, January 14, 2019, https://www.aaltci.org/news/long-term-care-insurance-associationnews/long-term-care-insurance-industry-paid-10-3-billion-in-claims-in-2018.

EXHIBIT 8 Number of Private Long-Term Care Insurance (LTCI) Policies in Effect, 2015 and 2018



Source: Long-Term Services and Supports State Scorecard, 2020.

This downward trend is consistent across nearly all states. As a result, LTCI plays a limited role in LTSS financing, accounting for just 4 percent of LTSS national spending in 2017.[10] Several factors contribute to the low rate of LTCI, including the complexity of LTCI policies, high costs and spikes in premiums, and a common misunderstanding that Medicare or Medigap will cover LTSS needs.

Recently, states have taken steps to improve this product. One promising example is Washington state, which established a public long-term benefit in 2019 with the enactment of the Long-Term Care Trust Act. The law's public long-term care benefit provides $36,500 coverage for all workers older than age 18. Financed through payroll deductions for all workers, the benefit could be used to pay for a variety of LTSS, including in-home care, nursing home care, and respite.[11]

10 AARP Public Policy Institute estimates are based on data from 2017 private long-term care insurance claims from the American Association for Long-Term Care Insurance, "Long Term Care Insurance Industry Paid $10.3 Billion in Claims in 2018," Facts, Statistics and Relevant Information, January 14, 2019, https://www.aaltci.org/news/long-term-care-insurance-associationnews/long-term-care-insurance-industry-paid-10-3-billion-in-claims-in-2018. As cited in Hado and Komisar, "Long-Term Services and Supports."

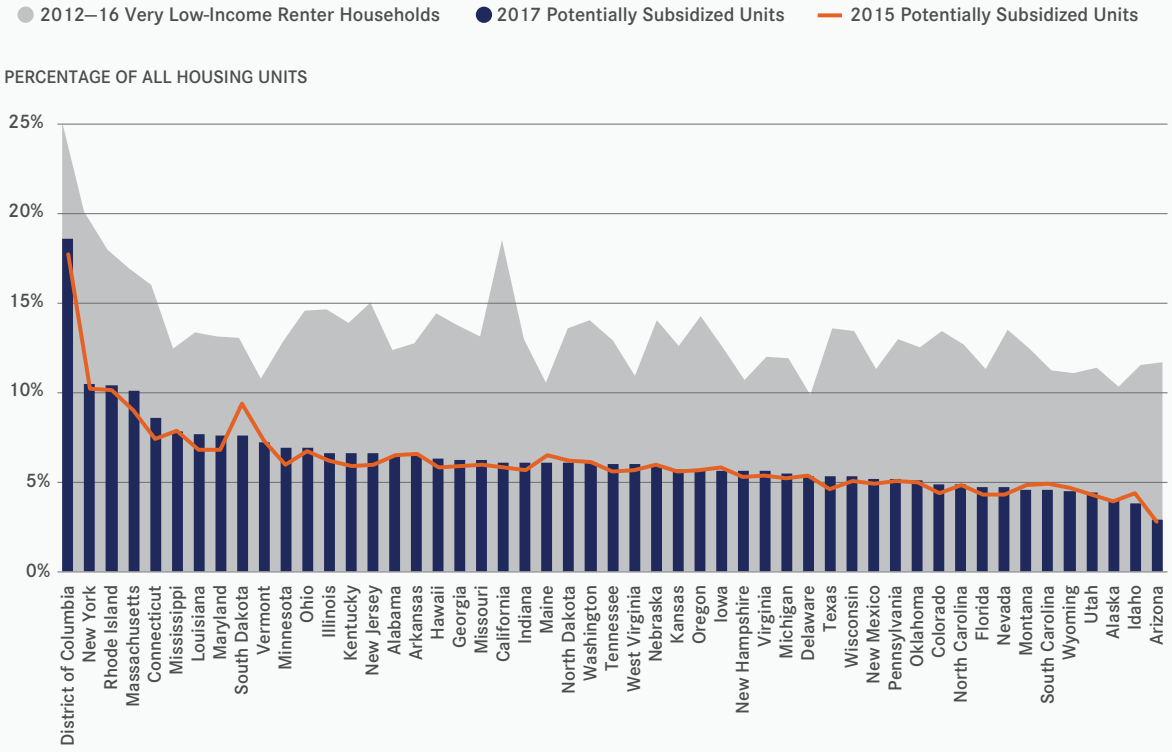
11 "Get the Facts," Washingtonians for a Responsible Future, January 23, 2020, https://responsiblefuture.org/facts/.

Affordable and Accessible Housing Remains a Significant Unmet Need

Housing is a major factor in overall health and well-being. Individuals who are overburdened with housing costs have less disposable income to pay for their health care needs or other services, like transportation, which could help them stay connected to the community or maintain employment. The lack of safe, suitable, affordable housing can prevent individuals from being able to remain in their communities as their needs for LTSS grow.

As shown in Exhibit 9, although there has been a small increase in subsidized housing units nationwide, need continues to outpace supply. There are 18.9 million very low-income renter households across the country and only 8.6 million potentially available subsidized housing units. Very low-income is defined as family income that is less than or equal to 50 percent of the median family income in a metropolitan area. Moreover, the supply of affordable housing is not the only factor impacting individuals with substantial LTSS needs. Housing must also be accessible and coupled with supportive community services to meet the needs of people with physical disabilities.

EXHIBIT 9 Demand Outpaces Supply for Subsidized Housing Opportunities in All States



Notes: Potentially subsidized units are place based units plus authorized housing choice vouchers. HUD defines very low-income as less than or equal to 50% HUD Area Median Family Income (HAMFI). Exhibit data arranged in descending order of 2017 potentially subsidized units percentage. Nationally, there were about 18.9 million renter households qualifying as very low-income and only 8.6 million subsidized housing opportunities, or less than 1 for every 2 low-moderate income renter households.

Source: Long-Term Services and Supports State Scorecard, 2020.

Two New Indicators

Adult Day Services Supply (Choice of Setting and Provider Dimension). This indicator is one of several indicators that measure the capacity of various types of HCBS. In order for people with LTSS needs to have a choice of setting or provider, options must be available. This indicator measures the total licensed capacity of adult day service providers compared with the population ages 65 and older (about two-thirds of adult day services users are 65 and older[12]). The National Center for Health Statistics defines an adult day service center as "a community-based center, generally open on weekdays, that provides long-term care services, including structured activities, health monitoring, socialization, and assistance with ADLs (activities of daily living) to adults with disabilities."[13]

HCBS Quality Benchmarking (Quality of Life and Quality of Care Dimension). High-performing LTSS systems should include the ability to benchmark results against other states; however, comparable cross-state measurement of HCBS quality is a long-standing gap in the *Scorecard*. This edition of the *Scorecard* begins to address this gap by introducing an HCBS Quality Cross-State Benchmarking Capability composite to assess states on their utilization of nationally available tools that enable state-to-state comparisons. Evidence suggests that robust and accurate quality reporting is a precursor to improving quality outcomes.[14] Unlike state-specific quality monitoring tools, the standardized tools enable direct comparison across states. Quality monitoring programs that include the ability to benchmark and make cross-state comparisons offer the best opportunity to identify promising practices, detect deficiencies, and effectively monitor HCBS quality across the country.

Four quality monitoring tools were identified for inclusion in the composite measure:

1. National Core Indicators—Aging and Disabilities (NCI-AD)
2. Consumer Assessment of Healthcare Providers and Systems—Home and Community-Based Services Survey (HCBS-CAHPS)
3. National Committee for Quality Assurance (NCQA) Statewide Accreditation
4. Behavioral Risk Factor Surveillance System—Emotional Support and Quality of Life Support Module (BRFSS-ES-QOL)

12 Jessica Penn Lendon and Vincent Rome, "Variation in Adult Day Services Center Participant Characteristics, by Center Ownership: United States, 2016," NCHS Data Brief 296, US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Hyattsville, MD, February 2018, https://www.cdc.gov/nchs/data/databriefs/db296.pdf.

13 Ibid, 6.

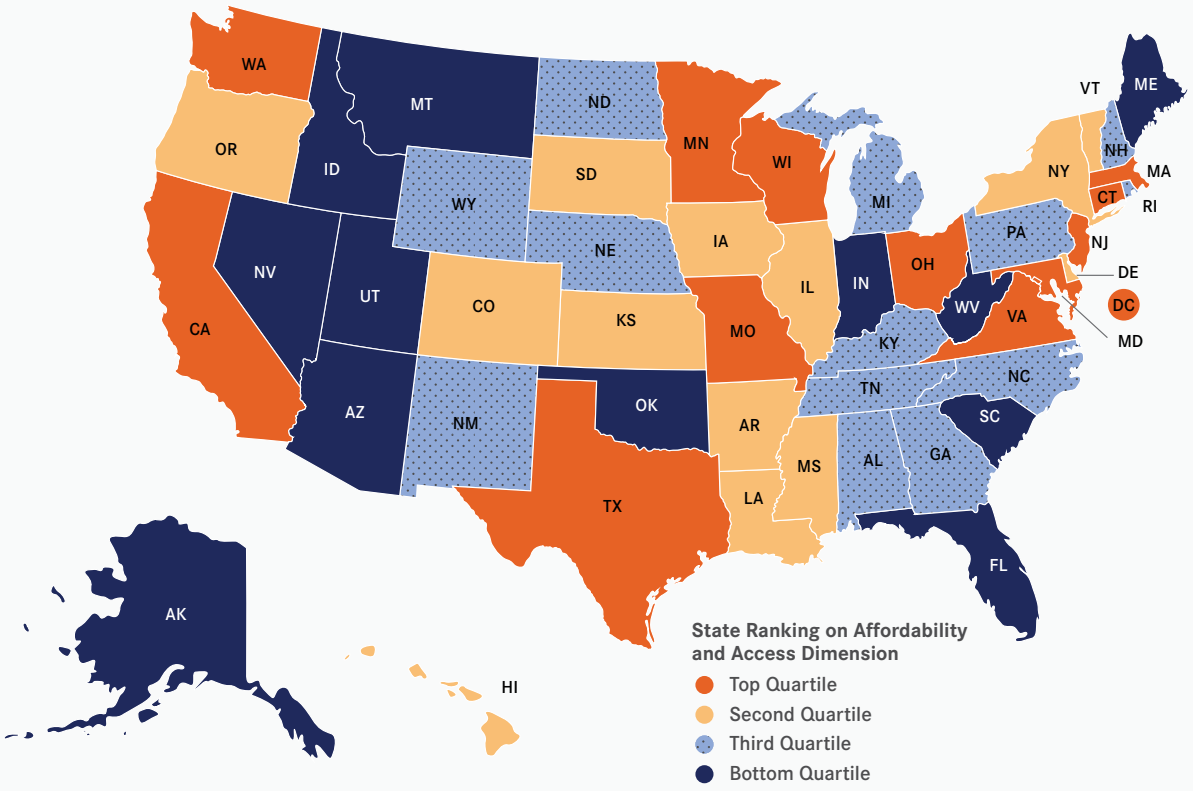
14 Agency for Healthcare Research and Quality, "Public Reporting as a Quality Improvement Strategy: A Systematic Review of the Multiple Pathways Public Reporting May Influence Quality of Health Care," AHRQ, Rockville, MD, August 17, 2011, https://effectivehealthcare.ahrq.gov/products/public-reporting-quality-improvement/research-protocol.

Key Findings by Dimension

DIMENSION 1 Affordability and Access

This dimension includes six indicators. These indicators for measuring affordability and access and the key findings are listed below. Exhibit 10 illustrates states' rankings by quartile in this dimension.

EXHIBIT 10 State Ranking on Affordability and Access Dimension



Source: Long-Term Services and Supports State Scorecard, 2020.

INDICATOR 1: Nursing Home Cost

- KEY FINDING. The cost of nursing home care is unaffordable for middle-income Americans in every state. The average annual per person cost of nursing home care is more than $100,000 a year in a private room, about 2.5 times the typical income for an older family. Even in the five most affordable states (Kansas, Missouri, Oklahoma, Texas, and Utah), nursing home costs would consume 176 percent of the income of the typical older family. When the cost of care exceeds median income by that much, many people with LTSS needs will ultimately exhaust their life savings and eventually turn to the Medicaid public safety net for assistance.

INDICATOR 2: Home Care Cost

- KEY FINDING. Home care services continue to be much more cost-effective than nursing home care for individuals and families. On average, the annual per person cost of home care is roughly $35,000 a year (for 30 hours of weekly care at $23 per hour), compared with

an average cost of $102,000 for nursing home care. Despite being relatively more affordable, home care still exceeds what many older households can afford to pay. Nationally, home care costs would consume more than three-quarters (80 percent) of the entire income of the typical, older middle-income family.

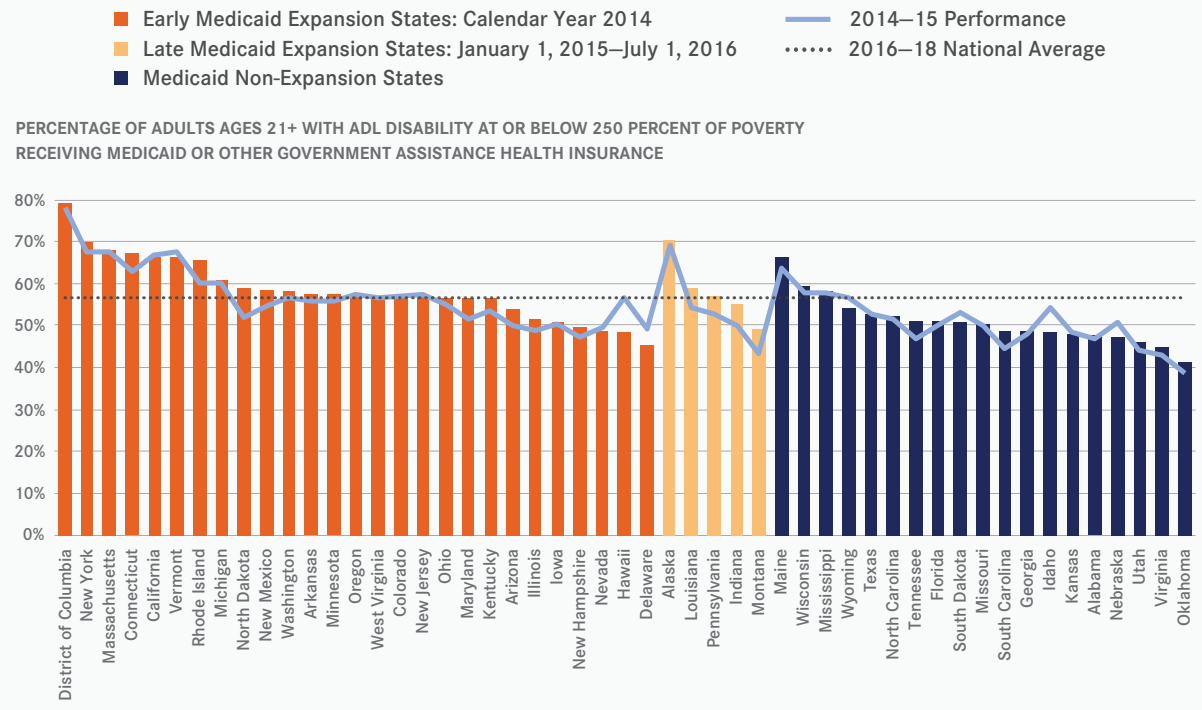
INDICATOR 3: Long-Term Care Insurance

- KEY FINDING. Despite the high cost and growing demand for LTSS, relatively few adults ages 40 and older purchase LTCI, and that number is declining. There was a decrease of 430,448 policies (6 percent) between 2015 and 2018. This downward trend is consistent across nearly all states.

INDICATOR 4: Low-Income People with Disabilities with Medicaid

- KEY FINDING. Eight states (Connecticut, Indiana, Louisiana, Maryland, Montana, North Dakota, Pennsylvania, and Rhode Island) significantly expanded their Medicaid safety net to cover more low-income adults with disabilities. As shown in Exhibit 11, Medicaid expansion appears to be a driving force in these results. For most states that expanded Medicaid benefits, expansion went into effect in calendar year 2014. Another group of five states expanded in 2015–16. These five "late expansion" states accounted for four of the eight states that showed significant improvement. Of the 19 states that had not expanded Medicaid by the end of 2018, none saw significant improvement and only 1 state (Maine) was in the top quartile. Sixteen of the 19 (84 percent) non-expansion states are below the national average.[15]

EXHIBIT 11 State Performance: Low-Income PWD with Medicaid, 2014—15 and 2016—18



Note: Medicaid Expansion dates from https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

Source: Long-Term Services and Supports State Scorecard, 2020.

15 Late expansion states expanded between January 1, 2015, and July 1, 2016. For all of these states, the baseline period is at least 50 percent pre-expansion, and the current period is mostly or entirely post-expansion. Therefore, in these five states, the difference reflects a pre- to post-expansion comparison.

INDICATOR 5: People with Disabilities with Medicaid LTSS

- KEY FINDING. Across the country, there is overall improvement in the percentage of Medicaid consumers with self-care needs (defined as having difficulty bathing, dressing, or getting around inside the home) who receive Medicaid LTSS. Seven states significantly improved. However, the gap between the highest-performing states and lowest-performing states widened. There was roughly a fourfold difference between the average performance of the top five states and the bottom five states. The top five states had an average of 86 Medicaid LTSS participants for every 100 people with self-care disabilities. The average in the bottom five was just 22 participants.

INDICATOR 6: ADRC/NWD Functions

- KEY FINDING. Two-thirds of states improved their ADRC or NWD access points to help consumers and family caregivers navigate LTSS options. Overall, the greatest improvement occurred with addressing target populations, streamlined eligibility for public programs, and person-centered counseling. High-performing states are also building strong collaborative partnerships between state aging and disability and state Medicaid agencies.

Advancing Action in Affordability and Access

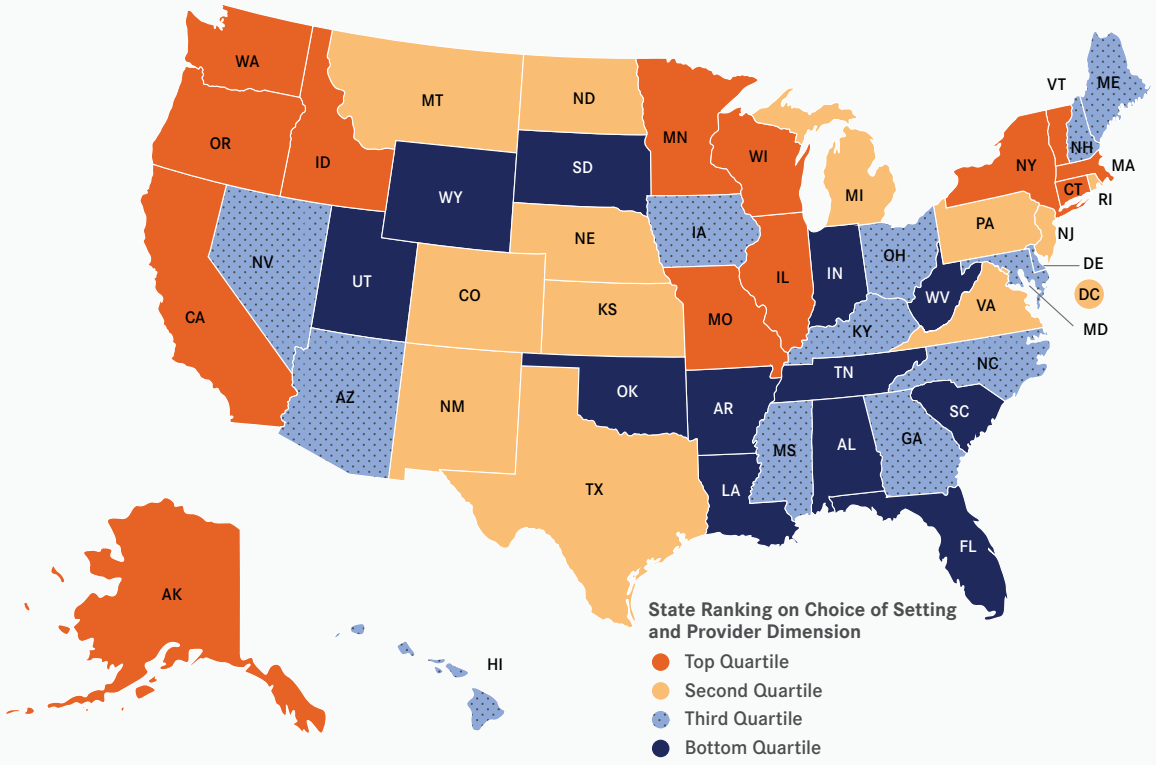
In light of these findings, stakeholders can advance action through the following:

- **Explore LTSS financing options.** The cost of LTSS exceeds the income for most middle-income Americans. Private LTCI is an option to help pay for LTSS; however, market forces determine the reach of these policies, and currently the private market leaves too many without coverage. The cost of LTSS must be more affordable and equitably shared among individuals, the government, and the private sector. States may benefit from conducting a study on a range of financing options and considering such options that make sense for their residents.
- **Enhance ADRC/NWD** programs to ensure that consumers of all incomes can understand and navigate private and public services without delay. States can strengthen their ADRC functions by improving person-centered counseling training, public outreach, and better coordination across the LTSS systems. For examples of promising practices that states have implemented, please refer to *No Wrong Door: Person- and Family-Centered Practices in Long-Term Services and Supports,* http://longtermscorecard.org/promising-practices/no-wrong-door.
- **Establish a robust safety net** so that Medicaid and state-funded programs cover services for older people and adults with disabilities when they exhaust their personal resources.

DIMENSION 2 Choice of Setting and Provider

This dimension includes seven indicators, including a new Adult Day Services Supply indicator that measures total licensed capacity of adult day services in each state. These indicators for measuring choice of setting and provider and the key findings are listed below. Exhibit 12 illustrates states' rankings by quartile in this dimension.

EXHIBIT 12 State Ranking on Choice of Setting and Provider Dimension



Source: Long-Term Services and Supports State Scorecard, 2020.

INDICATOR 1: Percentage of Medicaid- and State-Funded LTSS Spending Going to HCBS for Older People and Adults with Physical Disabilities (Medicaid LTSS Balance: Spending)

- KEY FINDING. Given the strong preference of consumers to receive care in their own homes and communities as long as possible, it is encouraging that half of states improved the balance of Medicaid and state LTSS spending for older adults and people with physical disabilities toward more HCBS. Thirteen of those states had a significant shift of over 20 percent. Now, almost a quarter (12) of states spend the majority of Medicaid and state LTSS funding for older people and adults with physical disabilities on HCBS (up from seven states in 2009). The range of performance among states, however, varies dramatically—from a high of 73.5 percent in New Mexico to a low of 13.5 percent in Kentucky.

"Almost one-quarter of states (12) spend the majority of Medicaid funding on HCBS (up from 7 states in 2009). "

INDICATOR 2: Estimated Percentage of Medicaid Aged/Disabled LTSS Users Receiving HCBS (Medicaid LTSS Balance: Users)

- KEY FINDING. Since most people prefer to receive HCBS rather than nursing home care, this measure is also a reflection of whether a state offers the care people want in the setting they prefer. Twelve states made significant improvement in the percentage of Medicaid beneficiaries who receive services in home- and community-based settings compared with nursing homes. The percentage between high- and low-performing states varied dramatically on this indicator. Among the top five states, 81 percent of Medicaid beneficiaries receive services in their homes and communities. However, only 34 percent of Medicaid beneficiaries in the bottom five states are receiving services in their home or community. Unlike the indicator on Medicaid LTSS balanced spending, this measure compares the percentage of people, not money, going toward HCBS.

INDICATOR 3: Self-Direction

- KEY FINDING. In 2019, there were more than 1.2 million participants in public programs who were self-directing their own LTSS. California, the leading state in this area in the previous *Scorecard*, is the top-ranking state again, accounting for nearly half (49 percent) of the national total, but other states are catching up. The number of people enrolled in "self-directed" LTSS programs has grown by almost 500,000 (67 percent increase) since the first edition of the *Scorecard*. Minnesota and New York are two states to recently improve on this measure. In Minnesota, the proportion of people self-directing their LTSS services has doubled since 2016. In New York, the rate of self-direction has more than tripled since 2016, catapulting New York from a mid-tier state to the top 10.

INDICATOR 4: Home Health Aide Supply

- KEY FINDING. The supply of direct care workers remains uneven among states. Home health aides can provide a range of services, from administering medication to helping with bathing and dressing, that support independent living and can provide family caregivers a break. The

majority of states (43) had no significant change in home health aide or personal care worker supply. In five states, the supply of direct care workers increased by 20 percent or more, while three states reported a significant decline.

INDICATOR 5: Assisted Living Supply

- KEY FINDING. The supply of assisted living and residential care units varies drastically, from a high of 102 units per 1,000 people ages 75 and older (North Dakota) to a low of 20 units (Louisiana). The bottom five states averaged just 24 units per 1,000 people ages 75 and older, while the top five states averaged 93 units, a fourfold difference. While some Medicaid or state-funded programs cover assisted living and residential care, most residents pay out of pocket. Costs differ between location and individual communities, but the median cost is nearly $50,000 a year.

INDICATOR 6: Adult Day Services Supply (NEW)

- KEY FINDING. Access to adult day services ranges widely and may be an issue depending on where an individual lives. The total licensed capacity of adult day service providers (compared to the population ages 65 and older) ranges from a high of 171 in California to just six in Oregon and Utah.

INDICATOR 7: Subsidized Housing Opportunities

- KEY FINDING. Nationally, there are 18.9 million very low-income renter households and only 8.6 million potentially available subsidized housing opportunities (including vouchers and place-based housing units). Only nine states have significantly increased the percentage of subsidized housing opportunities since 2015. Nationally, the small increase of 650,000 subsidized housing units since 2015 continues to fall short of current and future needs.

Advancing Action in Choice of Setting and Provider

In light of these findings, stakeholders can advance action through the following:

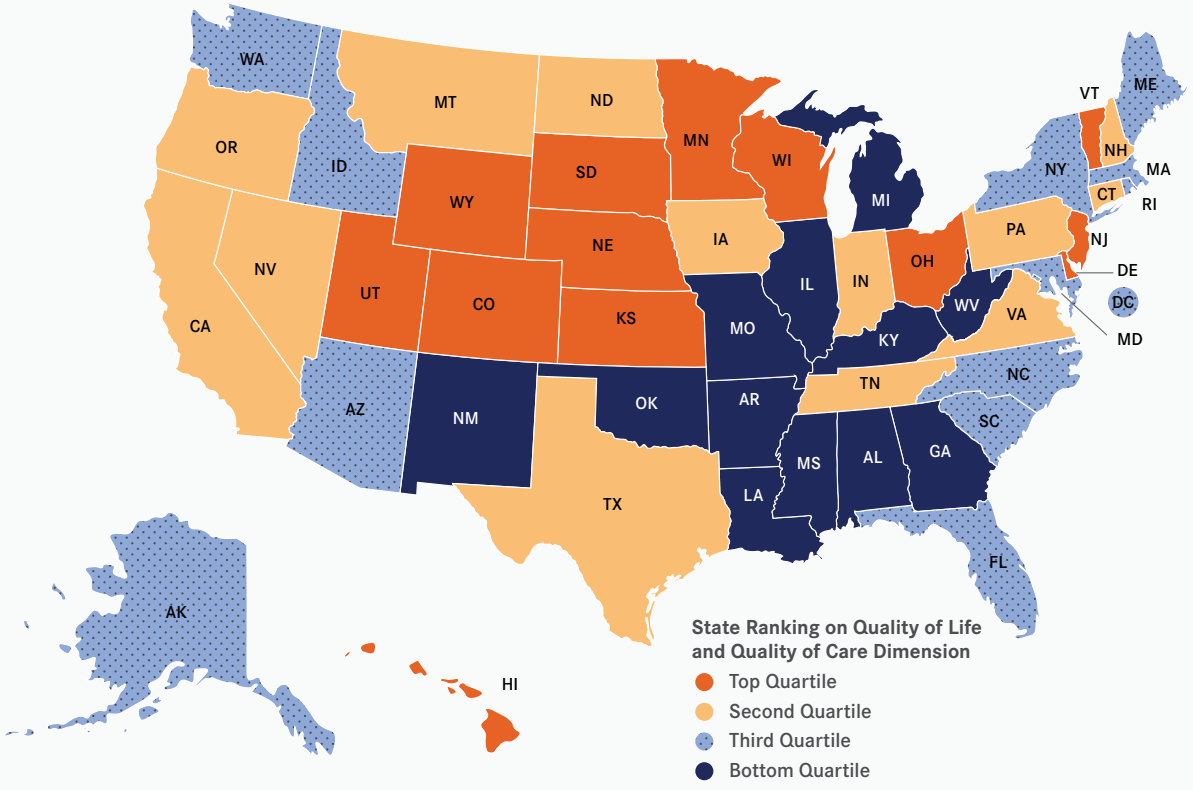
- **Address housing needs** through interventions that make housing affordable for low-income people and those with high LTSS and health care needs. States and localities can invest in affordable housing units, fund housing vouchers, and use zoning laws to leverage private-sector investment. States should explore alternative sources for funding housing with supports to benefit LTSS users, and health insurance companies should explore options to help meet those housing needs.
- **Support nursing home diversion initiatives** so more new Medicaid LTSS beneficiaries first receive care in the community. Transitioning someone back into the community after a nursing home stay can be difficult and stressful.
- **Dedicate a greater proportion of Medicaid and state funding to cost-effective home- and community-based services** that consumers overwhelmingly prefer.
- **Provide consumers and their families with more opportunities to self-direct and manage their own care needs.** States have the flexibility to design programs that give people the option to manage their own care budget, hire their own care providers (including family members) if they choose, and decide when and how they receive services.
- **Offer an array of home- and community-based options** to suit personal preferences and family needs. Policy makers should consider "unbundling" LTSS services so that consumers have additional choice in how they receive care. Consider incentives and initiatives for nursing home redesign (e.g., private rooms or green house models that offer consumers a home-like setting).

DIMENSION 3 Quality of Life and Quality of Care

This dimension includes four indicators. A new HCBS Quality Benchmarking indicator scores states on their level of adoption of standardized tools that can be used to provide cross-state comparison to monitor HCBS quality. The indicators for measuring quality of life and quality of care and the key findings are listed below. Exhibit 13 illustrates states' rankings by quartile in this dimension.

Due to persistent data gaps including in HCBS quality outcomes, quality of life other than employment, and staffing, this dimension is considered to be an incomplete measurement of the quality of life and quality of care construct. It therefore receives only one-half of the weight of the other four dimensions in determining states' overall ranks on LTSS system performance. Going forward there is a need for robust, standardized, and comparable data on quality of life, quality of care, and safety across all institutional and community settings.

EXHIBIT 13 State Ranking on Quality of Life and Quality of Care Dimension



Source: Long-Term Services and Supports State Scorecard, 2020.

INDICATOR 1: People with Disabilities' Rate of Employment

- KEY FINDING. For adults with disabilities, the ability to work is an important factor in quality of life. Not only does employment provide income, but working often gives adults a sense of purpose, self-worth, and the ability to connect with others. Nationally, the rate of employment for working-age adults with disabilities who need assistance with personal care was just 21 percent of the rate of working-age adults without disabilities. Two states (Minnesota and Nevada) have consistently maintained relative employment rates (ratio of employment rate of working-age adults with ADL disability to those without) of 30 percent or more in recent years. Since the last reporting period, five states (Idaho, Mississippi, North Dakota, Vermont, and Virginia) increased their relative employment rates among working-age adults with disabilities by 20 percent or more, and two states (Alaska and Wyoming) declined by 20 percent or more.

INDICATOR 2: Nursing Home Residents with Pressure Sores

- KEY FINDING. For the first time, the *Scorecard* measure of nursing home pressure sores includes three levels of "unstageable" pressure sores, in addition to stage 2–4 pressure sores. Unstageable pressure sores may be open or closed wounds that are completely covered with eschar (hard, black, dead tissue) or a non-removable dressing or device, making them difficult to diagnose. The revised measure provides a more complete picture of the incidence of pressure sores, which were previously undercounted in the publicly reported measure on Nursing Home Compare. North Dakota has the lowest percentage (4.8 percent) of high-risk nursing home residents with pressure sores. At the other end of the spectrum, the percentage in the District of Columbia was nearly triple (13 percent). The average across all states was 7.3 percent.

INDICATOR 3: Inappropriate Use of Antipsychotic Medications for Nursing Home Residents (Nursing Home Antipsychotic Use)

- KEY FINDING. As many as one in seven long-stay nursing home residents without a psychiatric diagnosis are sedated with antipsychotic medications. Fortunately, states continue to make progress on this measure; a majority of states (28) have significantly reduced inappropriate use of antipsychotic medications since 2015. The 5 states (Arizona, Louisiana, New York, Ohio, and Texas) with the sharpest decline reported decreases ranging from 31 percent to 44 percent. Nationally, inappropriate use of antipsychotic medications has steadily declined by over 30 percent since 2013—from 21.3 percent to 14.6 percent.

"Nationally, inappropriate use of antipsychotic medications has steadily declined by over 30 percent since 2013—from 21.3 percent to 14.6 percent."

INDICATOR 4: HCBS Quality Benchmarking (NEW)

- KEY FINDING. All states measure quality in their HCBS programs, yet each state uses a unique HCBS quality monitoring system. Despite these variations, a state's HCBS quality monitoring system should include the ability to benchmark results against other states. This new composite indicator scores states on their utilization of four standardized quality monitoring tools (NCI-AD, HCBS-CAHPS, NCQA, and BRFSS-ES-QOL) that can be used to benchmark HCBS quality and make cross-state comparisons. Three-quarters of states use at least one tool for cross-state benchmarking. Eleven states use multiple monitoring tools. The most commonly used of the four tools was NCI-AD,[16] used by 26 states (as of December 2019). Eleven states that used more than one tool used NCI-AD as one of their four monitoring tools.

Advancing Action in Quality of Life and Quality of Care

In light of these findings, stakeholders can advance action through the following:

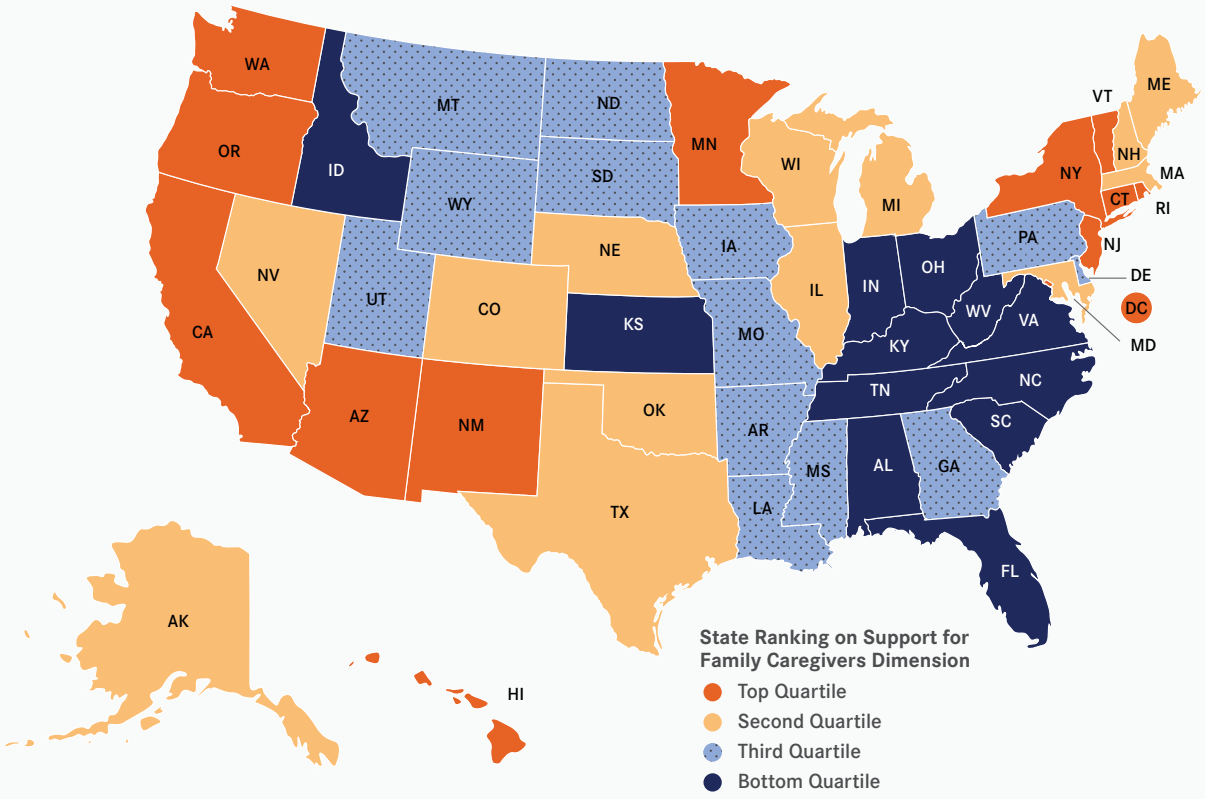
- **Seek consistent, state-level data** on LTSS quality, the availability of affordable and accessible housing, family caregiver respite funding, and other measures of key concern to the public.
- **Utilize HCBS quality outcome measures with cross-state benchmarking capabilities.** With more consumers choosing to receive care in the community, policy makers should consider strategies to effectively measure HCBS quality across states.
- **Consider employment initiatives** to train, recruit, and help connect working-age adults with disabilities to job opportunities. These job opportunities should also provide a living wage and benefits that allow individuals to be self-sufficient.
- **Enforce quality standards in nursing homes, with particular attention to the following:**
  - **Preventing pressure sores**, which are painful injuries to the skin that can make basic movements such as turning or lifting extremely painful.
  - **Ending inappropriate prescribing of antipsychotic medication**, which should never be used to sedate nursing home residents with dementia. Nursing home staff should consider non-pharmacological approaches to dementia care, such as cultural arts, dance, and expressive movements to promote social and behavioral changes.
  - **Increasing focus on preventing the spread of infections** and other quality concerns that can have serious harmful effects on the quality of life and quality of care of vulnerable nursing home residents.
  - **Strengthen ombudsman programs.** Although all states operate ombudsman programs, states decide how frequently ombudsmen visit each facility, how they respond to complaints, and what methods are used to monitor quality. States should evaluate their state ombudsman programs and determine if design changes are needed to adequately protect consumers. States may also consider expanding the reach of these programs to cover HCBS.

16 NCI-AD is a consumer experience survey that collects and maintains state data on the impact that publicly funded LTSS has on the quality of life and outcomes of consumers. NCI-AD is a collaborative effort between ADvancing States and Human Services Research Institute. ADvancing States, Arlington, VA. See https://nci-ad.org/.

DIMENSION 4 Support for Family Caregivers

This dimension includes policies that support family caregivers in four main indicators: Supporting Working Family Caregivers, Person- and Family-Centered Care, Nurse Delegation and Scope of Practice, and Transportation Policies. Key findings in each of the four areas are listed below. Exhibit 14 illustrates states' rankings by quartile in this dimension.

EXHIBIT 14 State Ranking on Support for Family Caregivers Dimension



Source: Long-Term Services and Supports State Scorecard, 2020.

INDICATOR 1: Supporting Working Family Caregivers

This indicator measures performance on six types of policies: (a) protection of family caregivers from employment discrimination, (b) family medical leave, (c) paid family leave, (d) mandatory paid sick days, (e) flexible use of sick time, and (f) unemployment insurance for family caregivers. States and localities have made significant progress passing legislation for paid family leave, paid sick days, and greater flexibility to use sick time for family caregiving responsibilities.

- KEY FINDING. **Protecting Caregivers from Employment Discrimination** – Only two states (Delaware and the District of Columbia) have statewide laws that specifically protect family caregivers from workplace discrimination as a protected classification under law. Connecticut has a statewide law, but the provisions do not specifically define family responsibility or family status, and therefore it is not clear whether the protections extend to all family relationships. Localities across 21 states now have provisions addressing family responsibility; About half specifically define family responsibility as a protected classification: for the others, family responsibility and family status are undefined. In addition to providing help for family

caregivers who live in these localities, local protections offer the opportunity to test and build momentum for statewide changes. See Exhibit B5 in Appendices for a list of states and localities that have laws protecting caregivers from employment discrimination.

- KEY FINDING. **Federal FMLA** – Ten states go beyond the federal minimum Family and Medical Leave Act (FMLA) by covering family members outside the scope of federal protections (e.g., grandparents and siblings), extending the length of leave, or covering smaller employers. The District of Columbia continues to have the most robust protections for family and medical leave. Two states that have paid family leave benefits (California and Washington) no longer have unpaid leave protections that exceed the federal FMLA requirements. However, New Jersey, which passed paid family medical leave legislation in 2008, has also recently expanded its state FMLA provisions to include smaller employers and cover extended family members.
- KEY FINDING. **Paid Family Leave** – Since 2016, the number of states with paid family leave legislation has tripled. Six additional states (Connecticut, District of Columbia, Massachusetts, New York, Oregon, and Washington) enacted paid family leave legislation, bringing the total number to nine. Of the six new states, paid family leave benefits are currently available in the District of Columbia, Massachusetts, New York, and Washington. Benefits in Connecticut and Oregon will become available after 2021. Among states with existing programs, New Jersey expanded its paid leave benefits to include smaller employers and permit employees longer lengths of leave.
- KEY FINDING. **Paid Sick Days** – More than one-third of states (20) have statewide or local laws mandating paid sick days to employees. Of those 20 states with either statewide or local paid sick leave laws, 13 enacted or expanded (e.g., covering additional employees or permitting longer lengths of leave) their policies in the past three years. See Exhibit B5 in Appendices for a list of states and localities that mandate paid sick days to employees.
- KEY FINDING. **Flexible Use of Sick Time** – More states and localities are allowing employees to use a portion of accrued sick time for purposes beyond their own illness. Workplace benefits that allow employees to use sick time for family caregiving responsibilities help employees manage work and family responsibilities. Nineteen states have statewide legislation and one state (New York) has locality legislation in New York City and Westchester County that now allows flexible use of sick time. See Exhibit B5 in Appendices for a list of states and localities that have provisions for flexible use of sick time.
- KEY FINDING. **Unemployment Insurance for Family Caregivers** – Family caregivers in half of states (25) can receive temporary financial assistance when returning to the workforce through state unemployment insurance programs if there is "good cause" for job loss due to an illness or disability of an immediate family member.

For more information on policies and practices in state unemployment insurance programs that provide potential temporary financial assistance to family caregivers, see the 2015 *Scorecard* research report, *Access to Unemployment Insurance Benefits for Family Caregivers: An Analysis of State Rules and Practices.*

Source: Liz Ben-Ishai, Rick McHugh, and Kathleen Ujvari, "Access to Unemployment Insurance Benefits for Family Caregivers: An Analysis of State Rules and Practices," AARP Public Policy Institute, Washington, DC, April 2015, http://www.longtermscorecard.org/publications/access-to-unemployment-insurance-benefits-for-family-caregivers.

INDICATOR 2: Person- and Family-Centered Care

This indicator measures performance on three types of policies: (a) state policies on financial protection for spouses of Medicaid beneficiaries who receive HCBS, (b) assessment of family caregivers' own needs, and (c) enactment of the CARE Act.

- KEY FINDING. **Spousal Impoverishment Protections** – There continues to be only a handful of states (7) that permit a spouse to keep the maximum amount of income and assets allowed under federal guidelines. This policy helps prevent married couples from falling into poverty or forcing a healthy spouse into Medicaid prematurely. By retaining more of the couples' own resources, the spouse who is not on Medicaid has a better chance to remain independent, pay for basic necessities without additional state assistance, and manage his or her own health care needs.
- KEY FINDING. **Family Caregiver Assessments** – In a high-performing LTSS system, caregivers' needs—including health, well-being, and work—are assessed and addressed with appropriate information, training, respite, and other services tailored to their individual preferences. The majority of states (41) conduct assessments of family caregivers for their own needs; however, most of these family caregiver assessments happen in smaller family caregiver support programs rather than in the broader Medicaid programs.
- KEY FINDING. **CARE Act Legislation** – States continue to make rapid progress on enactment of the CARE Act—model legislation that supports family caregivers when family members enter a hospital and transition back home. As of December 31, 2019, nine additional states have enacted the CARE Act, bringing the total to 41 states.

INDICATOR 3: Nurse Delegation and Scope of Practice

This indicator measures performance on two types of policies: (a) number of health maintenance tasks that can be delegated to direct care workers, and (b) nurse practitioner scope of practice.

- KEY FINDING. **Nurse Delegation** – Family caregivers benefit from decision makers expanding the types of health maintenance tasks (e.g., giving medications, tube feedings, providing routine respiratory care) that registered nurses can delegate to home care aides. Nurse delegation helps family caregivers who may have to leave work during the day or hire a nurse to perform these routine tasks. Eighteen states (up from 16) allow registered nurses to delegate a full range of a sample set of 16 tasks to home care aides. In 2011, when the *Scorecard* first measured nurse delegation, only 12 states allowed delegation of 14 or more sample tasks. That number has more than doubled, and half of states (26) allow delegation of at least 14 sample tasks. Still, the bottom-performing states lag significantly on this measure. Four states (Florida,[17] Indiana, Pennsylvania, and Rhode Island) do not permit delegation of any of the sample set of health maintenance tasks. Roughly a quarter of states (12) permit nurses to delegate only three or fewer tasks.
- KEY FINDING. **Scope of Practice** – Giving nurse practitioners authority to practice to the full extent of their education and training can ease the shortage of primary care providers. This can also help family caregivers by expanding options for care recipients to receive primary care services in the setting of their choice (e.g., medical offices, community health centers, adult day centers, at home). Twenty-three states allow patients to benefit from the full range of care nurse practitioners are educated and trained to provide.

17 On March 11, 2020, Florida enacted H.B. 607 (Direct Care Workers), which expands consumer access to nurse practitioners and certified nurse midwives and authorizes registered nurses to delegate certain clinical tasks to direct care workers (certified nursing assistants and home health aides). The law becomes effective July 1, 2020. These results are not reflected in the *2020 Scorecard* because enactment occurred after December 31, 2019, the cut-off date for this measure. However, these results will be reported in future reporting.

INDICATOR 4: Transportation Policies

- KEY FINDING. **Transportation Policies** – Many older people and adults with disabilities depend on volunteer drivers who provide transportation to medical appointments or to get around town. In most states, however, these volunteer drivers face liability exposure, spikes in car insurance premiums, or other regulatory barriers.[18] Although states can use policy options to protect volunteer drivers, relatively few states have done this. Only seven states (up from five in the last *Scorecard*) protect drivers from insurance cancelation or rate increases for volunteer driving activities. These policies make it easier to recruit volunteer drivers to help older adults and people with disabilities get around.

Advancing Action in Support for Family Caregivers

In light of these findings, stakeholders can advance action through the following:

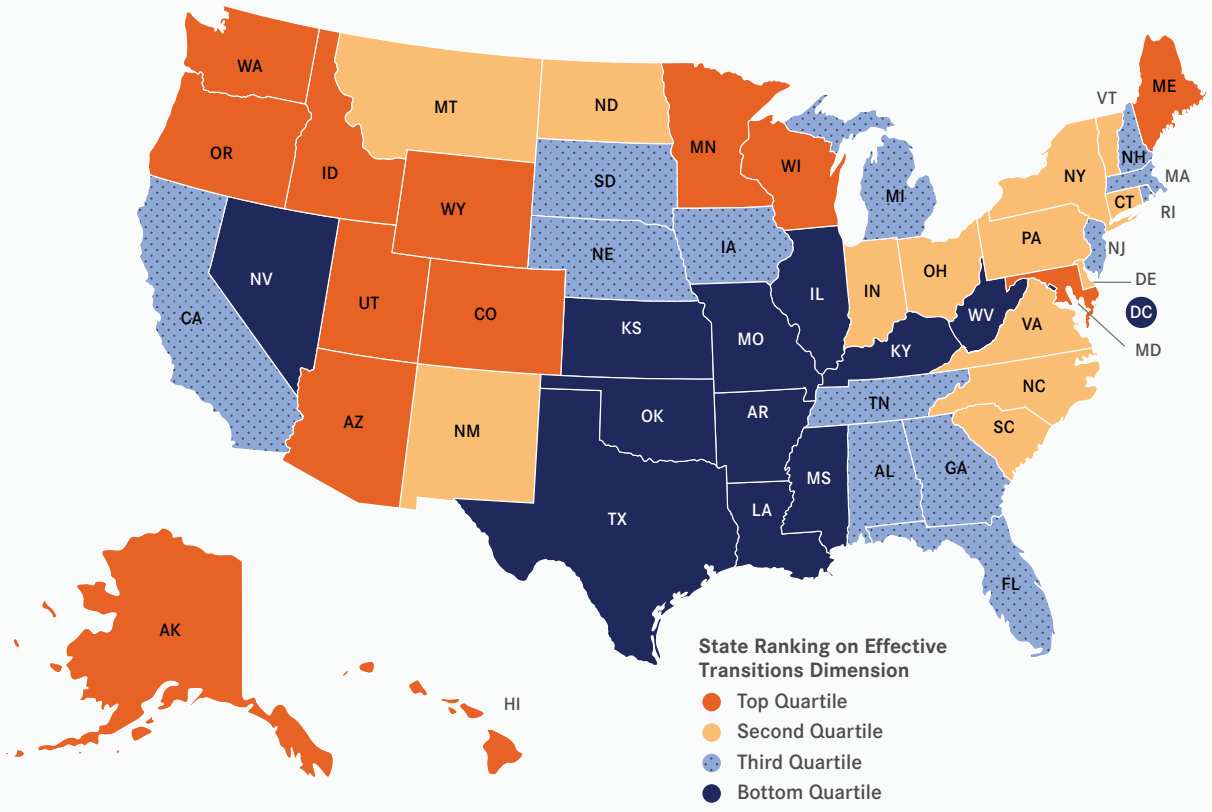
- **Streamline and conduct universal family caregiver assessments** to determine which supports family caregivers need for their own health and well-being. Family caregivers often experience physical and emotional strain; therefore, it is appropriate to consider their own needs as part of the care planning process.
- **Strengthen flexible workplace policies and employment supports** that help family caregivers balance competing demands from their job and family responsibilities. For example:
  - Federal, state, and local governments can increase baseline protections available under the Family and Medical Leave Act (FLMA) by covering more employees, expanding the definition of family, and protecting family caregivers against job discrimination.
  - States may want to establish paid family and medical leave or earned sick days, so family caregivers do not have to miss a paycheck when they provide care. Additionally, states may consider offering family caregivers access to short periods of leave to attend to caregiving duties, such as bringing a family member or close friend to a doctor's appointment.
  - Employers may wish to offer flexible workplace policies that provide employees the option to use their earned sick time for their own illness or the care of a family member. Additionally, employers may wish to offer family caregiving leave, a vacation donation program in which other employees donate unused vacation time to help colleagues in need, or add a subsidized caregiver backup benefit for employees.
- **Enact and effectively implement the CARE Act to prepare family caregivers with the training and instruction** they need to provide complex medical and nursing tasks upon a relative or close friend's discharge from a hospital.
- **Ensure community groups and nonprofits can inform and engage family caregivers** so they fully understand the benefits and protections available in their state, community, and workplace. This is particularly important when a state, locality, or employer offers more generous protections than FMLA. Depending on where someone lives, he or she may be able to collect unemployment insurance if there is good cause for job loss due to an illness or disability of a family member, receive paid family medical leave benefits, or assert other legal protections.
- **Expand access to health care by allowing nurse practitioners to care for people to the full extent of their education and training.** Primary care shortages can delay care, hurting patients and adding pressure on family caregivers, who may have to wait longer or travel farther to bring a family member to medical appointments.
- **Remove workforce barriers so nurses can delegate routine tasks,** such as medication administration, to an aide. This saves family caregivers from having to leave work to perform basic health maintenance tasks.

18 Katherine Freund et al., "Environmental Scan of Ride Share Services Available for Older Adults," University of Chicago, National Opinion Research Center, Chicago, IL, December 2019, https://reports.norc.org/white_paper/environmental-scan-of-ride-share-services-available-for-older-adults/.

DIMENSION 5 Effective Transitions

This dimension includes five indicators. These indicators for measuring effective transitions and the key findings are listed below. Exhibit 15 illustrates states' rankings by quartile in this dimension.

EXHIBIT 15 State Ranking on Effective Transitions Dimension



Source: Long-Term Services and Supports State Scorecard, 2020.

INDICATOR 1: Nursing Home Residents with Low Care Needs

- KEY FINDING. The high-performing states significantly outpace the low-performing states on this measure. On average, the bottom five states reported one out of five nursing home residents with low care needs, four times the average percentage of the top five states. In Missouri, which has the highest percentage of residents with low care needs, nearly one in four could potentially transition to a home- and community-based setting.

INDICATOR 2: Home Health Hospital Admissions

- KEY FINDING. Hospital admissions for patients receiving home health care remained steady in 47 states. On average, almost one out of every six (15.8 percent) home health patients were hospitalized. Three states (District of Columbia, North Dakota, and Wyoming) made significant improvements. Alaska was the only state with a significant decline but remained the top-performing state on this measure.

INDICATOR 3: Nursing Home Hospital Admissions

- KEY FINDING. Nationally, one in six (16.8 percent) long-stay nursing home residents were admitted to the hospital within six months of baseline assessment. Eight states (Arizona, Illinois, Michigan, New Mexico, New York, Ohio, Texas, and Virginia) significantly reduced hospital readmissions since the last edition of the *Scorecard*. On average, long-stay nursing home residents in the bottom 10 states are twice as likely to be admitted or readmitted to the hospital as residents in the top 10 states.

INDICATOR 4: Burdensome Transitions

- KEY FINDING. Fifteen states achieved significant progress in reducing excessive hospitalizations or other transitions for vulnerable nursing home residents at the end of life. Despite these improvements, more than a quarter of nursing home residents still experience a burdensome transition, and performance differs greatly among states. Roughly twice as many nursing home residents experience burdensome transitions in the bottom five performing states (35.2 percent) compared with the top five performing states (18.4 percent).

INDICATOR 5: Percentage of Short-Stay Residents Who Were Successfully Discharged to the Community (Successful Discharge to Community)

- KEY FINDING. Nationally, just over half (54 percent) of Medicare skilled nursing home residents were successfully discharged back to the community. The top five states for this indicator (Alaska, Arizona, Hawaii, Oregon, and Utah) successfully transitioned more than 60 percent of nursing home residents back to the community. Only Louisiana transitioned substantially fewer than 50 percent.

Advancing Action in Effective Transitions

In light of these findings, stakeholders can advance action through the following:

- **Reduce overreliance on nursing homes by doing the following:**
  - **Offering families options for counseling and diversion programs** to direct first-time Medicaid LTSS participants toward HCBS options. States can also consider implementing presumptive eligibility programs to fast-track eligibility for public HCBS programs that avoid unnecessary nursing home placement.
  - **Sustaining or creating transition programs** like Money Follows the Person, so nursing home residents who wish to return to the community can do so.
- **Eliminate barriers to home care services.** The federal government should allow nurse practitioners, clinical nurse specialists, and physician assistants to order home health services under Medicare. The change would improve access and potentially prevent the need for hospital or nursing home care.
- **Expand home- and facility-based palliative care** to provide dignity and comfort to individuals who want to avoid overly aggressive treatment or burdensome transitions across different care providers at the end of life.

Reflections

Better Data Are Needed to Assess State LTSS System Performance

Data gaps and data quality issues make it difficult to completely and comprehensively measure LTSS system performance. Improving consistent state-level data collection is a critical need, particularly in the domains of quality of life and quality of care. The main idea of a *Scorecard* is that measurement, tracking, transparency, and accountability are essential to sustained performance. Gaps in data are not just gaps in measurement: they will eventually manifest as gaps in system performance as well.

LTSS quality remains the most significant and persistent data gap in the *Scorecard*. This gap and others in the Quality of Life and Quality of Care dimension are so significant that they are reflected in the *Scorecard*'s core structure. The entire quality dimension is given only half weight in terms of assessing overall LTSS system performance, not because it is any less important, but because we consider it to be incomplete due to a lack of available data to measure multiple important aspects of quality of life and quality of care in institutional and community based settings.

The United States spent $235 billion in 2017 on LTSS services, and increasingly those services are delivered in home and community-based settings. This positive development aligns with people's stated values and preferences for remaining in the community. However, the lack of comparable sources of data limits cross-state comparisons and national progress.

Absent an accepted nationwide standard to measure HCBS quality, this *Scorecard* has included—for the first time—a measurement on cross-state benchmarking capacity. This measurement is not a substitute for HCBS quality outcome measures. Instead, it measures a state's potential capacity to learn from cross-state comparisons and emerging practices—a first step in advancing quality outcomes.

Major Progress on HCBS Spending Proves Progress Is Achievable

Nearly a quarter of states achieved a major milestone on LTSS balanced spending and now devote half or more of their Medicaid LTSS spending to HCBS (for older adults and people with physical disabilities). This achievement was unimaginable just nine years ago, when the *2011 Scorecard* reported that the average proportion of spending nationwide was just 37 percent for HCBS.

The dramatic shift, especially among higher-performing states, shows that progress is achievable when states collect data, measure and compare progress, and galvanize support among the public and private sectors.

High Performance Does Not Mean High Cost

High-performing LTSS systems that efficiently leverage the private and public sectors can be affordable and effective. For example, when family caregivers, who provide the largest share of help, are well supported with resources, care options, and workplace flexibility, they are better positioned to care for close family and friends and keep those individuals out of costly nursing homes. This in turn helps individuals preserve their resources and delay the need for public assistance and Medicaid.

Supporting family caregivers also has economic benefits. Most of the 41 million family caregivers in the United States are employed in the workforce.[19] A strong LTSS system is critical to making sure those caregivers can continue to fully participate in the workforce and contribute to the local economy.

19 Reinhard et al., *Valuing the Invaluable.*

Implementation Matters

Effective implementation requires coordination across different sectors. This is particularly true when public policy solutions are designed to influence private-sector action.

The CARE Act, for example—which sets standards and training requirements during a hospital stay—is most effective when hospitals commit to preparing their staff for working with family caregivers as members of their care team as well as helping inform the public of the related benefits and building trust with patients and families during a hospitalization.

Similarly, flexible workplace policies depend on employers for effective implementation. While states and localities can enact various policies, the ultimate test of performance is not just passing a law but ensuring that working caregivers are aware of those benefits and can easily access them.

Transportation Is a Major Need

This year, the *Scorecard* features just one transportation policy because of the lack of reliable data to evaluate transportation needs and opportunities across all states. Having only one transportation policy in this *Scorecard* does not minimize the important role transportation plays in LTSS systems. On the contrary, stakeholders at all levels should learn from, scale, and replicate emerging practices so communities can more systemically meet the transportation needs of older people and adults with disabilities in the community.

Adequate transportation services make it possible for individuals to fully engage in the community and stay healthy. The lack of transportation in some communities makes it more difficult for individuals to get to doctor appointments, shop for groceries and other basic necessities, attend religious services, and participate in social events. Individuals who are cut off from communities and interactions can feel socially isolated, impacting their health and well-being.

"About 40 percent of caregivers spend at least five hours a week providing or arranging transport."

Source: AARP, "Transportation: What Caregivers Need to Know," AARP, Washington, DC, January 17, 2020, https://www.aarp.org/caregiving/home-care/info-2020/transportation-services.html.

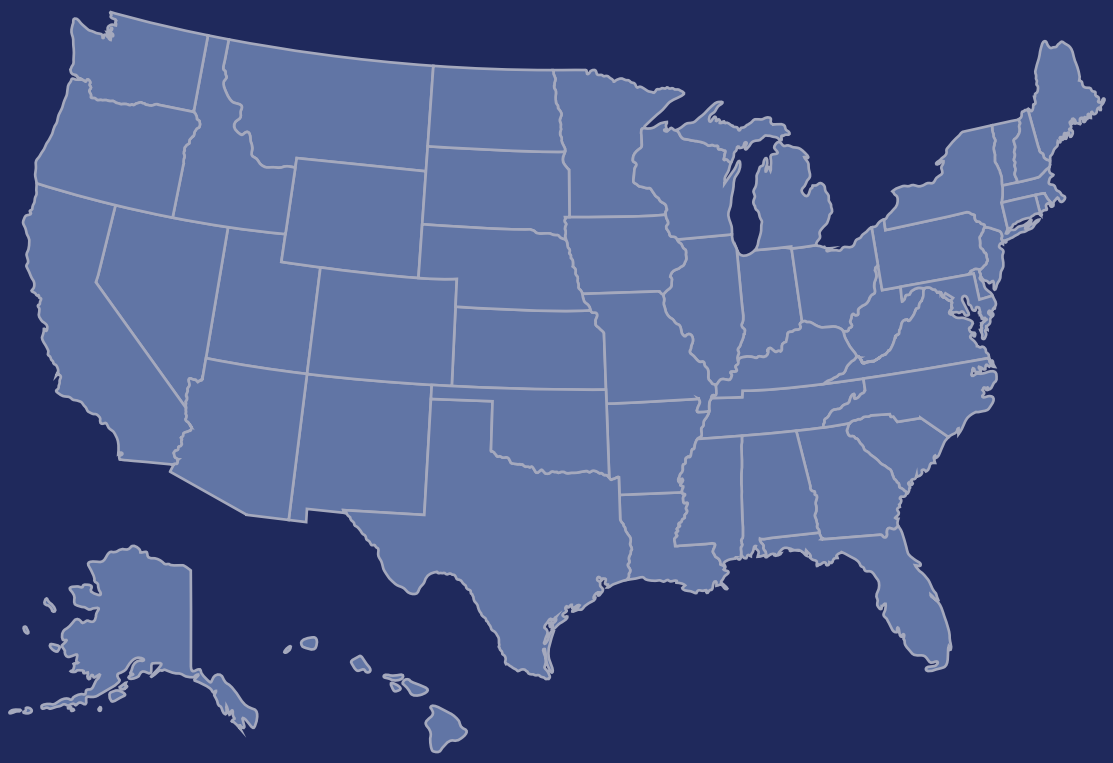
Significant and Widespread Performance Improvement across Two Dimensions—Choice of Setting and Provider, and Effective Transitions—Is Needed to Advance Person-Centered Care

The Effective Transitions dimension considers whether consumers within a system can meaningfully exercise their preferences on how and where to receive care. It is not uncommon for people who need LTSS to transition between care settings. While an individual may require periods of hospitalization or a short-term nursing home stay, disruptive transitions may make it difficult or impossible for those who wish to return home to do so.

Person-centered care also requires an adequate supply of HCBS. Consumer choices are only as good as the options available in their community. When a community does not have adequate HCBS, people must choose among the options that are available, not necessarily those they prefer. This impacts people of all incomes. Inadequate HCBS supply also adds pressure on family caregivers to fill in the gaps when services are not available.

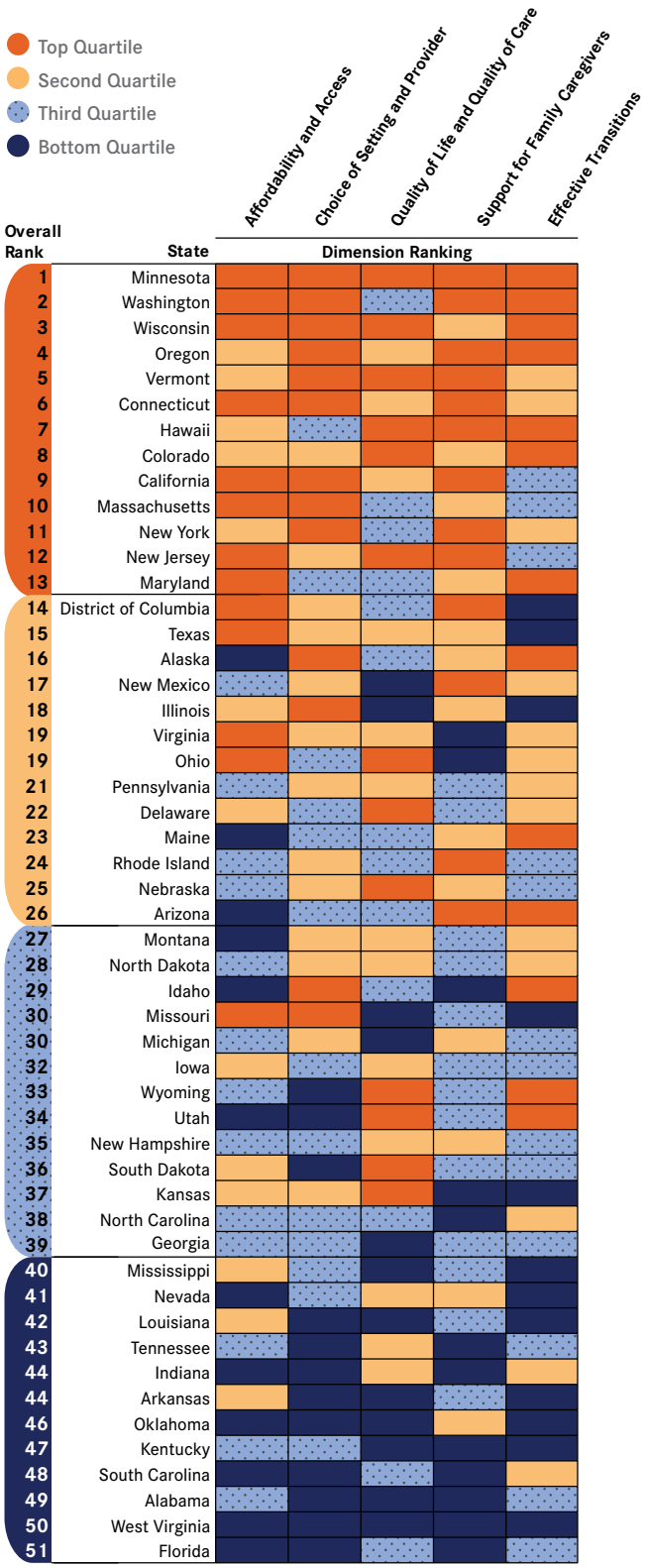
Long-Term Services and Supports State Scorecard
2020 Edition

APPENDICES



Appendices

EXHIBIT A1 Matrix Heat Map: Overall Ranking



How to Read the Heat Maps

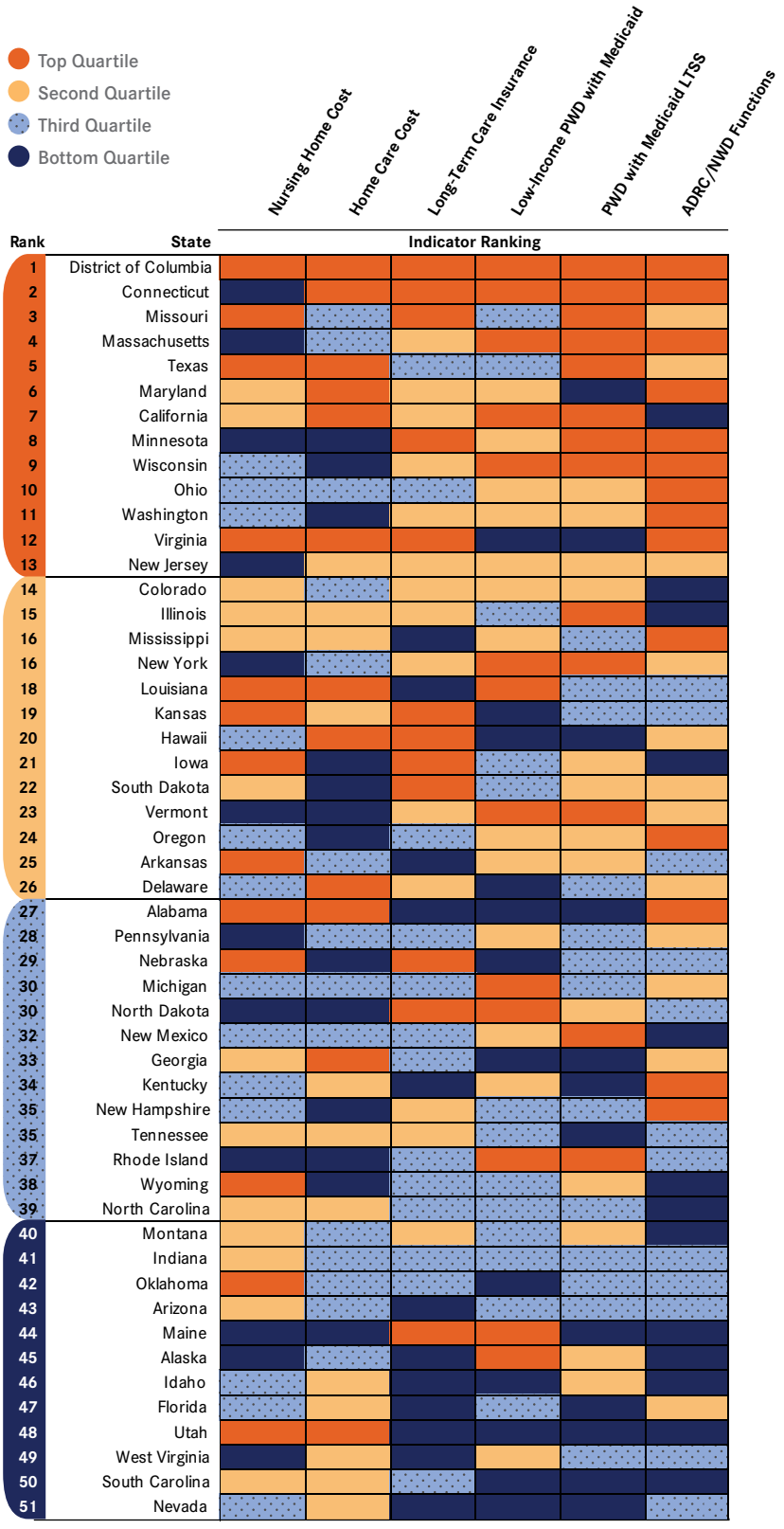
Matrix heat maps are our preferred method to visualize LTSS system performance multiple indicators or multiple dimensions in one image.

Like the geographic heat maps used within the report, the data are broken down into color-coded tiers of performance (usually quartiles, except for the Support for Family Caregivers dimension matrix heat map in Exhibit A5). Multiple columns show performance across indicators or dimension, and states are ordered from highest to lowest overall performance.

These heat maps use a divergent color scheme with two colors. This calls attention to both high and low performance. Dark shades identify the extremes of the performance spectrum (orange for high performance, and blue for poor), while light shades indicate an intermediate level of performance.

Source: Long-Term Services and Supports State Scorecard, 2020.

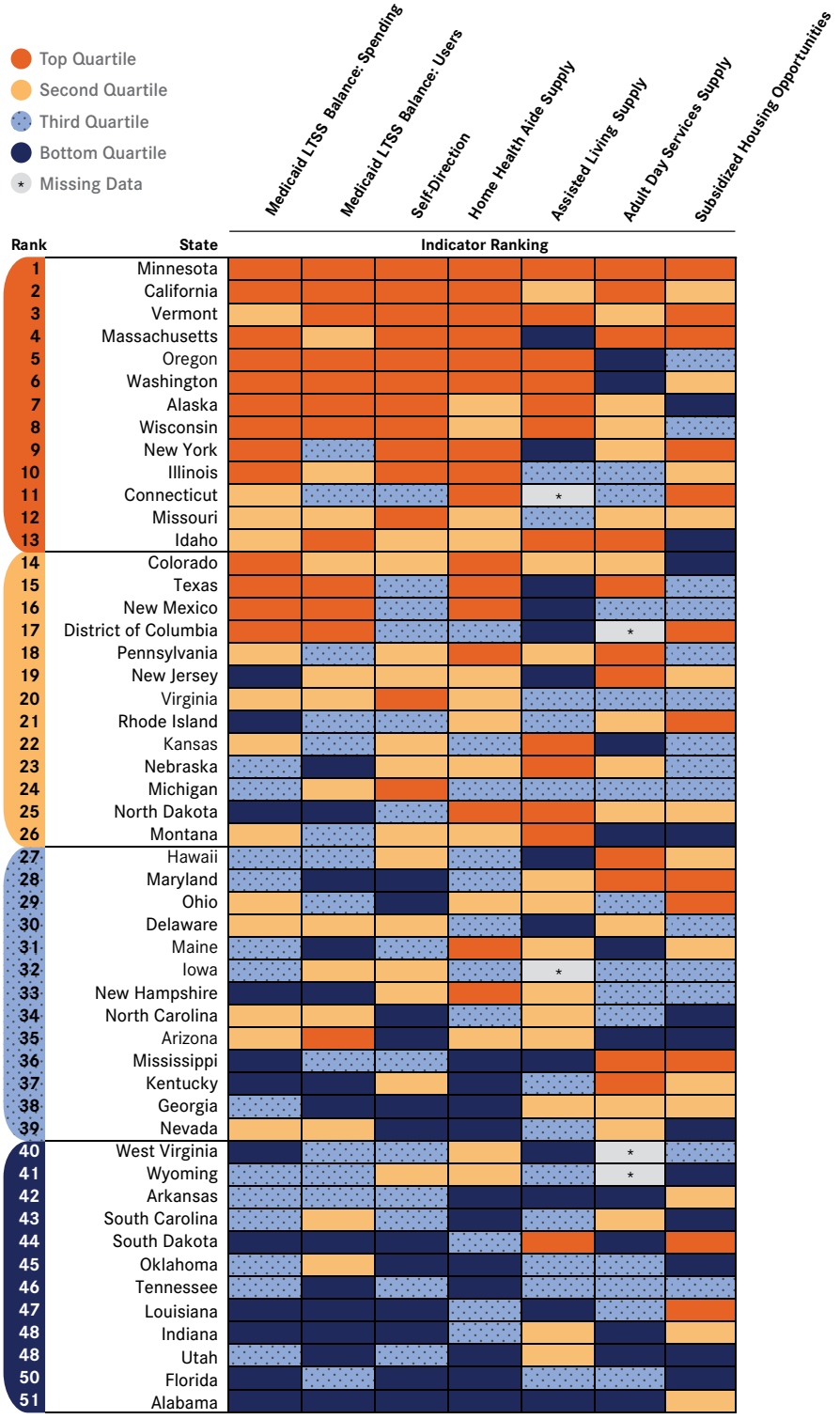
EXHIBIT A2 Matrix Heat Map: Affordability and Access



PWD = People with Disabilities.
ADRC/NWD = Aging and Disability Resource Center/No Wrong Door.

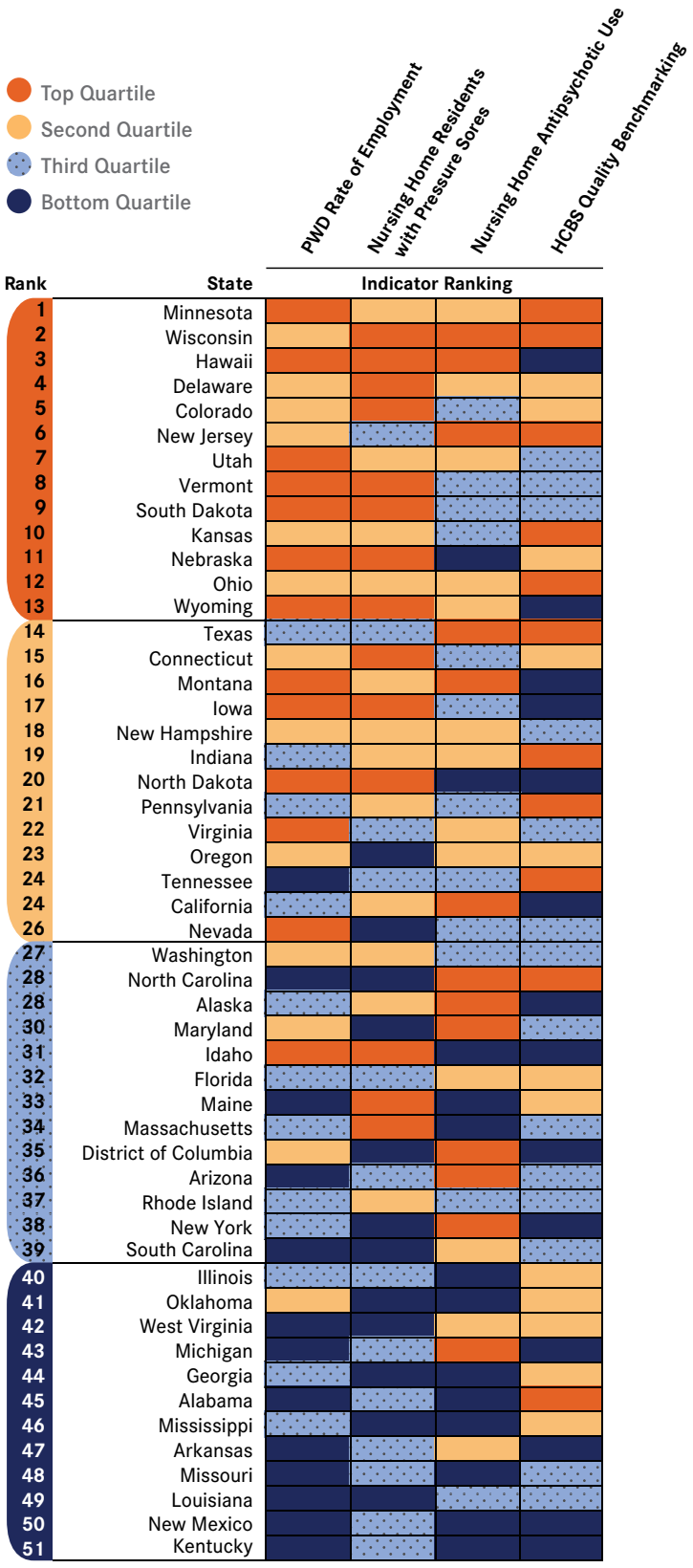
Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A3 Matrix Heat Map: Choice of Setting and Provider



Source: Long-Term Services and Supports State Scorecard, 2020.

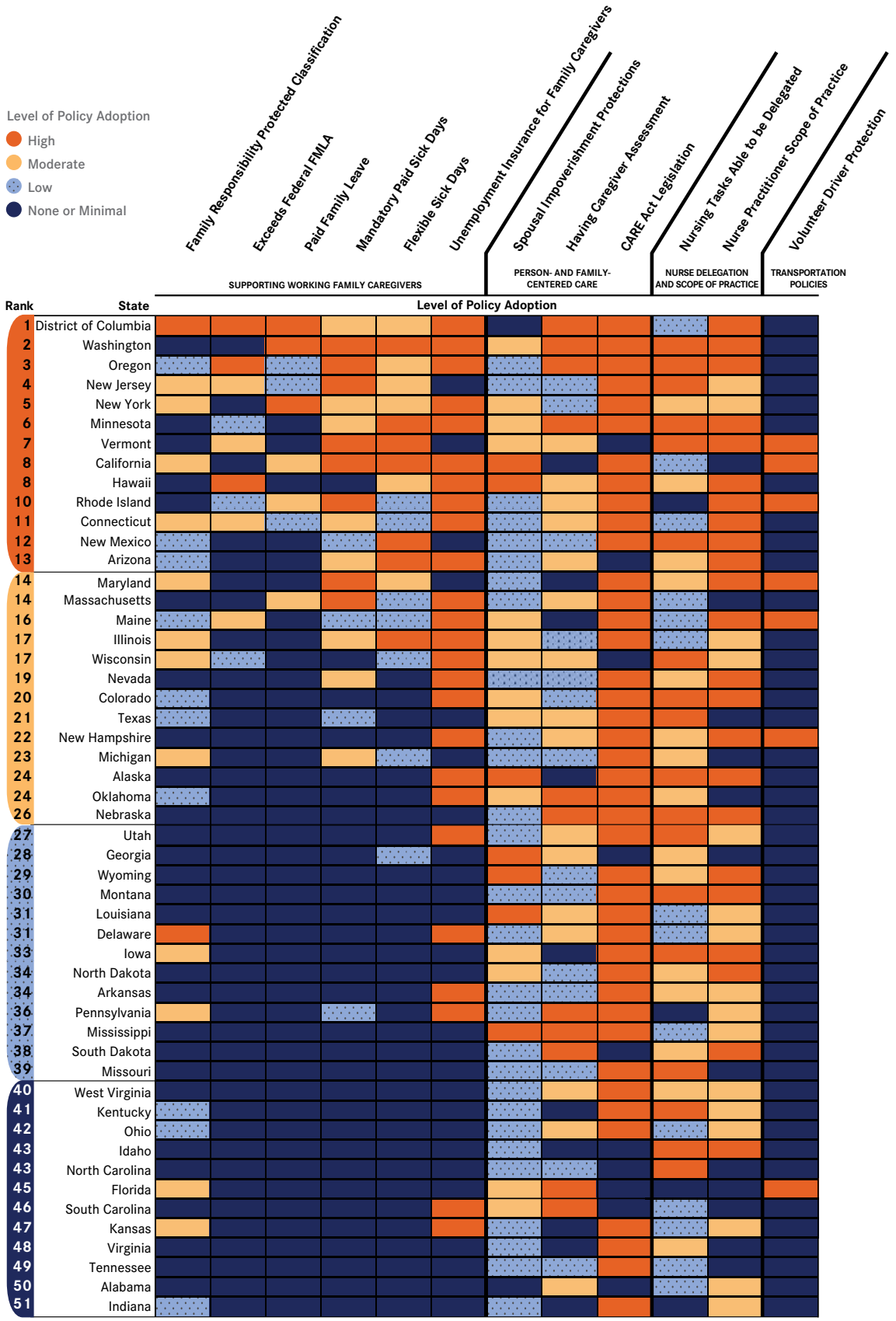
EXHIBIT A4 Matrix Heat Map: Quality of Life and Quality of Care



PWD = People with Disabilities

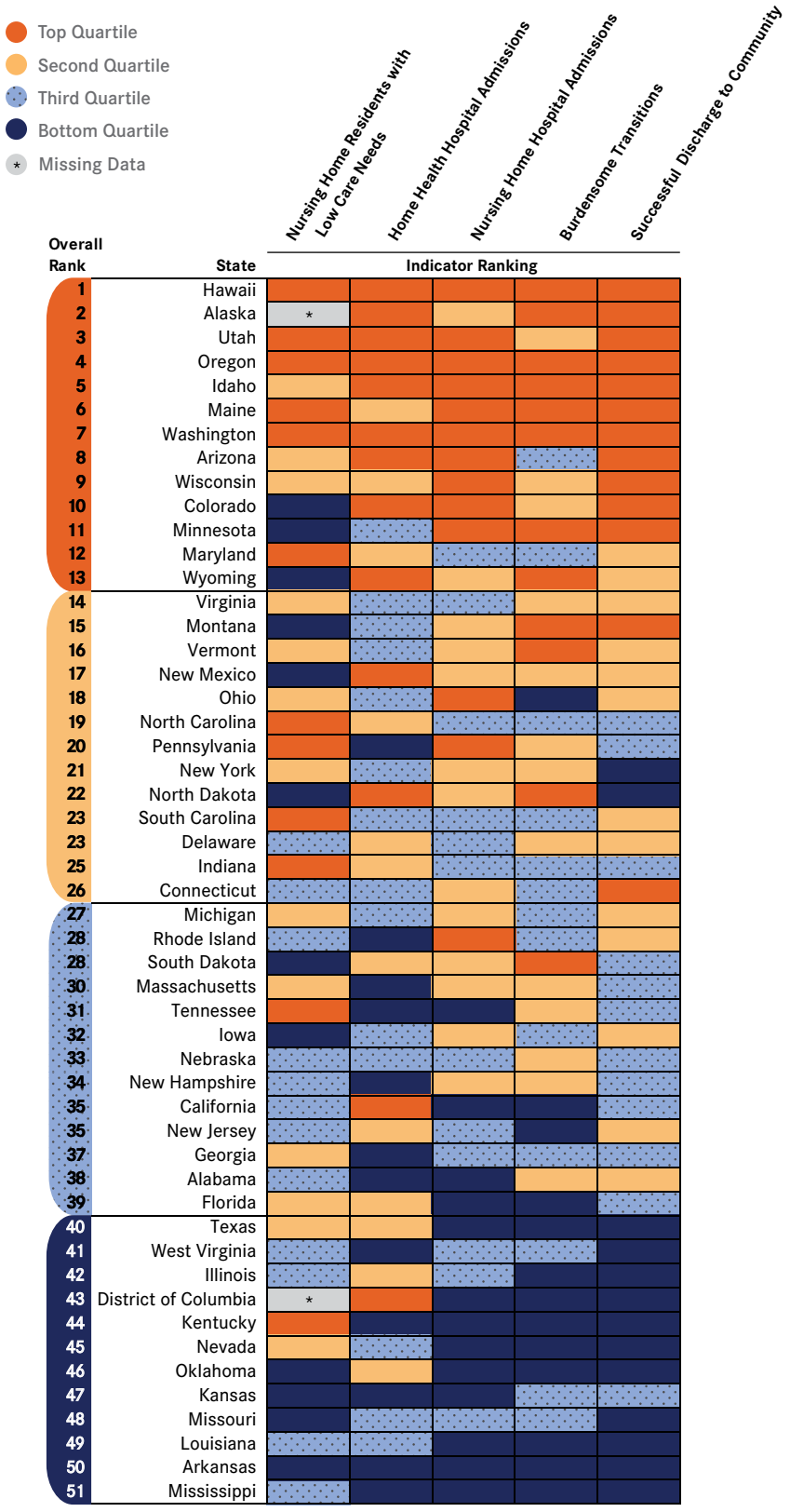
Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A5 Matrix Heat Map: Support for Family Caregivers



Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A6 Matrix Heat Map: Effective Transitions



Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A7 Change in State Performance: Number of States

Indicator	Performance Improvement	Performance Decline	No Significant Change	Missing Data
Affordability and Access				
Nursing Home Cost	1	6	44	0
Home Care Cost	0	6	45	0
Long-Term Care Insurance	0	24	27	0
Low-Income PWD with Medicaid	8	2	41	0
PWD with Medicaid LTSS	7	0	44	0
ADRC/NWD Functions	33	4	12	2
Choice of Setting and Provider				
Medicaid LTSS Balance: Spending	25	9	17	0
Medicaid LTSS Balance: Users	12	1	31	7
Home Health Aide Supply	5	3	43	0
Assisted Living Supply	3	1	43	4
Adult Day Services Supply	4	8	33	6
Subsidized Housing Opportunities	9	2	40	0
Quality of Life and Quality of Care				
PWD Rate of Employment	5	2	44	0
Nursing Home Antipsychotic Use	28	1	22	0
Support for Family Caregivers				
Supporting Working Family Caregivers	23	0	28	0
Person- and Family-Centered Care	29	5	17	0
Nurse Delegation and Scope of Practice	6	0	45	0
Transportation Policies	2	0	49	0
Effective Transitions				
Home Health Hospital Admissions	3	1	47	0
Nursing Home Hospital Admissions	8	1	42	0
Burdensome Transitions	15	3	33	0

Improvement or decline means a significant change (usually +/- 10% or equivalent) since a reference data year (usually three years prior). For some measures, a revised baseline is used, as the indicator definition or data source may have changed since the last *Scorecard*.

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A8 Indicator Data: Affordability and Access

	Median Annual Nursing Home Private Pay Cost as a Percentage of Median Household Income Ages 65+				Median Annual Home Care Private Pay Cost as a Percentage of Median Household Income Ages 65+				Private Long-Term Care Insurance Policies in Effect per 1,000 Population Ages 40+			
State	**2015–16**	**2018–19**	**Rank**	**Change**	**2015–16**	**2018–19**	**Rank**	**Change**	**2015**	**2018**	**Rank**	**Change**
United States	**243%**	**245%**		↔	**79%**	**80%**		↔	**47**	**43**		↔
Alabama	205%	208%	11	↔	72%	72%	9	↔	34	31	42	↔
Alaska	475%	638%	51	X	71%	82%	25	X	26	24	49	↔
Arizona	220%	224%	20	↔	76%	85%	32	X	33	28	45	X
Arkansas	204%	202%	9	↔	83%	82%	25	↔	31	27	48	X
California	249%	232%	25	↔	77%	71%	7	↔	45	42	24	↔
Colorado	206%	216%	14	↔	78%	82%	25	↔	58	52	15	X
Connecticut	334%	324%	45	↔	71%	70%	6	↔	66	63	9	↔
Delaware	265%	254%	32	↔	76%	76%	11	↔	59	51	17	X
District of Columbia	199%	196%	8	↔	46%	51%	1	X	146	138	1	↔
Florida	273%	281%	39	↔	78%	79%	18	↔	35	29	43	X
Georgia	202%	222%	18	↔	72%	76%	11	↔	37	33	38	X
Hawaii	225%	241%	30	↔	64%	67%	3	↔	114	110	3	↔
Idaho	233%	248%	31	↔	83%	78%	16	↔	33	28	45	X
Illinois	209%	218%	15	↔	84%	81%	22	↔	57	53	13	↔
Indiana	237%	232%	25	↔	83%	85%	32	↔	38	34	37	X
Iowa	171%	194%	7	X	88%	91%	39	↔	102	91	6	X
Kansas	174%	172%	2	↔	77%	81%	22	↔	85	78	8	↔
Kentucky	231%	239%	29	↔	85%	81%	22	↔	36	32	40	X
Louisiana	191%	187%	6	↔	75%	71%	7	↔	36	32	40	X
Maine	312%	325%	47	↔	102%	105%	50	↔	56	55	11	↔
Maryland	230%	222%	18	↔	59%	64%	2	↔	54	50	19	↔
Massachusetts	319%	311%	43	↔	89%	87%	35	↔	57	53	13	↔
Michigan	243%	267%	34	↔	81%	87%	35	↔	38	36	35	↔
Minnesota	224%	287%	40	X	97%	103%	47	↔	85	79	7	↔
Mississippi	238%	229%	24	↔	84%	77%	13	↔	33	29	43	X
Missouri	170%	168%	1	↔	80%	84%	30	↔	60	55	11	↔
Montana	222%	226%	21	↔	93%	89%	38	↔	56	50	19	X
Nebraska	199%	209%	12	↔	93%	93%	41	↔	116	103	5	X
Nevada	257%	236%	28	↔	74%	77%	13	↔	23	24	49	↔
New Hampshire	268%	280%	38	↔	83%	91%	39	↔	47	43	23	↔
New Jersey	290%	310%	42	↔	72%	78%	16	↔	51	48	21	↔
New Mexico	243%	270%	36	X	85%	87%	35	↔	43	41	27	↔
New York	374%	324%	45	✓	89%	84%	30	↔	44	42	24	↔
North Carolina	233%	226%	21	↔	76%	77%	13	↔	43	38	32	X
North Dakota	333%	328%	48	↔	97%	99%	46	↔	119	106	4	X
Ohio	237%	234%	27	↔	83%	82%	25	↔	45	41	27	↔
Oklahoma	164%	177%	3	↔	85%	82%	25	↔	37	33	38	X
Oregon	254%	269%	35	↔	84%	93%	41	X	46	40	30	X
Pennsylvania	305%	301%	41	↔	88%	86%	34	↔	43	39	31	↔
Rhode Island	303%	321%	44	↔	102%	104%	48	↔	40	38	32	↔
South Carolina	212%	226%	21	↔	77%	79%	18	↔	47	37	34	X
South Dakota	205%	220%	16	↔	95%	116%	51	X	120	111	2	↔
Tennessee	201%	220%	16	↔	76%	79%	18	↔	46	42	24	↔
Texas	184%	182%	5	↔	71%	73%	10	↔	41	35	36	X
Utah	174%	181%	4	↔	69%	69%	4	↔	36	28	45	X
Vermont	300%	338%	49	X	99%	104%	48	↔	52	47	22	↔
Virginia	208%	211%	13	↔	61%	69%	4	X	64	59	10	↔
Washington	252%	258%	33	↔	86%	94%	43	↔	69	51	17	X
West Virginia	275%	354%	50	X	73%	80%	21	↔	27	24	49	X
Wisconsin	258%	277%	37	↔	89%	97%	45	↔	58	52	15	X
Wyoming	197%	205%	10	↔	92%	96%	44	↔	44	41	27	↔

Key for Change: ✓ Performance improvement ↔ Little or no change in performance X Performance decline * No trend available

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A8 Indicator Data: Affordability and Access (continued)

	Percentage of Adults Ages 21+ with ADL Disability at or Below 250% of Poverty Receiving Medicaid or Other Government Assistance Health Insurance				Estimated Medicaid LTSS Users per 100 Population with ADL Disability				ADRC/No Wrong Door Functions (Composite Indicator, scale 0-100%)			
State	**2014—15**	**2016—18**	**Rank**	**Change**	**2014**	**2017**	**Rank**	**Change**	**2016**	**2019**	**Rank**	**Change**
United States	**55.2%**	**56.7%**		↔	**44**	**46**		↔	**60%**	**66%**		✓
Alabama	46.9%	47.7%	46	↔	21	21	49	↔	78%	89%	8	✓
Alaska	69.1%	70.4%	2	↔	49	42	21	↔	46%	41%	46	X
Arizona	49.9%	53.8%	29	↔	30	34	34	↔	51%	64%	28	✓
Arkansas	55.8%	57.5%	17	↔	45	42	21	↔	56%	57%	34	↔
California	66.8%	66.5%	6	↔	57	60	8	↔	0%	37%	47	*
Colorado	57.2%	56.9%	22	↔	45	49	16	↔	45%	52%	39	✓
Connecticut	62.8%	67.1%	5	✓	71	80	4	↔	87%	90%	7	✓
Delaware	49.2%	45.2%	49	↔	36	36	32	↔	73%	77%	22	✓
District of Columbia	78.1%	79.2%	1	↔	97	88	2	↔	74%	86%	10	✓
Florida	50.1%	51.1%	34	↔	24	24	47	↔	82%	82%	15	↔
Georgia	47.9%	48.7%	41	↔	24	27	45	↔	70%	81%	19	✓
Hawaii	56.6%	48.4%	43	X	16	28	43	✓	68%	79%	20	✓
Idaho	54.1%	48.4%	43	X	44	46	17	↔	38%	43%	44	✓
Illinois	48.7%	51.5%	32	↔	46	58	10	✓	47%	46%	41	↔
Indiana	49.8%	55.2%	27	✓	32	36	32	↔	41%	57%	34	✓
Iowa	50.5%	50.8%	35	↔	48	51	14	↔	0%	43%	44	*
Kansas	48.6%	48.2%	45	↔	36	34	34	↔	60%	63%	29	✓
Kentucky	53.4%	56.5%	25	↔	29	28	43	↔	72%	83%	12	✓
Louisiana	54.4%	59.0%	13	✓	32	33	38	↔	52%	56%	36	✓
Maine	63.6%	66.2%	7	↔	33	31	40	↔	51%	52%	39	↔
Maryland	51.4%	56.5%	25	✓	29	30	41	↔	80%	84%	11	✓
Massachusetts	67.7%	67.8%	4	↔	70	77	5	↔	88%	93%	3	✓
Michigan	60.0%	60.9%	10	↔	37	37	30	↔	70%	70%	26	↔
Minnesota	55.9%	57.5%	17	↔	81	83	3	↔	88%	92%	5	✓
Mississippi	57.9%	58.0%	16	↔	40	38	29	↔	72%	83%	12	✓
Missouri	50.0%	50.2%	37	↔	57	61	7	↔	81%	82%	15	↔
Montana	43.4%	49.4%	39	✓	33	40	26	✓	41%	44%	43	✓
Nebraska	50.9%	47.3%	47	↔	41	39	27	↔	48%	53%	38	✓
Nevada	49.6%	48.7%	41	↔	19	25	46	✓	56%	66%	27	✓
New Hampshire	47.4%	49.6%	38	↔	32	34	34	↔	88%	95%	2	✓
New Jersey	57.4%	56.9%	22	↔	46	51	14	↔	82%	82%	15	↔
New Mexico	54.7%	58.6%	14	↔	53	55	11	↔	29%	33%	48	✓
New York	67.4%	70.1%	3	↔	57	54	12	↔	50%	75%	23	✓
North Carolina	51.4%	52.4%	31	↔	34	34	34	↔	30%	24%	50	X
North Dakota	51.8%	59.1%	12	✓	43	41	24	↔	52%	54%	37	↔
Ohio	55.0%	56.6%	24	↔	45	45	18	↔	86%	96%	1	✓
Oklahoma	38.8%	41.4%	51	↔	36	33	38	↔	59%	60%	32	↔
Oregon	57.3%	57.2%	19	↔	37	42	21	↔	77%	88%	9	✓
Pennsylvania	52.6%	57.2%	19	✓	37	39	27	↔	79%	82%	15	✓
Rhode Island	60.1%	65.7%	9	✓	54	54	12	↔	56%	62%	30	✓
South Carolina	44.7%	49.0%	40	↔	19	24	47	✓	44%	46%	41	↔
South Dakota	53.2%	50.8%	35	↔	38	41	24	↔	51%	78%	21	✓
Tennessee	47.0%	51.2%	33	↔	22	21	49	↔	33%	58%	33	✓
Texas	52.9%	52.9%	30	↔	73	71	6	↔	72%	74%	24	✓
Utah	44.3%	46.0%	48	↔	21	19	51	↔	30%	28%	49	↔
Vermont	67.4%	66.2%	7	↔	93	100	1	↔	79%	73%	25	X
Virginia	43.1%	45.1%	50	↔	29	29	42	↔	73%	83%	12	✓
Washington	56.8%	58.2%	15	↔	39	44	19	↔	92%	93%	3	✓
West Virginia	56.7%	57.0%	21	↔	30	37	30	✓	61%	62%	30	↔
Wisconsin	57.7%	59.2%	11	↔	59	60	8	↔	79%	92%	5	✓
Wyoming	56.7%	54.4%	28	↔	35	43	20	✓	21%	13%	51	X

Key for Change: ✓ Performance improvement ↔ Little or no change in performance X Performance decline * No trend available

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A9 Indicator Data: Choice of Setting and Provider

	Percentage of Medicaid- and State-Funded LTSS Spending Going to HCBS for Older People and Adults with Physical Disabilities				Estimated Percentage of Medicaid Aged/Disabled LTSS Users Receiving HCBS				Number of People Self-Directing Services per 1,000 Population with Disabilities		
State	**2013**	**2016**	**Rank**	**Change**	**2014**	**2017**	**Rank**	**Change**	**2019**	**Rank**	**Change**
United States	**41.3%**	**45.1%**		✓	**61.7%**	**64.2%**		↔	**30.4**		*
Alabama	15.2%	14.8%	49	↔	31.2%	31.9%	50	↔	2.6	44	*
Alaska	63.2%	63.4%	6	↔	86.3%	83.9%	1	↔	35.2	12	*
Arizona	44.9%	44.7%	16	↔	76.6%	78.2%	10	↔	3.5	40	*
Arkansas	33.0%	33.9%	28	↔	52.4%	53.2%	31	↔	5.7	34	*
California	57.4%	57.0%	8	↔	78.7%	80.2%	7	↔	149.1	1	*
Colorado	47.8%	58.7%	7	✓	65.2%	68.5%	16	↔	15.0	19	*
Connecticut	29.8%	41.1%	20	✓	53.0%	54.6%	26	↔	8.0	30	*
Delaware	24.7%	35.6%	26	✓	*	55.5%	24	*	12.9	23	*
District of Columbia	57.7%	49.7%	13	X	77.9%	80.4%	5	↔	8.0	30	*
Florida	25.6%	23.6%	44	X	42.6%	47.0%	38	↔	1.7	47	*
Georgia	26.2%	29.6%	32	✓	49.7%	46.8%	39	↔	2.7	41	*
Hawaii	23.6%	27.8%	36	✓	*	54.3%	28	*	23.1	16	*
Idaho	44.1%	44.6%	17	↔	71.4%	80.0%	8	✓	11.6	26	*
Illinois	42.9%	54.6%	10	✓	58.9%	69.8%	13	✓	46.5	8	*
Indiana	20.0%	18.4%	47	↔	34.9%	38.1%	47	↔	0.4	51	*
Iowa	30.7%	26.4%	39	X	51.8%	59.5%	21	✓	26.5	14	*
Kansas	40.8%	39.5%	21	↔	50.6%	54.2%	29	↔	24.4	15	*
Kentucky	15.6%	13.5%	51	X	41.5%	41.1%	44	↔	13.7	21	*
Louisiana	30.2%	24.1%	43	X	46.7%	40.0%	46	X	1.9	46	*
Maine	34.2%	28.5%	34	X	37.7%	36.8%	49	↔	5.5	36	*
Maryland	24.6%	28.5%	34	✓	38.5%	42.4%	43	↔	1.6	48	*
Massachusetts	52.0%	64.2%	5	✓	65.4%	68.6%	15	↔	49.2	6	*
Michigan	24.8%	31.5%	29	✓	63.2%	61.6%	19	↔	36.1	11	*
Minnesota	66.8%	69.9%	3	✓	77.4%	80.5%	4	✓	60.6	3	*
Mississippi	23.1%	25.5%	41	✓	51.0%	50.7%	34	↔	6.8	33	*
Missouri	39.3%	42.7%	18	✓	63.8%	65.2%	18	↔	47.2	7	*
Montana	36.8%	38.2%	24	↔	47.5%	54.4%	27	✓	16.2	18	*
Nebraska	27.7%	29.6%	32	↔	44.9%	45.5%	42	↔	12.8	24	*
Nevada	37.8%	38.4%	22	↔	67.0%	69.2%	14	↔	2.7	41	*
New Hampshire	19.0%	14.0%	50	X	33.8%	41.0%	45	✓	12.6	25	*
New Jersey	18.2%	21.0%	46	✓	55.8%	65.3%	17	✓	20.6	17	*
New Mexico	64.4%	73.5%	1	✓	*	81.3%	2	*	10.9	27	*
New York	47.6%	53.3%	11	✓	43.9%	51.0%	33	✓	38.0	10	*
North Carolina	46.2%	41.9%	19	X	64.8%	61.5%	20	↔	2.6	44	*
North Dakota	17.1%	17.3%	48	↔	29.1%	27.7%	51	↔	5.6	35	*
Ohio	33.3%	37.1%	25	✓	48.3%	49.3%	36	↔	1.5	50	*
Oklahoma	28.1%	30.4%	31	✓	54.2%	55.1%	25	↔	2.7	41	*
Oregon	62.1%	64.7%	4	✓	79.7%	80.3%	6	↔	49.6	5	*
Pennsylvania	28.9%	38.3%	23	✓	42.6%	47.7%	37	✓	13.3	22	*
Rhode Island	21.8%	24.4%	42	✓	*	50.6%	35	*	10.8	28	*
South Carolina	27.8%	31.2%	30	✓	55.5%	56.3%	23	↔	4.0	38	*
South Dakota	19.5%	21.9%	45	✓	35.2%	37.4%	48	↔	1.6	48	*
Tennessee	33.3%	35.0%	27	↔	*	46.2%	40	*	4.0	38	*
Texas	55.5%	55.8%	9	↔	*	79.4%	9	*	4.4	37	*
Utah	25.6%	26.6%	38	↔	46.1%	45.6%	41	↔	8.9	29	*
Vermont	44.5%	45.7%	15	↔	*	81.1%	3	*	51.3	4	*
Virginia	45.6%	48.6%	14	✓	55.3%	57.0%	22	↔	27.0	13	*
Washington	62.6%	71.5%	2	✓	73.5%	77.0%	11	✓	43.2	9	*
West Virginia	30.1%	26.3%	40	X	49.8%	54.2%	29	↔	8.0	30	*
Wisconsin	51.9%	52.5%	12	↔	71.4%	75.5%	12	✓	64.0	2	*
Wyoming	21.8%	27.5%	37	✓	45.8%	51.3%	32	✓	14.5	20	*

Key for Change: ✓ Performance improvement ↔ Little or no change in performance X Performance decline * No trend available

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A9 Indicator Data: Choice of Setting and Provider (continued)

	Home Health and Personal Care Aides per 100 Population Ages 18+ with an ADL Disability				Assisted Living and Residential Care Units per 1,000 Population Ages 75+				Adult Day Services Total Licensed Capacity per 10,000 Population Ages 65+				Subsidized Housing Opportunities as a Percentage of All Housing Units			
State	2013–15	2016–18	Rank	Change	2014	2016	Rank	Change	2014	2016	Rank	Change	2015	2017–18	Rank	Change
United States	**22**	**22**		↔	**51**	**49**		↔	**64**	**61**		↔	**5.9%**	**6.2%**		↔
Alabama	10	8	51	✗	31	26	45	↔	10	9	43	↔	6.5%	6.5%	16	↔
Alaska	24	22	21	↔	80	89	4	↔	62	52	16	↔	3.9%	4.0%	49	↔
Arizona	20	20	23	↔	56	51	24	↔	11	8	44	✗	2.8%	2.9%	51	↔
Arkansas	13	14	41	↔	29	35	37	✓	24	14	41	✗	6.6%	6.5%	16	↔
California	28	29	5	↔	59	60	14	↔	178	171	1	↔	5.8%	6.1%	21	↔
Colorado	21	24	14	↔	54	52	22	↔	71	53	15	✗	4.4%	4.9%	41	✓
Connecticut	30	33	2	↔	*	*	*	*	42	34	25	↔	7.4%	8.6%	5	✓
Delaware	14	19	30	✓	33	30	43	↔	39	39	21	↔	5.4%	5.3%	35	↔
District of Columbia	17	16	37	↔	21	23	48	↔	*	*	*	*	17.7%	18.6%	1	↔
Florida	13	13	43	↔	44	47	27	↔	30	31	29	↔	4.3%	4.7%	43	↔
Georgia	11	11	47	↔	52	55	20	↔	38	38	22	↔	5.9%	6.2%	19	↔
Hawaii	13	15	39	↔	*	26	45	*	78	98	6	✓	5.8%	6.3%	18	↔
Idaho	31	23	17	✗	88	82	8	↔	*	71	8	*	4.4%	3.8%	50	✗
Illinois	23	24	14	↔	39	41	30	↔	28	21	34	✗	6.2%	6.6%	13	↔
Indiana	15	15	39	↔	50	52	22	↔	15	17	39	↔	5.7%	6.1%	21	↔
Iowa	19	16	37	↔	*	*	*	*	23	21	34	↔	5.8%	5.6%	31	↔
Kansas	21	19	30	↔	64	87	5	✓	*	8	44	*	5.6%	5.7%	29	↔
Kentucky	10	9	50	↔	47	39	32	↔	94	72	7	✗	5.9%	6.6%	13	✓
Louisiana	21	19	30	↔	20	20	49	↔	35	34	25	↔	6.8%	7.7%	7	✓
Maine	23	26	10	↔	63	61	13	↔	27	16	40	✗	6.5%	6.1%	21	↔
Maryland	14	18	33	✓	51	58	17	↔	128	122	4	↔	6.8%	7.6%	8	✓
Massachusetts	25	28	6	↔	30	34	39	↔	90	99	5	↔	9.0%	10.1%	4	✓
Michigan	17	18	33	↔	56	48	26	↔	20	23	32	↔	5.2%	5.5%	34	↔
Minnesota	34	33	2	↔	88	90	3	↔	79	66	10	↔	6.0%	6.9%	11	✓
Mississippi	10	10	49	↔	36	33	41	↔	120	67	9	✗	7.9%	7.8%	6	↔
Missouri	22	23	17	↔	49	43	29	↔	44	44	20	↔	6.0%	6.2%	19	↔
Montana	20	23	17	↔	83	80	9	↔	6	7	46	↔	4.8%	4.6%	45	↔
Nebraska	16	20	23	✓	90	73	10	↔	72	59	14	↔	6.0%	5.9%	28	↔
Nevada	13	12	45	↔	28	38	34	✓	40	36	24	↔	4.3%	4.7%	43	↔
New Hampshire	29	26	10	↔	55	59	15	↔	24	23	32	↔	5.3%	5.6%	31	↔
New Jersey	19	20	23	↔	36	35	37	↔	123	134	2	↔	6.0%	6.6%	13	✓
New Mexico	34	32	4	↔	32	34	39	↔	13	20	36	✓	4.9%	5.2%	38	↔
New York	42	47	1	↔	28	27	44	↔	40	45	19	↔	10.2%	10.5%	2	↔
North Carolina	16	17	35	↔	65	53	21	↔	33	31	29	↔	4.8%	4.9%	41	↔
North Dakota	16	25	12	✓	105	102	1	↔	10	48	17	✓	6.2%	6.1%	21	↔
Ohio	21	20	23	↔	54	59	15	↔	30	26	31	↔	6.7%	6.9%	11	↔
Oklahoma	14	12	45	↔	44	39	32	↔	33	34	25	↔	5.0%	5.1%	40	↔
Oregon	23	25	12	↔	121	95	2	✗	5	6	47	✓	5.7%	5.7%	29	↔
Pennsylvania	22	27	7	✓	64	58	17	↔	71	66	10	↔	5.1%	5.2%	38	↔
Rhode Island	17	20	23	↔	51	49	25	↔	57	61	12	↔	10.1%	10.4%	3	↔
South Carolina	13	14	41	↔	42	37	35	↔	47	46	18	↔	4.9%	4.6%	45	↔
South Dakota	15	17	35	↔	76	72	11	↔	29	18	38	✗	9.4%	7.6%	8	✗
Tennessee	13	13	43	↔	44	41	30	↔	17	20	36	↔	5.6%	6.0%	26	↔
Texas	27	27	7	↔	39	33	41	↔	130	125	3	↔	4.6%	5.3%	35	✓
Utah	12	11	47	↔	58	58	17	↔	*	6	47	*	4.3%	4.4%	48	↔
Vermont	31	27	7	↔	54	62	12	↔	63	61	12	↔	7.3%	7.2%	10	↔
Virginia	21	20	23	↔	56	45	28	↔	33	32	28	↔	5.4%	5.6%	31	↔
Washington	25	24	14	↔	103	85	6	↔	13	12	42	↔	6.1%	6.1%	21	↔
West Virginia	19	21	22	↔	26	24	47	↔	*	*	*	*	5.7%	6.0%	26	↔
Wisconsin	22	23	17	↔	92	84	7	↔	41	38	22	↔	5.1%	5.3%	35	↔
Wyoming	27	20	23	✗	*	37	35	*	*	*	*	*	4.7%	4.5%	47	↔

Key for Change: ✓ Performance improvement ↔ Little or no change in performance ✗ Performance decline * No trend available

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A10 Indicator Data: Quality of Life and Quality of Care

	Rate of Employment for Adults with ADL Disability Ages 18-64 Relative to Rate of Employment for Adults without ADL Disability Ages 18-64				Percentage of High-Risk Nursing Home Residents with Pressure Sores		
State	**2013—15**	**2016—18**	**Rank**	**Change**	**2018**	**Rank**	**Change**
United States	**21.4%**	**21.4%**		↔	**7.3%**		*
Alabama	18.4%	15.5%	51	↔	7.5%	27	*
Alaska	29.0%	19.6%	38	X	5.9%	15	*
Arizona	21.1%	17.8%	46	↔	7.7%	32	*
Arkansas	17.9%	16.5%	49	↔	7.7%	32	*
California	21.4%	21.5%	27	↔	7.0%	25	*
Colorado	22.9%	24.9%	15	↔	5.6%	10	*
Connecticut	25.2%	23.5%	21	↔	5.3%	3	*
Delaware	20.8%	22.8%	24	↔	5.4%	6	*
District of Columbia	20.4%	23.5%	21	↔	13.0%	51	*
Florida	19.8%	20.6%	33	↔	7.9%	35	*
Georgia	20.0%	21.3%	28	↔	9.0%	47	*
Hawaii	26.0%	26.9%	11	↔	5.2%	2	*
Idaho	18.6%	28.4%	8	✓	5.8%	13	*
Illinois	22.4%	21.1%	32	↔	7.5%	27	*
Indiana	20.3%	21.3%	28	↔	7.1%	26	*
Iowa	30.0%	26.6%	12	↔	5.3%	3	*
Kansas	28.1%	25.5%	14	↔	6.1%	17	*
Kentucky	15.7%	16.9%	48	↔	8.3%	37	*
Louisiana	17.4%	19.2%	39	↔	8.8%	44	*
Maine	18.9%	17.6%	47	↔	5.4%	6	*
Maryland	28.3%	24.3%	18	↔	8.9%	46	*
Massachusetts	21.3%	21.3%	28	↔	5.7%	12	*
Michigan	18.1%	18.6%	44	↔	7.7%	32	*
Minnesota	33.3%	31.1%	4	↔	5.9%	15	*
Mississippi	16.5%	19.8%	37	✓	9.3%	48	*
Missouri	18.8%	18.9%	41	↔	7.9%	35	*
Montana	30.4%	27.1%	10	↔	6.3%	19	*
Nebraska	28.4%	27.7%	9	↔	5.6%	10	*
Nevada	36.5%	34.9%	2	↔	8.6%	41	*
New Hampshire	24.7%	24.7%	16	↔	6.1%	17	*
New Jersey	24.2%	23.6%	19	↔	8.3%	37	*
New Mexico	22.1%	19.2%	39	↔	8.3%	37	*
New York	22.4%	20.3%	36	↔	8.6%	41	*
North Carolina	19.5%	18.8%	42	↔	9.8%	50	*
North Dakota	25.3%	38.1%	1	✓	4.8%	1	*
Ohio	23.0%	21.9%	26	↔	6.7%	23	*
Oklahoma	24.3%	24.7%	16	↔	9.6%	49	*
Oregon	23.8%	23.6%	19	↔	8.5%	40	*
Pennsylvania	20.5%	20.6%	33	↔	6.9%	24	*
Rhode Island	20.6%	20.4%	35	↔	6.4%	20	*
South Carolina	19.6%	18.1%	45	↔	8.6%	41	*
South Dakota	29.6%	32.6%	3	↔	5.5%	9	*
Tennessee	16.1%	18.7%	43	↔	7.5%	27	*
Texas	21.4%	21.3%	28	↔	7.6%	31	*
Utah	27.7%	30.2%	6	↔	6.4%	20	*
Vermont	19.3%	30.8%	5	✓	5.4%	6	*
Virginia	22.2%	26.3%	13	✓	7.5%	27	*
Washington	22.6%	23.4%	23	↔	6.6%	22	*
West Virginia	18.6%	16.4%	50	↔	8.8%	44	*
Wisconsin	22.7%	22.1%	25	↔	5.8%	13	*
Wyoming	34.1%	29.2%	7	X	5.3%	3	*

Key for Change: ✓ Performance improvement ↔ Little or no change in performance X Performance decline * No trend available

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A10 Indicator Data: Quality of Life and Quality of Care (continued)

	Percentage of Long-Stay Nursing Home Residents Who Inappropriately Receive Antipsychotic Medication				HCBS Quality Cross-State Benchmarking Capability		
State	**2015**	**2018**	**Rank**	**Change**	**2015–19**	**Rank**	**Change**
United States	**17.3%**	**14.6%**		✓	**1.3**		*
Alabama	19.9%	20.2%	51	↔	2.2	11	*
Alaska	14.5%	11.6%	6	✓	0	38	*
Arizona	17.4%	12.5%	10	✓	1.0	31	*
Arkansas	16.9%	14.0%	19	✓	0	38	*
California	13.2%	10.8%	4	✓	0	38	*
Colorado	15.4%	15.0%	29	↔	2.0	12	*
Connecticut	17.3%	16.5%	37	↔	1.5	20	*
Delaware	13.3%	13.6%	15	↔	1.6	16	*
District of Columbia	13.3%	10.0%	3	✓	0	38	*
Florida	17.5%	14.0%	19	✓	1.5	20	*
Georgia	19.8%	18.1%	46	✓	2.0	12	*
Hawaii	8.0%	7.8%	1	↔	0	38	*
Idaho	16.8%	17.7%	43	↔	0	38	*
Illinois	20.3%	18.7%	48	↔	1.5	20	*
Indiana	16.4%	14.4%	24	✓	2.5	8	*
Iowa	16.5%	14.6%	27	✓	0	38	*
Kansas	19.9%	16.5%	37	✓	2.7	6	*
Kentucky	20.2%	17.3%	39	✓	0	38	*
Louisiana	21.5%	15.8%	34	✓	0.6	37	*
Maine	17.8%	17.4%	42	↔	1.6	16	*
Maryland	14.1%	12.2%	8	✓	1.0	31	*
Massachusetts	18.9%	17.8%	44	↔	1.0	31	*
Michigan	13.4%	13.0%	13	↔	0	38	*
Minnesota	13.5%	13.3%	14	↔	3.5	2	*
Mississippi	21.1%	18.2%	47	✓	2.0	12	*
Missouri	19.4%	18.8%	49	↔	1.2	24	*
Montana	15.0%	12.8%	11	✓	0	38	*
Nebraska	19.4%	17.3%	39	✓	1.6	16	*
Nevada	16.6%	15.1%	30	✓	1.2	24	*
New Hampshire	17.2%	14.1%	21	✓	1.0	31	*
New Jersey	12.9%	9.6%	2	✓	2.5	8	*
New Mexico	16.6%	17.3%	39	↔	0	38	*
New York	15.6%	11.2%	5	✓	0	38	*
North Carolina	14.4%	12.0%	7	✓	3.0	5	*
North Dakota	18.5%	17.8%	44	↔	0	38	*
Ohio	19.6%	14.4%	24	✓	3.1	3	*
Oklahoma	19.8%	18.9%	50	↔	1.8	15	*
Oregon	17.4%	14.3%	23	✓	1.6	16	*
Pennsylvania	16.4%	15.5%	32	↔	2.7	6	*
Rhode Island	17.2%	16.1%	35	↔	0.8	36	*
South Carolina	14.2%	13.6%	15	↔	1.2	24	*
South Dakota	16.7%	16.3%	36	↔	1.2	24	*
Tennessee	20.0%	14.9%	28	✓	3.6	1	*
Texas	20.8%	12.8%	11	✓	2.5	8	*
Utah	17.9%	13.7%	17	✓	1.2	24	*
Vermont	16.8%	15.7%	33	↔	1.2	24	*
Virginia	17.1%	14.2%	22	✓	1.0	31	*
Washington	16.1%	15.1%	30	↔	1.2	24	*
West Virginia	16.1%	13.9%	18	✓	1.5	20	*
Wisconsin	12.9%	12.2%	8	↔	3.1	3	*
Wyoming	12.4%	14.4%	24	X	0	38	*

Key for Change: ✓ Performance improvement ↔ Little or no change in performance X Performance decline * No trend available

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A11 Indicator Data: Support for Family Caregivers (Policy-Level Scores)

	Supporting Working Family Caregivers											
	Family Responsibility Protected Classification (out of 2.0)		Exceeds Federal FMLA (out of 4.0)		Paid Family Leave (out of 4.0)		Mandatory Paid Sick Days (out of 3.0)		Flexible Sick Days (out of 3.0)		Unemployment Insurance for Family Caregivers (out of 1.0)	
State	2014	2019	2016	2019	2016	2019	2016	2019	2016	2019	2016	2019
United States	**0.23**	**0.29**	**0.29**	**0.29**	**0.25**	**0.50**	**0.51**	**0.85**	**0.58**	**0.75**	**0.49**	**0.49**
Alabama	0	0	0	0	0	0	0	0	0	0	0	0
Alaska	0	0	0	0	0	0	0	0	0	0	1.00	1.00
Arizona	0	0.30	0	0	0	0	1.00	2.00	1.13	2.25	1.00	1.00
Arkansas	0	0	0	0	0	0	0	0	0	0	1.00	1.00
California	0	0.60	0.75	0	3.25	3.25	2.50	2.50	2.25	2.25	1.00	1.00
Colorado	0.30	0.30	0	0	0	0	0	0	0	0	1.00	1.00
Connecticut	1.00	1.00	1.75	1.75	0	2.00	2.00	2.00	1.00	1.00	1.00	1.00
Delaware	2.00	2.00	0	0	0	0	0	0	0	0	1.00	1.00
District of Columbia	2.00	2.00	3.00	3.00	1.75	3.50	2.00	2.00	2.00	2.00	1.00	1.00
Florida	0.60	0.60	0	0	0	0	0	0	0	0	0	0
Georgia	0	0	0	0	0	0	0	0	0.63	1.25	0	0
Hawaii	0	0	2.00	2.00	0	0	0	0	2.00	2.00	1.00	1.00
Idaho	0	0	0	0	0	0	0	0	0	0	0	0
Illinois	0.60	0.60	0	0	0	0	1.00	2.00	2.25	2.25	1.00	1.00
Indiana	0	0.30	0	0	0	0	0	0	0	0	0	0
Iowa	0	0.60	0	0	0	0	0	0	0	0	0	0
Kansas	0.60	0.60	0	0	0	0	0	0	0	0	1.00	1.00
Kentucky	0.30	0.30	0	0	0	0	0	0	0	0	0	0
Louisiana	0	0	0	0	0	0	0	0	0	0	0	0
Maine	0.30	0.30	1.25	1.25	0	0	0	1.50	1.00	1.00	1.00	1.00
Maryland	0.60	0.60	0	0	0	0	1.50	2.50	2.00	2.00	0	0
Massachusetts	0	0	0	0	0	3.25	2.50	2.50	1.75	1.75	1.00	1.00
Michigan	0.60	0.60	0	0	0	0	0	2.00	0	1.00	0	0
Minnesota	0	0	0.50	0.50	0	0	1.00	2.00	2.25	2.25	1.00	1.00
Mississippi	0	0	0	0	0	0	0	0	0	0	0	0
Missouri	0	0	0	0	0	0	0	0	0	0	0	0
Montana	0	0	0	0	0	0	0	0	0	0	0	0
Nebraska	0	0	0	0	0	0	0	0	0	0	0	0
Nevada	0	0	0	0	0	0	0	2.00	0	0	1.00	1.00
New Hampshire	0	0	0	0	0	0	0	0	0	0	1.00	1.00
New Jersey	0.60	0.60	0.50	1.75	1.50	2.50	2.00	3.00	2.00	2.00	0	0
New Mexico	0	0.30	0	0	0	0	0	1.50	0	3.00	0	0
New York	0.60	0.60	0	0	1.50	3.50	2.00	2.00	1.00	2.00	1.00	1.00
North Carolina	0	0	0	0	0	0	0	0	0	0	0	0
North Dakota	0	0	0	0	0	0	0	0	0	0	0	0
Ohio	0.30	0.30	0	0	0	0	0	0	0	0	0	0
Oklahoma	0	0.30	0	0	0	0	0	0	0	0	1.00	1.00
Oregon	0.30	0.30	2.00	2.00	0	1.50	2.50	2.50	2.00	2.00	1.00	1.00
Pennsylvania	0.60	0.60	0	0	0	0	1.50	1.50	0	0	1.00	1.00
Rhode Island	0	0	0.50	0.50	2.75	2.75	0	2.50	0	1.75	1.00	1.00
South Carolina	0	0	0	0	0	0	0	0	0	0	1.00	1.00
South Dakota	0	0	0	0	0	0	0	0	0	0	0	0
Tennessee	0	0	0	0	0	0	0	0	0	0	0	0
Texas	0.30	0.30	0	0	0	0	0	1.50	0	0	0	0
Utah	0	0	0	0	0	0	0	0	0	0	1.00	1.00
Vermont	0	0	1.25	1.25	0	0	2.50	3.00	2.25	2.25	0	0
Virginia	0	0	0	0	0	0	0	0	0	0	0	0
Washington	0	0	0.75	0	1.75	3.50	2.00	3.00	2.75	2.75	1.00	1.00
West Virginia	0	0	0	0	0	0	0	0	0	0	0	0
Wisconsin	0	0.60	0.75	0.75	0	0	0	0	1.25	1.25	1.00	1.00
Wyoming	0	0	0	0	0	0	0	0	0	0	0	0

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A11 Indicator Data: Support for Family Caregivers (Policy-Level Scores) (continued)

	Person- and Family-Centered Care						Nurse Delegation and Scope of Practice				Transportation Policies	
	Spousal Impoverishment Protections (out of 2.0)		Having Caregiver Assessment (out of 2.5)		CARE Act Legislation (out of 1.0)		Nursing Tasks Able to be Delegated (out of 4.0)		Nurse Practitioner Scope of Practice (out of 1.0)		Volunteer Driver Protection (out of 1.0)	
State	2016	2019	2016	2019	2016	2019	2016	2019	2016	2019	2015-16	2019
United States	**0.92**	**0.90**	**0.97**	**1.34**	**0.63**	**0.80**	**2.66**	**2.69**	**0.59**	**0.61**	**0.10**	**0.14**
Alabama	0.51	0	1.60	1.60	0	0	0.50	0.50	0.50	0.50	0	0
Alaska	2.00	2.00	0	0	1.00	1.00	4.00	4.00	1.00	1.00	0	0
Arizona	0.50	0.50	1.60	1.60	0	0	3.50	3.50	1.00	1.00	0	0
Arkansas	0.50	0.50	0	1.00	1.00	1.00	3.50	3.50	0.50	0.50	0	0
California	2.00	2.00	0	0	1.00	1.00	0.50	0.50	0	0	1.00	1.00
Colorado	1.50	1.50	1.00	1.00	1.00	1.00	4.00	4.00	1.00	1.00	0	0
Connecticut	0.50	0.50	0	1.60	1.00	1.00	0.50	0.50	1.00	1.00	0	0
Delaware	0.51	0.50	1.90	1.90	1.00	1.00	0.75	0.75	0.50	0.50	0	0
District of Columbia	1.00	0	1.60	2.20	1.00	1.00	2.50	2.50	1.00	1.00	0	0
Florida	1.50	1.50	1.60	2.20	0	0	0	0	0	0	1.00	1.00
Georgia	2.00	2.00	1.90	1.60	0	0	3.50	3.50	0	0	0	0
Hawaii	1.65	2.00	1.60	1.60	1.00	1.00	3.50	3.50	1.00	1.00	0	0
Idaho	0.50	0.50	0	0	0	0	4.00	4.00	1.00	1.00	0	0
Illinois	2.00	1.63	1.30	1.30	1.00	1.00	0.50	0.50	0.50	0.50	0	0
Indiana	0.50	0.50	0	0	1.00	1.00	0	0	0.50	0.50	0	0
Iowa	1.00	1.00	0	0	0	1.00	4.00	4.00	1.00	1.00	0	0
Kansas	0.50	0.50	0	0	0	1.00	1.50	1.50	0.50	0.50	0	0
Kentucky	0.50	0.50	0	0	0	1.00	4.00	4.00	0.50	0.50	0	0
Louisiana	2.00	2.00	1.60	1.90	1.00	1.00	2.00	2.25	0.50	0.50	0	0
Maine	1.50	1.50	0	0	1.00	1.00	2.25	2.25	1.00	1.00	1.00	1.00
Maryland	0.50	0.50	0	0	1.00	1.00	3.50	3.50	1.00	1.00	0	1.00
Massachusetts	1.50	0.50	1.60	1.60	1.00	1.00	0.50	0.50	0	0	0	0
Michigan	0.50	0.50	1.00	1.00	1.00	1.00	3.25	3.25	0	0	0	0
Minnesota	0.60	1.50	2.20	2.50	1.00	1.00	4.00	4.00	1.00	1.00	0	0
Mississippi	2.00	2.00	1.00	2.50	1.00	1.00	1.25	1.25	0.50	0.50	0	0
Missouri	0.50	0.50	0	1.30	0	1.00	4.00	4.00	0	0	0	0
Montana	0.50	0.50	1.00	1.30	0	1.00	4.00	4.00	1.00	1.00	0	0
Nebraska	0.50	0.50	2.20	2.20	1.00	1.00	4.00	4.00	1.00	1.00	0	0
Nevada	0.50	0.50	1.00	1.30	1.00	1.00	3.75	3.75	1.00	1.00	0	0
New Hampshire	0.50	0.50	1.60	1.90	1.00	1.00	3.25	3.25	1.00	1.00	1.00	1.00
New Jersey	0.50	0.50	0	1.30	1.00	1.00	3.50	4.00	0.50	0.50	0	0
New Mexico	0.58	0.53	0	1.00	1.00	1.00	4.00	4.00	1.00	1.00	0	0
New York	1.53	1.49	0	1.00	1.00	1.00	2.75	2.75	0.50	0.50	0	0
North Carolina	0.50	0.50	1.00	1.00	0	0	4.00	4.00	0	0	0	0
North Dakota	0.28	1.00	1.00	1.00	0	1.00	3.50	3.50	0.50	1.00	0	0
Ohio	0.50	0.50	1.00	1.60	0	1.00	1.75	1.75	0.50	0.50	0	0
Oklahoma	1.01	1.00	1.30	2.20	1.00	1.00	3.50	3.50	0	0	0	0
Oregon	0.50	0.50	1.00	2.50	1.00	1.00	4.00	4.00	1.00	1.00	0	0
Pennsylvania	0.50	0.50	1.90	2.20	1.00	1.00	0	0	0.50	0.50	0	0
Rhode Island	0.50	0.50	1.00	1.60	1.00	1.00	0	0	1.00	1.00	0	1.00
South Carolina	1.45	1.41	1.90	2.20	0	0	0.25	0.50	0	0	0	0
South Dakota	0.50	0.50	2.20	2.20	0	0	3.25	3.25	0.50	1.00	0	0
Tennessee	0.50	0.50	1.00	1.30	0	1.00	0.50	0.50	0	0	0	0
Texas	1.00	1.00	2.20	1.90	0	1.00	4.00	4.00	0	0	0	0
Utah	0.50	0.50	1.60	1.60	1.00	1.00	4.00	4.00	0.50	0.50	0	0
Vermont	1.50	1.47	0	1.60	0	0	4.00	4.00	1.00	1.00	1.00	1.00
Virginia	0.50	0.50	0	0	1.00	1.00	3.00	3.00	0	0	0	0
Washington	0.82	0.80	2.50	2.50	1.00	1.00	4.00	4.00	1.00	1.00	0	0
West Virginia	0.50	0.50	0	1.60	1.00	1.00	3.00	3.00	0.50	0.50	0	0
Wisconsin	1.11	1.08	1.30	1.60	0	0	3.50	4.00	0.50	0.50	0	0
Wyoming	2.00	2.00	1.30	1.30	1.00	1.00	2.75	2.75	1.00	1.00	0	0

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A12 Indicator Data: Support for Family Caregivers (Category Totals)

	Supporting Working Family Caregivers			Person- and Family-Centered Care			Nurse Delegation and Scope of Practice		
State	**2014–16**	**2019**	**Change**	**2016**	**2019**	**Change**	**2016**	**2019**	**Change**
United States	**2.35**	**3.17**	✓	**2.52**	**3.04**	✓	**3.25**	**3.30**	↔
Alabama	0	0	↔	2.11	1.60	X	1.00	1.00	↔
Alaska	1.00	1.00	↔	3.00	3.00	↔	5.00	5.00	↔
Arizona	3.13	5.55	✓	2.10	2.10	↔	4.50	4.50	↔
Arkansas	1.00	1.00	↔	1.50	2.50	✓	4.00	4.00	↔
California	9.75	9.60	↔	3.00	3.00	↔	0.50	0.50	↔
Colorado	1.30	1.30	↔	3.50	3.50	↔	5.00	5.00	↔
Connecticut	6.75	8.75	✓	1.50	3.10	✓	1.50	1.50	↔
Delaware	3.00	3.00	↔	3.41	3.40	↔	1.25	1.25	↔
District of Columbia	11.75	13.50	✓	3.60	3.20	X	3.50	3.50	↔
Florida	0.60	0.60	↔	3.10	3.70	✓	0	0	↔
Georgia	0.63	1.25	✓	3.90	3.60	X	3.50	3.50	↔
Hawaii	5.00	5.00	↔	4.25	4.60	✓	4.50	4.50	↔
Idaho	0	0	↔	0.50	0.50	↔	5.00	5.00	↔
Illinois	4.85	5.85	✓	4.30	3.93	X	1.00	1.00	↔
Indiana	0	0.30	✓	1.50	1.50	↔	0.50	0.50	↔
Iowa	0	0.60	✓	1.00	2.00	✓	5.00	5.00	↔
Kansas	1.60	1.60	↔	0.50	1.50	✓	2.00	2.00	↔
Kentucky	0.30	0.30	↔	0.50	1.50	✓	4.50	4.50	↔
Louisiana	0	0	↔	4.60	4.90	✓	2.50	2.75	✓
Maine	3.55	5.05	✓	2.50	2.50	↔	3.25	3.25	↔
Maryland	4.10	5.10	✓	1.50	1.50	↔	4.50	4.50	↔
Massachusetts	5.25	8.50	✓	4.10	3.10	X	0.50	0.50	↔
Michigan	0.60	3.60	✓	2.50	2.50	↔	3.25	3.25	↔
Minnesota	4.75	5.75	✓	3.80	5.00	✓	5.00	5.00	↔
Mississippi	0	0	↔	4.00	5.50	✓	1.75	1.75	↔
Missouri	0	0	↔	0.50	2.80	✓	4.00	4.00	↔
Montana	0	0	↔	1.50	2.80	✓	5.00	5.00	↔
Nebraska	0	0	↔	3.70	3.70	↔	5.00	5.00	↔
Nevada	1.00	3.00	✓	2.50	2.80	✓	4.75	4.75	↔
New Hampshire	1.00	1.00	↔	3.10	3.40	✓	4.25	4.25	↔
New Jersey	6.60	9.85	✓	1.50	2.80	✓	4.00	4.50	✓
New Mexico	0	4.80	✓	1.58	2.53	✓	5.00	5.00	↔
New York	6.10	9.10	✓	2.53	3.49	✓	3.25	3.25	↔
North Carolina	0	0	↔	1.50	1.50	↔	4.00	4.00	↔
North Dakota	0	0	↔	1.28	3.00	✓	4.00	4.50	✓
Ohio	0.30	0.30	↔	1.50	3.10	✓	2.25	2.25	↔
Oklahoma	1.00	1.30	✓	3.31	4.20	✓	3.50	3.50	↔
Oregon	7.80	9.30	✓	2.50	4.00	✓	5.00	5.00	↔
Pennsylvania	3.10	3.10	↔	3.40	3.70	✓	0.50	0.50	↔
Rhode Island	4.25	8.50	✓	2.50	3.10	✓	1.00	1.00	↔
South Carolina	1.00	1.00	↔	3.35	3.61	✓	0.25	0.50	✓
South Dakota	0	0	↔	2.70	2.70	↔	3.75	4.25	✓
Tennessee	0	0	↔	1.50	2.80	✓	0.50	0.50	↔
Texas	0.30	1.80	✓	3.20	3.90	✓	4.00	4.00	↔
Utah	1.00	1.00	↔	3.10	3.10	↔	4.50	4.50	↔
Vermont	6.00	6.50	✓	1.50	3.07	✓	5.00	5.00	↔
Virginia	0	0	↔	1.50	1.50	↔	3.00	3.00	↔
Washington	8.25	10.25	✓	4.32	4.30	↔	5.00	5.00	↔
West Virginia	0	0	↔	1.50	3.10	✓	3.50	3.50	↔
Wisconsin	3.00	3.60	✓	2.41	2.68	✓	4.00	4.50	✓
Wyoming	0	0	↔	4.30	4.30	↔	3.75	3.75	↔

Key for Change: ✓ Performance improvement ↔ Little or no change in performance X Performance decline

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A12 Indicator Data: Support for Family Caregivers (Category Totals) (continued)

	Transportation Policies			Support for Family Caregivers Dimension Total Composite Score			
State	2015–16	2019	Change	2017	2020	Rank	Change
United States	**0.10**	**0.14**	↔	**8.22**	**9.65**		✓
Alabama	0	0	↔	3.11	2.60	50	X
Alaska	0	0	↔	9.00	9.00	24	↔
Arizona	0	0	↔	9.73	12.15	13	✓
Arkansas	0	0	↔	6.50	7.50	34	✓
California	1.00	1.00	↔	14.25	14.10	8	↔
Colorado	0	0	↔	9.80	9.80	20	↔
Connecticut	0	0	↔	9.75	13.35	11	✓
Delaware	0	0	↔	7.66	7.65	31	↔
District of Columbia	0	0	↔	18.85	20.20	1	✓
Florida	1.00	1.00	↔	4.70	5.30	45	✓
Georgia	0	0	↔	8.03	8.35	28	✓
Hawaii	0	0	↔	13.75	14.10	8	✓
Idaho	0	0	↔	5.50	5.50	43	↔
Illinois	0	0	↔	10.15	10.78	17	✓
Indiana	0	0	↔	2.00	2.30	51	✓
Iowa	0	0	↔	6.00	7.60	33	✓
Kansas	0	0	↔	4.10	5.10	47	✓
Kentucky	0	0	↔	5.30	6.30	41	✓
Louisiana	0	0	↔	7.10	7.65	31	✓
Maine	1.00	1.00	↔	10.30	11.80	16	✓
Maryland	0	1.00	✓	10.10	12.10	14	✓
Massachusetts	0	0	↔	9.85	12.10	14	✓
Michigan	0	0	↔	6.35	9.35	23	✓
Minnesota	0	0	↔	13.55	15.75	6	✓
Mississippi	0	0	↔	5.75	7.25	37	✓
Missouri	0	0	↔	4.50	6.80	39	✓
Montana	0	0	↔	6.50	7.80	30	✓
Nebraska	0	0	↔	8.70	8.70	26	↔
Nevada	0	0	↔	8.25	10.55	19	✓
New Hampshire	1.00	1.00	↔	9.35	9.65	22	✓
New Jersey	0	0	↔	12.10	17.15	4	✓
New Mexico	0	0	↔	6.58	12.33	12	✓
New York	0	0	↔	11.88	15.84	5	✓
North Carolina	0	0	↔	5.50	5.50	43	↔
North Dakota	0	0	↔	5.28	7.50	34	✓
Ohio	0	0	↔	4.05	5.65	42	✓
Oklahoma	0	0	↔	7.81	9.00	24	✓
Oregon	0	0	↔	15.30	18.30	3	✓
Pennsylvania	0	0	↔	7.00	7.30	36	✓
Rhode Island	0	1.00	✓	7.75	13.60	10	✓
South Carolina	0	0	↔	4.60	5.11	46	✓
South Dakota	0	0	↔	6.45	6.95	38	✓
Tennessee	0	0	↔	2.00	3.30	49	✓
Texas	0	0	↔	7.50	9.70	21	✓
Utah	0	0	↔	8.60	8.60	27	↔
Vermont	1.00	1.00	↔	13.50	15.57	7	✓
Virginia	0	0	↔	4.50	4.50	48	↔
Washington	0	0	↔	17.57	19.55	2	✓
West Virginia	0	0	↔	5.00	6.60	40	✓
Wisconsin	0	0	↔	9.41	10.78	17	✓
Wyoming	0	0	↔	8.05	8.05	29	↔

Key for Change: ✓ Performance improvement ↔ Little or no change in performance X Performance decline

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A13 Indicator Data: Effective Transitions

	Percentage of Nursing Home Residents with Low Care Needs			Percentage of Home Health Patients with a Hospital Admission				Percentage of Long-Stay Nursing Home Residents Hospitalized within a Six-Month Period			
State	**2017**	**Rank**	**Change**	**2014**	**2017**	**Rank**	**Change**	**2014**	**2016**	**Rank**	**Change**
United States	**8.9%**		*	**15.9%**	**15.8%**		↔	**17.6%**	**16.8%**		↔
Alabama	11.1%	32	*	17.1%	17.4%	50	↔	19.0%	18.7%	40	↔
Alaska	*	*	*	12.3%	13.8%	1	X	11.1%	13.0%	18	X
Arizona	7.1%	14	*	14.9%	14.8%	10	↔	8.2%	7.2%	2	✓
Arkansas	14.5%	43	*	17.4%	17.0%	47	↔	24.3%	23.4%	49	↔
California	9.3%	26	*	14.5%	14.4%	3	↔	18.5%	18.8%	41	↔
Colorado	13.1%	41	*	14.5%	14.5%	5	↔	8.5%	8.8%	5	↔
Connecticut	12.3%	37	*	16.8%	16.4%	38	↔	13.9%	12.7%	16	↔
Delaware	10.0%	28	*	17.1%	15.8%	22	↔	15.6%	16.0%	30	↔
District of Columbia	*	*	*	16.7%	15.1%	12	✓	19.4%	19.4%	43	↔
Florida	7.2%	15	*	15.3%	15.4%	18	↔	21.7%	21.4%	47	↔
Georgia	8.4%	23	*	16.4%	16.7%	41	↔	17.4%	16.2%	32	↔
Hawaii	3.0%	3	*	14.6%	14.5%	5	↔	5.1%	4.7%	1	↔
Idaho	8.0%	18	*	14.4%	14.4%	3	↔	12.1%	11.2%	9	↔
Illinois	10.0%	28	*	15.7%	15.7%	21	↔	19.9%	17.3%	35	✓
Indiana	5.2%	7	*	16.4%	15.8%	22	↔	17.0%	17.2%	34	↔
Iowa	15.9%	45	*	16.7%	16.0%	29	↔	15.2%	14.2%	21	↔
Kansas	18.2%	47	*	17.3%	16.7%	41	↔	19.3%	18.6%	39	↔
Kentucky	5.6%	10	*	17.2%	16.8%	44	↔	21.0%	20.7%	46	↔
Louisiana	12.2%	35	*	15.9%	16.1%	31	↔	26.8%	26.3%	50	↔
Maine	2.1%	1	*	16.4%	15.5%	19	↔	11.9%	12.2%	12	↔
Maryland	5.1%	6	*	16.4%	15.3%	16	↔	15.9%	15.5%	28	↔
Massachusetts	9.1%	24	*	16.9%	16.9%	46	↔	12.6%	12.9%	17	↔
Michigan	8.3%	20	*	15.9%	15.9%	26	↔	16.9%	15.3%	25	✓
Minnesota	12.8%	38	*	16.5%	16.2%	36	↔	7.0%	7.2%	2	↔
Mississippi	11.8%	34	*	17.2%	16.8%	44	↔	28.2%	28.0%	51	↔
Missouri	24.0%	49	*	16.5%	16.1%	31	↔	18.8%	17.5%	36	↔
Montana	14.8%	44	*	14.8%	16.0%	29	↔	12.0%	12.6%	14	↔
Nebraska	12.2%	35	*	16.6%	16.1%	31	↔	15.7%	15.8%	29	↔
Nevada	9.1%	24	*	15.4%	16.1%	31	↔	19.4%	19.9%	45	↔
New Hampshire	11.5%	33	*	16.5%	17.5%	51	↔	13.7%	13.4%	20	↔
New Jersey	10.6%	31	*	16.0%	15.8%	22	↔	19.7%	18.2%	38	↔
New Mexico	13.0%	40	*	15.1%	14.7%	7	↔	15.0%	13.1%	19	✓
New York	6.8%	13	*	16.4%	16.4%	38	↔	14.1%	12.6%	14	✓
North Carolina	4.7%	4	*	16.1%	15.6%	20	↔	16.4%	16.1%	31	↔
North Dakota	13.1%	41	*	17.6%	14.7%	7	✓	13.8%	14.4%	22	↔
Ohio	7.3%	16	*	16.0%	15.9%	26	↔	13.4%	11.9%	11	✓
Oklahoma	20.7%	48	*	15.5%	15.2%	14	↔	22.8%	23.3%	48	↔
Oregon	5.5%	9	*	14.7%	14.7%	7	↔	8.8%	9.4%	6	↔
Pennsylvania	5.9%	11	*	16.7%	16.7%	41	↔	13.6%	12.5%	13	↔
Rhode Island	10.5%	30	*	15.9%	17.0%	47	↔	8.6%	8.2%	4	↔
South Carolina	5.2%	7	*	16.1%	16.3%	37	↔	19.0%	18.0%	37	↔
South Dakota	16.2%	46	*	14.9%	15.8%	22	↔	15.5%	15.3%	25	↔
Tennessee	4.7%	4	*	16.9%	17.0%	47	↔	19.4%	18.8%	41	↔
Texas	8.3%	20	*	14.8%	15.2%	14	↔	21.4%	19.6%	44	✓
Utah	2.9%	2	*	13.7%	14.1%	2	↔	11.3%	10.3%	7	↔
Vermont	8.2%	19	*	16.1%	16.1%	31	↔	13.7%	14.8%	23	↔
Virginia	7.6%	17	*	16.7%	15.9%	26	↔	17.6%	15.4%	27	✓
Washington	6.2%	12	*	14.9%	14.8%	10	↔	11.1%	11.6%	10	↔
West Virginia	9.3%	26	*	17.6%	16.5%	40	↔	16.8%	16.5%	33	↔
Wisconsin	8.3%	20	*	16.6%	15.3%	16	↔	11.7%	11.1%	8	↔
Wyoming	12.8%	38	*	16.8%	15.1%	12	✓	16.4%	15.1%	24	↔

Key for Change: ✓ Performance improvement ↔ Little or no change in performance X Performance decline * No trend available

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A13 Indicator Data: Effective Transitions (continued)

	Percentage of Nursing Home Residents with One or More Potentially Burdensome Transitions at End of Life				Percentage of Short-Stay Residents Who were Successfully Discharged to the Community		
State	**2013**	**2016**	**Rank**	**Change**	**2017–18**	**Rank**	**Change**
United States	**29.8%**	**28.6%**		↔	**53.9%**		*
Alabama	28.9%	24.7%	18	✓	55.2%	26	*
Alaska	14.0%	18.6%	3	X	62.6%	3	*
Arizona	26.5%	26.8%	32	↔	60.9%	5	*
Arkansas	33.6%	31.6%	44	↔	50.7%	45	*
California	33.9%	33.4%	47	↔	52.0%	37	*
Colorado	23.7%	23.8%	13	↔	58.6%	9	*
Connecticut	28.4%	26.0%	26	✓	57.8%	12	*
Delaware	28.7%	25.8%	24	✓	55.7%	20	*
District of Columbia	33.0%	33.3%	46	↔	51.7%	39	*
Florida	40.6%	39.2%	51	↔	51.9%	38	*
Georgia	29.5%	26.9%	33	✓	54.3%	30	*
Hawaii	15.5%	16.2%	1	↔	68.5%	1	*
Idaho	17.3%	17.9%	2	↔	59.8%	7	*
Illinois	33.4%	30.2%	41	✓	49.9%	48	*
Indiana	26.0%	26.5%	28	↔	52.7%	36	*
Iowa	27.7%	27.3%	34	↔	55.7%	20	*
Kansas	30.6%	28.2%	38	✓	53.9%	31	*
Kentucky	28.4%	29.6%	40	↔	51.0%	44	*
Louisiana	36.7%	33.6%	48	✓	43.8%	51	*
Maine	21.9%	21.8%	9	↔	58.6%	9	*
Maryland	27.2%	26.7%	31	↔	57.0%	15	*
Massachusetts	25.3%	25.7%	23	↔	55.0%	27	*
Michigan	27.6%	27.8%	36	↔	55.3%	23	*
Minnesota	21.8%	23.2%	12	↔	59.9%	6	*
Mississippi	36.9%	35.7%	50	↔	49.7%	50	*
Missouri	27.6%	27.7%	35	↔	50.0%	47	*
Montana	20.2%	20.7%	6	↔	59.2%	8	*
Nebraska	25.0%	25.1%	22	↔	53.7%	32	*
Nevada	28.2%	31.0%	43	X	51.7%	39	*
New Hampshire	24.2%	24.3%	16	↔	53.4%	33	*
New Jersey	29.8%	29.4%	39	↔	55.3%	23	*
New Mexico	23.9%	24.8%	19	↔	55.8%	19	*
New York	26.5%	24.2%	15	✓	51.3%	43	*
North Carolina	28.7%	27.8%	36	↔	55.0%	27	*
North Dakota	19.2%	20.1%	5	↔	49.9%	48	*
Ohio	34.3%	31.8%	45	✓	56.8%	16	*
Oklahoma	32.7%	30.4%	42	✓	51.4%	41	*
Oregon	22.5%	21.0%	8	↔	61.4%	4	*
Pennsylvania	27.3%	24.8%	19	✓	53.1%	34	*
Rhode Island	34.5%	26.6%	30	✓	55.3%	23	*
South Carolina	28.3%	26.5%	28	↔	56.0%	17	*
South Dakota	23.1%	20.7%	6	✓	53.1%	34	*
Tennessee	26.8%	25.8%	24	↔	54.4%	29	*
Texas	35.4%	34.0%	49	↔	51.4%	41	*
Utah	28.3%	25.0%	21	✓	63.1%	2	*
Vermont	15.4%	21.9%	10	X	55.9%	18	*
Virginia	26.6%	24.4%	17	✓	57.5%	14	*
Washington	21.3%	22.8%	11	↔	57.8%	12	*
West Virginia	28.0%	26.2%	27	↔	50.6%	46	*
Wisconsin	22.9%	23.8%	13	↔	58.2%	11	*
Wyoming	20.9%	19.3%	4	↔	55.5%	22	*

Key for Change: ✓ Performance improvement ↔ Little or no change in performance X Performance decline * No trend available

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A14 Detailed Indicator Data: Private Pay Affordability

State	Median Household Income Ages 65+, 2018	Median Annual Cost of Care, 2019		Median Cost as a Percentage of Median Household Income*	
		Nursing Home Private Room	30 Hours/Week of Home Care	Nursing Home Private Room	30 Hours/Week of Home Care
United States	**$44,992**	**$102,200**	**$35,880**	**245%**	**80%**
Alabama	$37,977	$81,395	$28,080	208%	72%
Alaska	$59,339	$362,628	$46,769	638%	82%
Arizona	$46,152	$97,638	$39,000	224%	85%
Arkansas	$37,762	$73,000	$29,640	202%	82%
California	$54,272	$127,750	$43,680	232%	71%
Colorado	$51,537	$113,150	$40,560	216%	82%
Connecticut	$54,629	$166,988	$37,440	324%	70%
Delaware	$54,744	$136,328	$38,220	254%	76%
District of Columbia	$50,873	$127,750	$42,900	196%	51%
Florida	$43,804	$112,639	$34,320	281%	79%
Georgia	$42,781	$85,775	$31,980	222%	76%
Hawaii	$65,078	$160,418	$42,713	241%	67%
Idaho	$42,678	$102,748	$35,100	248%	78%
Illinois	$44,955	$82,125	$37,440	218%	81%
Indiana	$41,342	$102,200	$35,880	232%	85%
Iowa	$42,995	$82,537	$39,000	194%	91%
Kansas	$42,989	$74,095	$34,320	172%	81%
Kentucky	$38,254	$91,250	$31,200	239%	81%
Louisiana	$36,345	$68,109	$26,520	187%	71%
Maine	$40,435	$125,925	$41,870	325%	105%
Maryland	$59,536	$120,085	$37,440	222%	64%
Massachusetts	$49,756	$158,545	$42,900	311%	87%
Michigan	$42,816	$111,508	$36,660	267%	87%
Minnesota	$47,054	$132,448	$47,580	287%	103%
Mississippi	$36,415	$85,045	$28,860	229%	77%
Missouri	$41,038	$68,255	$34,320	168%	84%
Montana	$42,745	$92,608	$37,440	226%	89%
Nebraska	$42,851	$92,345	$40,560	209%	93%
Nevada	$46,406	$111,325	$35,100	236%	77%
New Hampshire	$50,240	$125,925	$44,070	280%	91%
New Jersey	$53,637	$139,795	$39,000	310%	78%
New Mexico	$39,989	$96,725	$35,100	270%	87%
New York	$45,302	$148,190	$40,560	324%	84%
North Carolina	$41,169	$91,980	$31,200	226%	77%
North Dakota	$44,824	$143,832	$43,618	328%	99%
Ohio	$41,406	$93,805	$35,880	234%	82%
Oklahoma	$40,928	$67,525	$34,710	177%	82%
Oregon	$47,314	$124,100	$43,680	269%	93%
Pennsylvania	$41,762	$124,830	$36,660	301%	86%
Rhode Island	$42,424	$127,750	$42,120	321%	104%
South Carolina	$42,161	$91,250	$32,729	226%	79%
South Dakota	$42,361	$86,323	$43,680	220%	116%
Tennessee	$39,933	$87,600	$31,840	220%	79%
Texas	$44,319	$77,015	$32,760	182%	73%
Utah	$53,670	$91,250	$37,440	181%	69%
Vermont	$44,302	$135,415	$42,510	338%	104%
Virginia	$51,401	$98,550	$35,849	211%	69%
Washington	$52,150	$119,173	$47,580	258%	94%
West Virginia	$36,147	$138,335	$28,080	354%	80%
Wisconsin	$41,362	$112,785	$39,000	277%	97%
Wyoming	$44,870	$96,360	$44,054	205%	96%

*These ratios are calculated at the market, not state level, and may not be exactly equal to the ratio of state median cost to state median income.
Data: Genworth 2019 Cost of Care Survey; 2018 American Community Survey, Table B19049.

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A15 Detailed Indicator Data: ADRC/NWD Functions, 2019

State	State Governance and Administration (10 criteria)	Target Populations (5 criteria)	Public Outreach and Coordination (8 criteria)	Person-Centered Counseling (9 criteria)	Streamlined Eligibility for Public Programs (9 criteria)	Overall Percentage Score	Rank
United States	**60%**	**78%**	**66%**	**77%**	**58%**	**67%**	
Alabama	91%	93%	83%	92%	89%	89%	8
Alaska	18%	67%	38%	60%	37%	41%	46
Arizona	37%	87%	58%	84%	67%	64%	28
Arkansas	19%	67%	67%	98%	46%	57%	34
California	27%	67%	42%	41%	24%	37%	47
Colorado	52%	53%	63%	53%	39%	52%	39
Connecticut	88%	100%	98%	90%	78%	90%	7
Delaware	62%	87%	83%	74%	83%	77%	22
District of Columbia	87%	93%	85%	90%	76%	86%	10
Florida	69%	100%	63%	96%	89%	82%	15
Georgia	93%	100%	81%	77%	59%	81%	19
Hawaii	84%	87%	81%	79%	67%	79%	20
Idaho	44%	67%	50%	34%	31%	43%	44
Illinois	57%	33%	42%	37%	56%	46%	41
Indiana	45%	73%	63%	77%	37%	57%	34
Iowa	46%	60%	46%	50%	22%	43%	44
Kansas	47%	87%	69%	76%	50%	63%	29
Kentucky	93%	100%	69%	86%	70%	83%	12
Louisiana	47%	67%	65%	66%	41%	56%	36
Maine	39%	73%	44%	74%	39%	52%	39
Maryland	71%	87%	83%	98%	81%	84%	11
Massachusetts	90%	100%	98%	100%	81%	93%	3
Michigan	59%	93%	71%	75%	63%	70%	26
Minnesota	90%	93%	96%	99%	83%	92%	5
Mississippi	88%	100%	67%	96%	70%	83%	12
Missouri	82%	100%	65%	100%	70%	82%	15
Montana	16%	67%	54%	57%	39%	44%	43
Nebraska	49%	73%	63%	58%	30%	53%	38
Nevada	58%	80%	73%	85%	43%	66%	27
New Hampshire	92%	100%	92%	97%	96%	95%	2
New Jersey	92%	67%	65%	97%	81%	82%	15
New Mexico	7%	33%	31%	69%	26%	33%	48
New York	67%	93%	67%	95%	61%	75%	23
North Carolina	0%	47%	35%	46%	4%	24%	50
North Dakota	53%	60%	58%	74%	30%	54%	37
Ohio	98%	100%	85%	99%	96%	96%	1
Oklahoma	58%	47%	56%	80%	56%	60%	32
Oregon	91%	100%	75%	99%	78%	88%	9
Pennsylvania	74%	100%	79%	99%	67%	82%	15
Rhode Island	64%	73%	56%	61%	59%	62%	30
South Carolina	26%	73%	50%	70%	28%	46%	41
South Dakota	69%	100%	71%	93%	69%	78%	21
Tennessee	44%	73%	65%	63%	56%	58%	33
Texas	83%	60%	85%	59%	78%	74%	24
Utah	34%	13%	25%	35%	26%	28%	49
Vermont	33%	73%	81%	93%	91%	73%	25
Virginia	91%	100%	71%	95%	65%	83%	12
Washington	88%	100%	100%	93%	91%	93%	3
West Virginia	54%	100%	56%	77%	39%	62%	30
Wisconsin	91%	93%	90%	100%	89%	92%	5
Wyoming	5%	27%	13%	26%	4%	13%	51

Note: ADRC/NWD = Aging and Disability Resource Center/No Wrong Door.
Data: AARP PPI (2019), ADRC/No Wrong Door state survey conducted in collaboration with The Lewin Group and US Administration for Community Living (unpublished). Washington, DC: AARP Public Policy Institute.

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A16 Detailed Indicator Data: Subsidized Housing

State	Authorized Vouchers, 2017	Place Based Units, 2017*	Total Potentially Subsidized Units, 2017	Percentage of Housing Units Potentially Subsidized	Rank	Very Low-Income Renter Households, 2012-16**
United States	**2,462,457**	**6,120,425**	**8,582,882**	**6.2%**		**18,934,680**
Alabama	35,765	111,754	147,519	6.5%	16	273,605
Alaska	4,737	8,134	12,871	4.0%	49	31,895
Arizona	23,874	65,313	89,187	2.9%	51	341,405
Arkansas	24,349	65,030	89,379	6.5%	16	170,820
California	333,360	534,246	867,606	6.1%	21	2,573,855
Colorado	33,551	84,199	117,750	4.9%	41	305,980
Connecticut	41,234	89,390	130,624	8.6%	5	239,080
Delaware	5,156	18,045	23,201	5.3%	35	41,125
District of Columbia	15,018	44,450	59,468	18.6%	1	76,810
Florida	109,569	340,136	449,705	4.7%	43	1,031,525
Georgia	66,239	202,480	268,719	6.2%	19	569,545
Hawaii	13,362	21,260	34,622	6.3%	18	76,330
Idaho	7,261	20,982	28,243	3.8%	50	78,880
Illinois	103,699	253,093	356,792	6.6%	13	778,645
Indiana	41,554	136,332	177,886	6.1%	21	367,885
Iowa	23,162	55,392	78,554	5.6%	31	170,435
Kansas	13,648	59,212	72,860	5.7%	29	156,870
Kentucky	37,086	94,784	131,870	6.6%	13	271,410
Louisiana	55,871	104,357	160,228	7.7%	7	268,585
Maine	13,235	32,232	45,467	6.1%	21	76,840
Maryland	53,596	132,153	185,749	7.6%	8	317,660
Massachusetts	90,779	203,608	294,387	10.1%	4	480,585
Michigan	61,253	190,476	251,729	5.5%	34	542,930
Minnesota	36,148	132,305	168,453	6.9%	11	304,615
Mississippi	27,148	76,761	103,909	7.8%	6	160,825
Missouri	44,886	128,215	173,101	6.2%	19	360,170
Montana	6,577	17,071	23,648	4.6%	45	61,260
Nebraska	12,956	37,318	50,274	5.9%	28	114,645
Nevada	15,797	44,416	60,213	4.7%	43	162,445
New Hampshire	10,094	25,575	35,669	5.6%	31	66,600
New Jersey	75,742	164,372	240,114	6.6%	13	537,455
New Mexico	15,081	34,076	49,157	5.2%	38	103,450
New York	257,788	623,618	881,406	10.5%	2	1,646,285
North Carolina	65,431	163,462	228,893	4.9%	41	565,040
North Dakota	8,509	14,383	22,892	6.1%	21	47,650
Ohio	99,350	261,072	360,422	6.9%	11	747,615
Oklahoma	24,994	63,175	88,169	5.1%	40	212,890
Oregon	36,032	65,569	101,601	5.7%	29	243,090
Pennsylvania	90,447	204,775	295,222	5.2%	38	724,725
Rhode Island	10,959	38,035	48,994	10.4%	3	83,120
South Carolina	27,801	78,931	106,732	4.6%	45	246,605
South Dakota	6,606	23,648	30,254	7.6%	8	48,945
Tennessee	38,715	140,513	179,228	6.0%	26	369,805
Texas	165,600	419,148	584,748	5.3%	35	1,418,920
Utah	11,619	37,584	49,203	4.4%	48	116,735
Vermont	7,947	16,492	24,439	7.2%	10	35,130
Virginia	52,117	147,566	199,683	5.6%	31	414,050
Washington	57,335	134,639	191,974	6.1%	21	417,065
West Virginia	15,641	37,915	53,556	6.0%	26	96,740
Wisconsin	31,154	112,861	144,015	5.3%	35	356,385
Wyoming	2,625	9,872	12,497	4.5%	47	29,720

*Multiple data sources, updated through approximately 2017 at the time of analysis.
**Households making less than or equal to HUD Area Median Family Income (HAMFI).

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A17 Detailed Indicator Data: HCBS Cross-State Quality Benchmarking

State	NCI-AD (out of 2.5)		HCBS CAHPS** (out of 1.5) 2017-2019	BRFSS (out of 1.0) 2015-2017	NCQA (out of 1.0) 2019	Total Score (out of 5.0) 2019
	Participation 2019	Two year max sample size*				
United States	**0.86**		**0.28**	**0.09**	**0.14**	**1.30**
Alabama	1.2	*	0	0	1.0	2.2
Alaska	0	0	0	0	0	0
Arizona	0	0	1.0	0	0	1.0
Arkansas	0	0	0	0	0	0
California	0	0	0	0	0	0
Colorado	2.0	998	0	0	0	2.0
Connecticut	0	0	1.5	0	0	1.5
Delaware	1.6	675	0	0	0	1.6
District of Columbia	0	0	0	0	0	0
Florida	0	0	1.5	0	0	1.5
Georgia	2.0	803	0	0	0	2.0
Hawaii	0	0	0	0	0	0
Idaho	0	0	0	0	0	0
Illinois	0	0	1.5	0	0	1.5
Indiana	2.5	1,453	0	0	0	2.5
Iowa	0	0	0	0	0	0
Kansas	1.2	440	0.5**	0	1.0	2.7
Kentucky	0	0	0	0	0	0
Louisiana	0	0	0	0.6	0	0.6
Maine	1.6	552	0	0	0	1.6
Maryland	0	0	1.0	0	0	1.0
Massachusetts	0	0	0	0	1.0	1.0
Michigan	0	0	0	0	0	0
Minnesota	2.5	3,758	0	1.0	0	3.5
Mississippi	2.0	965	0**	0	0	2.0
Missouri	1.2	*	0	0	0	1.2
Montana	0	0	0	0	0	0
Nebraska	1.6	672	0	0	0	1.6
Nevada	1.2	406	0	0	0	1.2
New Hampshire	0	0	1.0	0	0	1.0
New Jersey	2.0	921	0.5**	0	0	2.5
New Mexico	0	0	0	0	0	0
New York	0	0	0	0	0	0
North Carolina	2.0	965	0	0	1.0	3.0
North Dakota	0	0	0	0	0	0
Ohio	2.5	1,554	0	0.6	0	3.1
Oklahoma	1.2	*	0	0.6	0	1.8
Oregon	1.6	683	0	0	0	1.6
Pennsylvania	1.2	403	0.5**	0	1.0	2.7
Rhode Island	0	0	0	0.8	0	0.8
South Carolina	1.2	*	0	0	0	1.2
South Dakota	1.2	*	0	0	0	1.2
Tennessee	2.0	858	0	0.6	1.0	3.6
Texas	2.5	1,783	0	0	0	2.5
Utah	1.2	*	0	0	0	1.2
Vermont	1.2	428	0	0	0	1.2
Virginia	0	0	0	0	1.0	1.0
Washington	1.2	464	0	0	0	1.2
West Virginia	0	0	1.5	0	0	1.5
Wisconsin	2.5	2,250	0	0.6	0	3.1
Wyoming	0	0	0	0	0	0

* Sample size from published annual reports. 2019 participation score based on largest sample from last two published reports (greater sample size = higher score). States that adopted NCI-AD more recently may not have any published annual reports by December 2019 when data were finalized, or have only one published report. An asterisk in the sample size column indicates that no annual report was available.

** Due to overlap of functionality, states using both NCI-AD and HCBS CAHPS receive base credit for one tool only. For example, Kansas reported using CAHPS in 2019, and therefore earned 1.5 points of credit. However, because the state already received credit for NCI-AD, they are only awarded 0.5 points for HCBS CAHPS instead of the full 1.5 points. Similar -1.0 point adjustments were made to Mississippi, New Jersey, and Pennsylvania. See scoring algorithm in Exhibit B4 in Appendix B for detail.

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A18 Detailed Indicator Data: Health Maintenance Tasks Able to be Delegated to LTSS Workers and Nurse Practitioner Scope of Practice

	Health Maintenance Tasks, 2019 (0.25 points each task)										
State	Administer Oral Medications	Administer Medication on an as Needed Basis	Administer Medication via Pre-Filled Insulin or Insulin Pen	Draw up Insulin for Dosage Measurement	Administer Intramuscular Injection Medications	Administer Glucometer Test	Administer Medication through Tubes	Insert Suppository	Administer Eye/Ear Drops	Gastrostomy Tube Feeding	Administer Enema
Alabama						Y					
Alaska	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Arizona	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y
Arkansas	Y	Y	Y			Y	Y	Y	Y	Y	Y
California						Y					Y
Colorado	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Connecticut *	–					Y			–	–	
Delaware						Y					
District of Columbia *	Y	Y	Y	–	Y	Y	–	Y	Y		Y
Florida											
Georgia	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y
Hawaii **	Y	Y	Y			Y	Y	Y	Y	Y	Y
Idaho	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Illinois						Y					
Indiana **											
Iowa	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Kansas						Y		Y	Y		Y
Kentucky ***	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Louisiana *		**Y**				Y		**Y**		Y	Y
Maine	Y		Y			Y		Y	Y	Y	Y
Maryland	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y
Massachusetts						Y					
Michigan	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Minnesota	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mississippi						Y				Y	Y
Missouri	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Montana ***	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nebraska	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nevada **	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
New Hampshire *	Y	Y	Y	–	Y	Y	Y	Y	Y	Y	Y
New Jersey	Y	Y	Y	**Y**	**Y**	Y	Y	Y	Y	Y	Y
New Mexico ***	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
New York *	Y	Y	Y		Y	Y	–	Y	Y	Y	Y
North Carolina	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
North Dakota	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ohio						Y		Y	Y	Y	Y
Oklahoma	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y
Oregon	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Pennsylvania ***											
Rhode Island											
South Carolina											Y
South Dakota	Y	Y	Y	Y		Y		Y	Y	Y	Y
Tennessee	Y	Y									
Texas ***	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Utah ***	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Vermont	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Virginia	Y	Y	Y	Y		Y		Y	Y	Y	Y
Washington	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
West Virginia	Y	Y	Y			Y	Y	Y	Y	Y	Y
Wisconsin ***	Y	Y	Y	**Y**	**Y**	Y	Y	Y	Y	Y	Y
Wyoming	Y	Y				Y	Y	Y	Y	Y	Y

Legend

Y State responded yes to health maintenance task for 2019 survey.

Y / 1.0 Improvement from last *Scorecard*.

– Baseline data revised due to survey reporting error in *2017 Scorecard*.

* Revised baseline due to state reporting error in 2016 nurse delegation survey (CT, DC, LA, NH, NY)

** Hawaii, Indiana, and Nevada did not provide updated survey data. 2016 data repeated.

*** Survey responses based upon AARP interpretation of state Board of Nursing regulations (KY, MT, NM, PA, TX, UT, WI)

Four states allowed additional delegation of medical/nursing tasks since the last *Scorecard*. Louisiana gave the ability to administer medication on an as needed basis and insert a suppository. New Jersey added the ability for direct care workers to draw up insulin for dosage measurement and administer intramuscular injection medications. South Carolina gave the ability to perform ostomy care including skin care and changing an appliance. Wisconsin added the ability to draw up insulin for dosage measurement and administering intramuscular injection medications.

North Dakota and South Dakota were the only states to improve their performance in Scope of Practice, both moving from reduced to full scope.

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A18 Detailed Indicator Data: Health Maintenance Tasks Able to be Delegated to LTSS Workers and Nurse Practitioner Scope of Practice (continued)

	Health Maintenance Tasks, 2019 (0.25 points each task)							Nurse Practitioner Scope of Practice (1.0 point Full, 0.5 points Reduced)		Combined Score		
State	Perform Intermittent Catheterization	Perform Ostomy Care Including Skin Care and Changing Appliance	Perform Nebulizer Treatment	Administer Oxygen Therapy	Perform Ventilator Respiratory Care	Total Number of Tasks Able to be Delegated 2019	Change from 2016	2016	2019	Total Score 2016 (out of 5.0)	Total Score 2019 (out of 5.0)	Rank 2019
Alabama		Y				2		0.5	0.5	1.00	1.00	42
Alaska	Y	Y	Y	Y	Y	16		1.0	1.0	5.00	5.00	1
Arizona	Y	Y	Y	Y		14		1.0	1.0	4.50	4.50	13
Arkansas	Y	Y	Y	Y	Y	14		0.5	0.5	4.00	4.00	23
California						2		0	0	0.50	0.50	45
Colorado	Y	Y	Y	Y	Y	16		1.0	1.0	5.00	5.00	1
Connecticut *		Y				2		1.0	1.0	1.50	1.50	40
Delaware	Y	Y				3		0.5	0.5	1.25	1.25	41
District of Columbia *		Y		Y		10		1.0	1.0	3.50	3.50	28
Florida						0		0	0	0	0	51
Georgia	Y	Y	Y	Y		14		0	0	3.50	3.50	28
Hawaii **	Y	Y	Y	Y	Y	14		1.0	1.0	4.50	4.50	13
Idaho	Y	Y	Y	Y	Y	16		1.0	1.0	5.00	5.00	1
Illinois		Y				2		0.5	0.5	1.00	1.00	42
Indiana **						0		0.5	0.5	0.50	0.50	45
Iowa	Y	Y	Y	Y	Y	16		1.0	1.0	5.00	5.00	1
Kansas	Y			Y		6		0.5	0.5	2.00	2.00	38
Kentucky ***	Y	Y	Y	Y	Y	16		0.5	0.5	4.50	4.50	13
Louisiana *	Y	Y	Y	–	Y	9	+2	0.5	0.5	2.25	2.75	36
Maine	Y	Y				9		1.0	1.0	3.25	3.25	32
Maryland	Y	Y	Y	Y		14		1.0	1.0	4.50	4.50	13
Massachusetts		Y				2		0	0	0.50	0.50	45
Michigan	Y	Y				13		0	0	3.25	3.25	32
Minnesota	Y	Y	Y	Y	Y	16		1.0	1.0	5.00	5.00	1
Mississippi	Y	Y				5		0.5	0.5	1.75	1.75	39
Missouri	Y	Y	Y	Y	Y	16		0	0	4.00	4.00	23
Montana ***	Y	Y	Y	Y	Y	16		1.0	1.0	5.00	5.00	1
Nebraska	Y	Y	Y	Y	Y	16		1.0	1.0	5.00	5.00	1
Nevada **	Y	Y	Y	Y		15		1.0	1.0	4.75	4.75	12
New Hampshire *	Y	Y		Y		13		1.0	1.0	4.25	4.25	21
New Jersey	Y	Y	Y	Y	Y	16	+2	0.5	0.5	4.00	4.50	13
New Mexico ***	Y	Y	Y	Y	Y	16		1.0	1.0	5.00	5.00	1
New York *	–	–	Y	Y	–	11		0.5	0.5	3.25	3.25	32
North Carolina	Y	Y	Y	Y	Y	16		0	0	4.00	4.00	23
North Dakota	Y	Y	Y			14		0.5	**1.0**	4.00	4.50	13
Ohio	Y	Y				7		0.5	0.5	2.25	2.25	37
Oklahoma	Y	Y	Y	Y		14		0	0	3.50	3.50	28
Oregon	Y	Y	Y	Y	Y	16		1.0	1.0	5.00	5.00	1
Pennsylvania ***						0		0.5	0.5	0.50	0.50	45
Rhode Island						0		1.0	1.0	1.00	1.00	42
South Carolina		**Y**				2	+1	0	0	0.25	0.50	45
South Dakota	Y	Y	Y	Y		13		0.5	**1.0**	3.75	4.25	21
Tennessee						2		0	0	0.50	0.50	45
Texas ***	Y	Y	Y	Y	Y	16		0	0	4.00	4.00	23
Utah ***	Y	Y	Y	Y	Y	16		0.5	0.5	4.50	4.50	13
Vermont	Y	Y	Y	Y	Y	16		1.0	1.0	5.00	5.00	1
Virginia		Y	Y	Y		12		0	0	3.00	3.00	35
Washington	Y	Y	Y	Y	Y	16		1.0	1.0	5.00	5.00	1
West Virginia		Y	Y		Y	12		0.5	0.5	3.50	3.50	28
Wisconsin ***	Y	Y	Y	Y	Y	16	+2	0.5	0.5	4.00	4.50	13
Wyoming		Y	Y	Y		11		1.0	1.0	3.75	3.75	27

Legend

Y State responded yes to health maintenance task for 2019 survey.

Y / **1.0** Improvement from last *Scorecard*.

– Baseline data revised due to survey reporting error in *2017 Scorecard*.

* Revised baseline due to state reporting error in 2016 nurse delegation survey (CT, DC, LA, NH, NY)

** Hawaii, Indiana, and Nevada did not provide updated survey data. 2016 data repeated.

*** Survey responses based upon AARP interpretation of state Board of Nursing regulations (KY, MT, NM, PA, TX, UT, WI)

Four states allowed additional delegation of medical/nursing tasks since the last *Scorecard*. Louisiana gave the ability to administer medication on an as needed basis and insert a suppository. New Jersey added the ability for direct care workers to draw up insulin for dosage measurement and administer intramuscular injection medications. South Carolina gave the ability to perform ostomy care including skin care and changing an appliance. Wisconsin added the ability to draw up insulin for dosage measurement and administering intramuscular injection medications.

North Dakota and South Dakota were the only states to improve their performance in Scope of Practice, both moving from reduced to full scope.

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A19 Summary of Indicator Rankings by State

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

* Final rank for overall LTSS system performance across five dimensions.

Source: Long-Term Services and Supports State Scorecard, 2020.

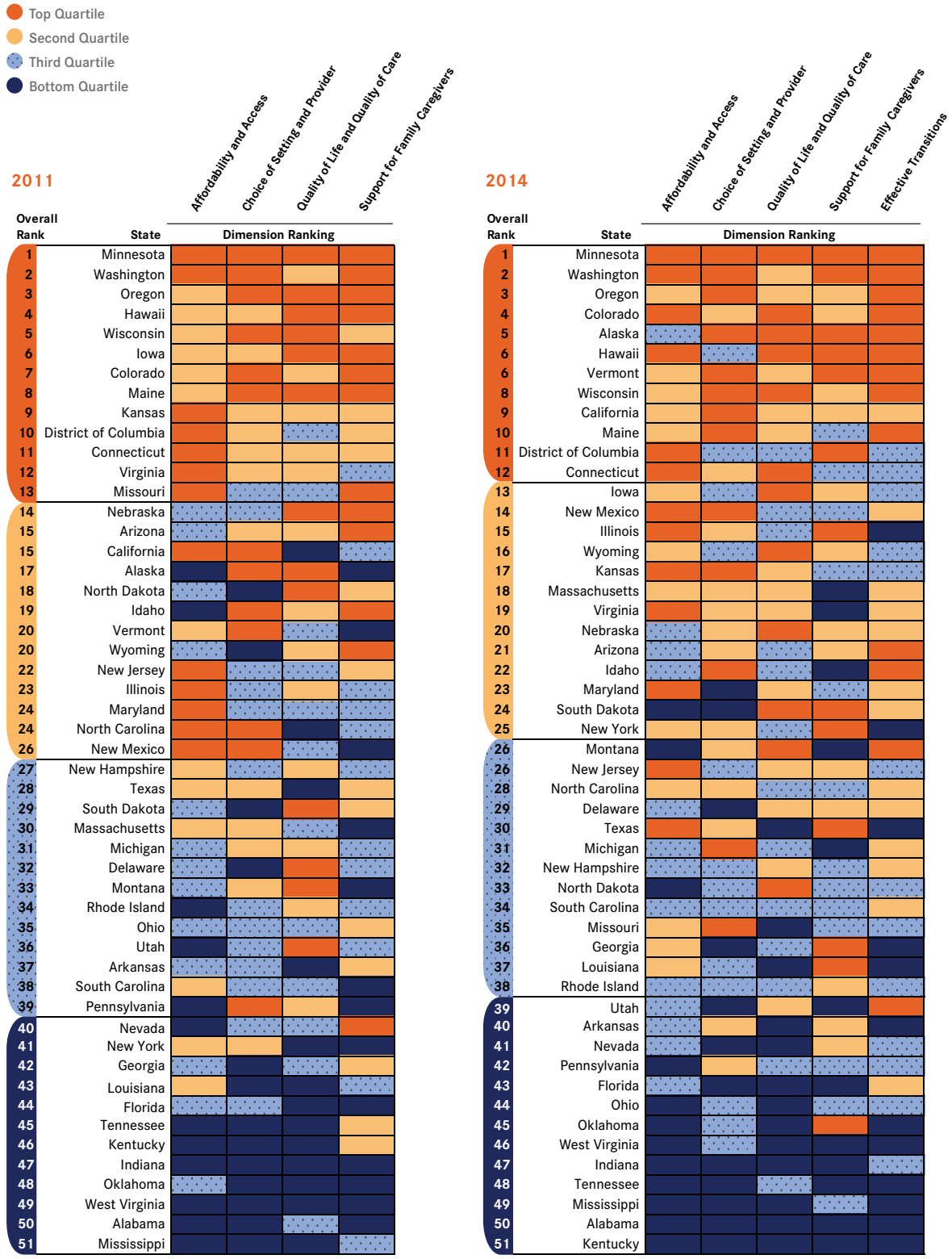
EXHIBIT A20 Summary of Change in Performance by State

	Across All Dimensions, Number of Indicators for Which States Improved, Declined, or Stayed About the Same:			
State	**Improved**	**Declined**	**Same**	**No Trend***
United States	**5**	**0**	**16**	**0**
Alabama	2	2	17	0
Alaska	1	7	13	0
Arizona	4	3	14	0
Arkansas	3	2	16	0
California	1	0	19	1
Colorado	3	2	16	0
Connecticut	7	0	13	1
Delaware	4	1	15	1
District of Columbia	4	3	13	1
Florida	2	2	17	0
Georgia	5	2	14	0
Hawaii	5	1	13	2
Idaho	3	4	13	1
Illinois	6	2	13	0
Indiana	4	1	16	0
Iowa	4	3	12	2
Kansas	5	0	15	1
Kentucky	4	3	14	0
Louisiana	7	3	11	0
Maine	1	2	18	0
Maryland	8	0	13	0
Massachusetts	4	1	16	0
Michigan	3	0	18	0
Minnesota	6	1	14	0
Mississippi	5	2	14	0
Missouri	2	0	19	0
Montana	6	1	14	0
Nebraska	3	1	17	0
Nevada	6	1	14	0
New Hampshire	4	1	16	0
New Jersey	7	0	14	0
New Mexico	6	1	13	1
New York	9	0	12	0
North Carolina	1	3	17	0
North Dakota	7	1	13	0
Ohio	6	0	15	0
Oklahoma	4	1	16	0
Oregon	6	3	12	0
Pennsylvania	7	0	14	0
Rhode Island	7	0	13	1
South Carolina	4	1	16	0
South Dakota	4	3	14	0
Tennessee	3	0	17	1
Texas	6	1	13	1
Utah	2	1	17	1
Vermont	3	3	14	1
Virginia	6	1	14	0
Washington	4	1	16	0
West Virginia	3	3	14	1
Wisconsin	5	1	15	0
Wyoming	4	4	11	2

Note: Showing change in 21 indicators where there is comparable current and reference year data.
* Baseline year data not comparable, or missing data for baseline and/or current data year.

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A21 Matrix Heat Maps for Four *LTSS State Scorecard*s, 2011 to 2020



Indicator sets and definitions vary significantly between *Scorecards*. Dimension and overall ranks are not directly comparable between *Scorecards* and therefore a change in rank does not necessarily indicate a change in either absolute or relative performance and should not be interpreted as such. Comparison at the indicator level is the best way to understand changes in system performance.

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A21 Matrix Heat Maps for Four *LTSS State Scorecard*s, 2011 to 2020 (continued)

Top Quartile
Second Quartile
Third Quartile
Bottom Quartile

2017

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

2020

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

Indicator sets and definitions vary significantly between *Scorecards*. Dimension and overall ranks are not directly comparable between *Scorecards* and therefore a change in rank does not necessarily indicate a change in either absolute or relative performance and should not be interpreted as such. Comparison at the indicator level is the best way to understand changes in system performance.

Source: Long-Term Services and Supports State Scorecard, 2020.

EXHIBIT A22 State Ranking on LTSS System Performance by Dimension

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

Source: Long-Term Services and Supports State Scorecard, 2020.

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Exhibit B2 Methodology Overview

The scoring and ranking methodology in this *Scorecard* is based on the same methodology used in previous *LTSS State Scorecards*. As in the *2017 Scorecard*, the Quality of Life and Quality of Care dimension is given half the weight of the other dimensions in determining the overall rank, and the Support for Family Caregivers dimension is calculated as a single composite rather than an average of indicator ranks.

Dimensions and Indicators: The *Scorecard* measures LTSS system performance using 26 indicators (or policy categories) across five dimensions:

- **Affordability and Access** (6 indicators) includes the relative affordability of private pay LTSS, the proportion of individuals with private long-term care insurance, the reach of Medicaid and the Medicaid LTSS safety net for people with disabilities who have modest incomes, and the ease of navigating the LTSS system.
- **Choice of Setting and Provider** (7 indicators) includes the balance between institutional services and home- and community-based services (HCBS), the extent of self-direction, and the supply and availability of alternatives to nursing homes, including subsidized housing units, residential care options such as assisted living, adult day services, and the supply of home health and personal care aides.
- **Quality of Life and Quality of Care** (4 indicators) includes employment of people with disabilities living in the community, two indicators of quality in nursing homes, and a measure of the capability for cross-state benchmarking of HCBS quality measures. This dimension has a long-standing gap in HCBS quality measures that are comparable across states, as well as additional data gaps such as quality of life other than employment. Because of these gaps, the Quality of Life and Quality of Care dimension is considered to be incomplete and receives only one-half of the weight of the other four dimensions in determining states' overall ranks on LTSS system performance.
- **Support for Family Caregivers** (12 policy areas, grouped into 4 broad categories) includes supports for working caregivers, person- and family-centered care, nurse delegation and scope of practice, and transportation policies.
- **Effective Transitions** (5 indicators) includes measures of hospitalization and institutionalization that should be minimized in a high-performing LTSS system.

Indicators had to be clear, important, meaningful, and have comparable data available at the state level. These 26 indicators were selected because they represent the best available measures at the state level. While no single indicator can fully capture LTSS system performance, taken together they provide a useful measure of how state LTSS systems compare across a range of important dimensions.

Ranking Methodology: The *Scorecard* ranks the states from highest to lowest performance on each indicator in the Access, Choice, Quality, and Transitions dimensions. Within each of these four dimensions, individual indicator ranks are averaged and the averages are then re-ranked for dimension-level ranks. In the case of missing data or ties in rank, minor adjustments are made to values used in calculating the average:

- For ties: the average rank is given for the computation of the dimension or overall average (e.g., two states tied at third; both get a score of 3.5 for the calculation of the dimension average).
- For missing data: a constant value is added to all ranks so that the average rank for the indicator is 26 (e.g., if two states are missing data for an indicator, the remaining states rank 2 to 50 for the calculation of the dimension average.

The Support for Family Caregivers dimension is calculated differently. The dimension score is a single composite across all 12 policy areas, and the dimension rank is based on the total dimension score.

The five dimension ranks are then averaged (with the Quality dimension being given half weight) and re-ranked to compute the overall ranking of LTSS system performance. Ties in dimension rank are adjusted as above for calculating overall scores and rankings.

Exhibit B3 Measuring Change Over Time

One of the main goals of this report is to assess how state long-term services and supports (LTSS) systems improved or declined between the *2017 Scorecard* and the *2020 Scorecard*. However, state ranks at the dimension and overall levels should not be directly compared between the current *Scorecard* and prior *Scorecards*. There are significant changes in the methodology and indicator sets, so changes in rank may not reflect actual changes in relative performance. Tables B3.1 and B3.2 below show a comparison of the indicators and policy categories between the *2017* and *2020 Scorecards*.

TABLE B3.1 Comparison of Indicator Sets for the *2017* and *2020 LTSS State Scorecards*

Dimension	*2017 Scorecard* Indicator	*2020 Scorecard* Indicator	Reference Year Data Available?	Change from *2017 Scorecard*
Affordability and Access	Nursing Home Cost	Nursing Home Cost	Yes	
	Home Care Cost	Home Care Cost	Yes	
	Long-Term Care Insurance	Long-Term Care Insurance	Yes	Revised Definition
	Low-Income PWD with Medicaid	Low-Income PWD with Medicaid	Yes	
	PWD with Medicaid LTSS	PWD with Medicaid LTSS	Yes	Revised Definition
	ADRC/NWD Functions	ADRC/NWD Functions	Yes	
Choice of Setting and Provider	Medicaid LTSS Balance: Spending	Medicaid LTSS Balance: Spending	Yes	
	Medicaid LTSS Balance: New Users	Medicaid LTSS Balance: Users	Yes	Replaced Indicator
	Participant Direction	Self-Direction	No	
	Home Health Aide Supply	Home Health Aide Supply	Yes	
	Assisted Living Supply	Assisted Living Supply	Yes	
		Adult Day Services Supply	Yes	New Indicator
	Subsidized Housing Opportunities	Subsidized Housing Opportunities	Yes	
Quality of Life and Quality of Care	PWD Rate of Employment	PWD Rate of Employment	Yes	
	Nursing Home Pressure Sores	Nursing Home Residents with Pressure Sores	No	Revised Definition
	Nursing Home Antipsychotic Use	Nursing Home Antipsychotic Use	Yes	
		HCBS Quality Benchmarking	No	New Indicator
Effective Transitions	Nursing Home Low Care Needs	Nursing Home Residents with Low Care Needs	No	Revised Definition
	Home Health Hospital Admissions	Home Health Hospital Admissions	Yes	Revised Definition
	Nursing Home Hospital Admissions	Nursing Home Hospital Admissions	Yes	
	Burdensome Transitions	Burdensome Transitions	Yes	Revised Definition
	Long Nursing Home Stays	Successful Discharge to Community	No	Replaced Indicator
	Transitions Back to Community			

Notes: Policies in the Support for Family Caregivers dimension are shown in Table B3.2 below. Even when the indicator is unchanged, the *2020 Scorecard* reference year data may not exactly match the *2017 Scorecard* current year data. Different years of data, data updates, or additional information since the production of the *2017 Scorecard* may result in some differences.

TABLE B3.2 Comparison of Policies Included in the Support for Family Caregivers Dimension for the *2017* and *2020 LTSS State Scorecards*

Category	*2017 Scorecard* Policy	*2020 Scorecard* Policy
Supporting Working Caregivers	Family Responsibility Protected Classification	Family Responsibility Protected Classification
	Exceeds Federal FMLA	Exceeds Federal FMLA
	Paid Family Leave and Sick Days	Paid Family Leave
		Mandatory Paid Sick Days
		Flexible Sick Days
	Unemployment Insurance	Unemployment Insurance
Person- and Family-Centered Care	Spousal Impoverishment Protections	Spousal Impoverishment Protections
	Caregiver Assessment	Caregiver Assessment
	CARE Act Legislation	CARE Act Legislation
Nurse Delegation and Scope of Practice	Nursing Tasks Able to be Delegated	Nursing Tasks Able to be Delegated
	Nurse Practitioner Scope of Practice	Nurse Practitioner Scope of Practice
Transportation Policies	Protection from Increases in Liability or Rates	Volunteer Driver Protection
	Exempt from Livery Laws	
	Volunteer Driver Investment	
	Statewide Coordinating Council	
	Medicaid Non-Medical Transportation	

Notes: Reference year data are available for all policies included in the *2020 Scorecard*. Scoring algorithms have changed between the *2017* and *2020 Scorecards* for many policies; policy, category, and overall composite scores should not be compared between *Scorecards*.

Change in performance can be directly measured at the indicator level. Baseline year data (typically 3 years prior to the most current data) are available for 21 of the 26 indicators in the *Scorecard*. For these 21 indicators, the *Scorecard* reports both current data and baseline data, and identifies meaningful change (either positive or negative). Note that the period of time covered by the data varies by indicator. Some measures have significant data lag, so the change measured in the *2020 Scorecard* may have occurred prior to the publication of the *2017 Scorecard*.

To aid in the interpretation of indicator-level change, appendix data tables show current and baseline values for each trended indicator, and also indicate the magnitude of changes by a green check mark for a substantial improvement, a red X for a substantial decline, and a black two-headed arrow for little or no change.

For count- or ratio-scaled data, usually indicators of the form (number of elements)/(population subgroup), a threshold of 10 or 20 percent change in the ratio was used. For example, if a state had a baseline rate of 40 long-term care insurance policies in effect per 1,000 people ages 40 and older in 2015, a ratio of 36 or lower in 2018 would be classified as a decline, and a ratio of 44 or higher would be classified as an improvement. A ratio of 37 through 43 would be classified as "little or no change" so as not to highlight small changes in the data that may not reflect meaningful change.

For percentage data, a threshold of 10 or 20 percent change in the odds was used in order for meaningful change to be possible for any starting value, and for the indication of change to be the same whether the indicator is expressed in a positive or negative way. The odds (or odds ratio) is the ratio of the probability of something happening (or the proportion of the sample in which something is true) to the probability of it not happening, or more generally, Odds = P/(1 – P), where P is the proportion, percentage, or probability. For example, a percentage of 20 percent corresponds to an odds of 20%/80% = 0.25, and a percentage of 60 percent corresponds to an odds of 60%/40% = 1.5.

The Support for Family Caregivers dimension comprises 12 policy areas grouped into 4 categories. A threshold of 0.2 points of linear change (current value – reference year value) was used to indicate change at the category level. Since some policies are scored against national minimum and maximum values, there could be a slight change in score even if state policy is unchanged. A small threshold of 0.2 points was used so as not to indicate meaningful change without an actual change in state policy.

Table B3.3 below shows the threshold used to indicate substantial improvement for each indicator. Indicators based on survey data that may have uncorrelated sampling errors use a 20 percent threshold instead of 10 percent (as do the two estimated Medicaid LTSS user measures) to reduce the likelihood that random variation is classified as a significant change.

TABLE B3.3 Thresholds and Type of Change for Identifying Substantial Change

Indicator	Threshold	Type of Change
Affordability and Access Dimension		
Nursing Home Cost	+/-10%	Ratio
Home Care Cost	+/-10%	Ratio
Long-Term Care Insurance	+/-10%	Ratio
Low-Income PWD with Medicaid	+/-20%	Odds Ratio
PWD with Medicaid LTSS	+/-20%	Odds Ratio
ADRC/NWD Functions	+/-10%	Odds Ratio
Choice of Setting and Provider		
Medicaid LTSS Balance: Spending	+/-10%	Odds Ratio
Medicaid LTSS Balance: Users	+/-20%	Odds Ratio
Home Health Aide Supply	+/-20%	Ratio
Assisted Living Supply	+/-20%	Ratio
Adult Day Services Supply	+/-20%	Ratio
Subsidized Housing Opportunities	+/-10%	Odds Ratio
Quality of Life and Quality of Care		
PWD Rate of Employment	+/-20%	Odds Ratio
Nursing Home Antipsychotic Use	+/-10%	Odds Ratio
Support for Family Caregivers		
Supporting Working Family Caregivers	+/-0.2	Linear
Person- and Family-Centered Care	+/-0.2	Linear
Nurse Delegation and Scope of Practice	+/-0.2	Linear
Transportation Policies	+/-0.2	Linear
Effective Transitions		
Home Health Hospital Admissions	+/-10%	Odds Ratio
Nursing Home Hospital Admissions	+/-10%	Odds Ratio
Burdensome Transitions	+/-10%	Odds Ratio

Exhibit B4 Detailed Indicator Descriptions

Indicator Description and Data Sources

1 Median Annual Nursing Home Private Pay Cost as a Percentage of Median Household Income Ages 65+:

The ratio of the median daily private-room rate (multiplied by 365 days) divided by the median household income for households headed by someone aged 65 or older. The ratio of the median nursing home cost to median income was calculated at the "region" level and then averaged across all regions in a state, weighted by the proportion of the state population in each region.

Regions are defined by Genworth as collections of counties and map approximately to the Metropolitan Statistical Areas (MSA) established by the US Office of Management and Budget. MSA boundaries are redrawn every 10 years; for this *Scorecard*, the baseline and current-year data are based on different MSA vintages. Change over time in this measure may therefore be due to a combination of changes in one or more of the following: cost (numerator), income (denominator), and market (region definition).

Cost data for the current year are from the *Genworth 2019 Cost of Care Survey* and income data are from the AARP Public Policy Institute (PPI) analysis of the *2018 American Community Survey Public Use Microdata Sample*. Baseline cost data are from the *Genworth 2016 Cost of Care Survey*, and income data are from the *2015 American Community Survey*.

Genworth, *Genworth 2016 Cost of Care Survey* and *Genworth 2019 Cost of Care Survey*. (Richmond, VA: Genworth Financial, 2016, 2019). Detailed tables were provided by Genworth to AARP Public Policy Institute for use in the indicator calculation. Summary reports are available at https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/cost-of-care/179703_CofC_Annual_060316.pdf and https://www.genworth.com/aging-and-you/finances/cost-of-care.html and https://pro.genworth.com/riiproweb/productinfo/pdf/282102.pdf.

US Census Bureau, ACS PUMS, *American Community Survey Public Use Microdata Sample*. (Washington, DC: US Census Bureau, 2015, 2018), https://www.census.gov/programs-surveys/acs/data/pums.html.

2 Median Annual Home Care Private Pay Cost as a Percentage of Median Household Income Ages 65+:

The ratio of the median annual private pay cost of licensed home health aide services (based on 30 hours of care per week multiplied by 52 weeks) divided by the median household income for households headed by someone aged 65 or older. The ratio of the median nursing home cost to median income was calculated at the "region" level and then averaged across all regions in a state, weighted by the proportion of the state population in each region.

Regions are defined by Genworth as collections of counties and map approximately to the Metropolitan Statistical Areas (MSA) established by the US Office of Management and Budget. MSA boundaries are redrawn every 10 years; for this *Scorecard*, the baseline and current-year data are based on different MSA vintages. Change over time in this measure may therefore be due to a combination of changes in one or more of the following: cost (numerator), income (denominator), and market (region definition).

Cost data for the current year are from the *Genworth 2019 Cost of Care Survey* and income data are from the AARP Public Policy Institute analysis (PPI) of the *2018 American Community Survey Public Use Microdata Sample*. Baseline cost data are from the *Genworth 2016 Cost of Care Survey*, and income data are from the *2015 American Community Survey*.

Genworth, *Genworth 2016 Cost of Care Survey* and *Genworth 2019 Cost of Care Survey*. (Richmond, VA: Genworth Financial, 2016, 2019). Detailed tables were provided by Genworth to AARP Public Policy Institute for use in the indicator calculation. Summary reports are available at https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/cost-of-care/179703_CofC_Annual_060316.pdf and https://www.genworth.com/aging-and-you/finances/cost-of-care.html and https://pro.genworth.com/riiproweb/productinfo/pdf/282102.pdf.

US Census Bureau, ACS PUMS, *American Community Survey Public Use Microdata Sample*. (Washington, DC: US Census Bureau, 2015, 2018), https://www.census.gov/programs-surveys/acs/data/pums.html.

3 Private Long-Term Care Insurance Policies in Effect per 1,000 Population Ages 40+:

This is the number of group and individual stand-alone and hybrid private long-term care insurance (LTCI) policies in force (for people of all ages) per 1,000 population ages 40 or older in the state. This is not exactly the proportion of people ages 40+ with private LTCI, because data on the age of policyholders at the state level are not available. Historically, about three-fourths of group policyholders and nearly all individual policyholders have been ages 40+.

LTCI policy data are from the AARP Public Policy Institute analysis of 2018 National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Experience Reporting - Form 5, end-of-year inforce counts, by company type. In addition, California Public Employee Retirement System (CalPERS) group LTCI policies are separately reported as NAIC does not report CalPERS counts. LTCI policy data excludes federal LTCI group policy counts as the Office of Personnel Management would not authorize the release of 2018 data. 2015 baseline LTCI policy data was rebased to exclude 2015 federal LTCI group policy counts.

Population data are from the US Census Bureau Population Estimates, 2018. 2015 baseline LTCI policy and population data are from the same sources.

NAIC, "Long-Term Care Insurance Experience Reporting – Form 5" (unpublished, Kansas City, MO: National Association of Insurance Commissioners, 2015, 2018), http://store.naic.org/prod_serv_home.htm.

CalPERS, *Facts at a Glance: January 2014—15 Comprehensive Annual Financial Report* (Sacramento, CA: California Public Employees' Retirement System, 2015), www.calpers.ca.gov/. CalPERS, *2018 Long-Term Care Program Report, March 20, 2018* (Sacramento, CA: California Public Employees' Retirement System, 2018), https://www.calpers.ca.gov/docs/board-agendas/201803/pension/item-4c-attach-1-a.pdf.

US Census Bureau, *Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States: April 1, 2010 to July 1, 2018* (Washington, DC: US Census Bureau, 2018), https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html.

4 Percentage of Adults Ages 21+ with ADL Disability at or Below 250% of Poverty Receiving Medicaid or Other Government Assistance Health Insurance:

The percentage of adults ages 21+ with a self-care difficultly (difficulty dressing or bathing; a reasonable approximation to activities of daily living disability) at or below 250% of the poverty threshold who have health insurance through Medicaid, medical assistance, or any kind of government assistance plan for those with low incomes or a disability. We chose 250% of poverty in order to fully capture the effect of state policies extending Medicaid eligibility for LTSS up to 300% of Supplemental Security Income.

The percentage of the target population that has Medicaid or other government assistance health insurance was calculated for each year, and this percentage was averaged across the three "current years" and two "reference years" to create the current and baseline indicator values.

Data are from AARP Public Policy Institute analysis of 2016–2018 *American Community Survey Public Use Microdata Sample.* 2014–2015 baseline data are from the same source.

US Census Bureau, ACS PUMS, *American Community Survey Public Use Microdata Sample* (Washington, DC: US Census Bureau, 2014, 2015, 2016, 2017, 2018), https://www.census.gov/programs-surveys/acs/data/pums.html.

5 Estimated Medicaid LTSS Users per 100 Population with ADL Disability:

This measure is an estimate of the number of older people and people with physical disabilities receiving Medicaid LTSS during the year, divided by the number of people in the state with an ADL disability (difficulty with self-care) as measured by the American Community Survey. Because of changes in data availability, this measure is not comparable to similar measures in previous *Scorecards*.

Most, but not all, Medicaid LTSS users have ADL/self-care disabilities. Some have LTSS needs, on account of intellectual disabilities or dementia, but do have difficulty with self-care. Because of data limitations, it was not possible to subset LTSS users by type of disability for a count of LTSS users with ADL disabilities.

Denominator data are from the *American Community Survey*.

Numerator data are estimated by the AARP Public Policy Institute from multiple sources. Nursing home users and HCBS users are estimated separately and added together. Therefore, a single individual receiving services in the community and in a nursing home would be estimated twice. However, this group is fairly small and this measurement issue is constant across all states so has little impact on state ranking on this indicator. This indicator is an estimate derived from multiple sources, not a precise measurement. Small differences in indicator value or rank may not be meaningful; however, the uncertainty in any state's estimate is small compared to the variation between states.

Nursing home users are estimated from the CMS Medicare and Medicaid Statistical Supplement (data available 2003-04, 2006-11) and Kaiser Family Foundation and UCSF analysis of 12 months of OSCAR data (available 2003-17). The Statistical Supplement contains the number of unique Medicaid nursing homes in each data year; the OSCAR analysis is a near-census of nursing home residents, and contains data on primary payer.

For each of the 8 years that both sources had data, we calculated a conversion factor for each state.

$$K_{state,year} = \frac{U_{state,year}}{C_{state,year}}$$

Where $U_{state,year}$ is unique Medicaid nursing home user count from the Statistical Supplement and $C_{state,year}$ is the near-census of nursing home current residents with Medicaid as primary payer from analysis of OSCAR data.

Obvious outliers and implausible values were removed, and the remaining values were averaged to create a state-specific scale factor K'_{state}. 17 states had at least one data year removed, and 7 states had three or more years removed. For Arizona, which did not have any plausible values in the data, the national average value K = 1.863 was used.

For the current year (2017) and reference year (2014), the estimated number of unique Medicaid nursing home users was given by

$$ENH_{state,year} = K'_{state} * C_{state,year}$$

HCBS users are estimated from Kaiser Family Foundation's (KFF) Medicaid Home and Community-Based Services Enrollment and Spending report series, supplemented by additional sources on a case by case basis. This report provides counts of HCBS users by type of service (3 types in 2014: home health, personal care, and 1915(c) waivers; 6 types in 2017: home health, personal care, 1915(c) waivers, 1915(k), community first choice (CFC), 1115 waivers); counts are not unduplicated between service type, and duplication may be significant and cannot be ignored. Current year data were 2017 (from the 2019 KFF report) and reference year data were 2014 (from the 2018 report).

The general formula for the estimated number of unique HCBS users in a state is

$$EHCBS_{state,year} = \frac{1}{2}\left(\sum_{types} H_{state,year,type} + \max_{types}\left(H_{state,year,type}\right)\right)$$

where $H_{state,year,type}$ is the data in the KFF Enrollment and Spending report and the first half of the right side equation is the total number of HCBS users if there is no duplication between service types, and the second half is the total number of HCBS users if there is 100% duplication to the maximum extent possible given the reported data. The estimated unduplicated count is the midpoint between these two extremes. The service types indexed in the equation above are all that are included in the KFF report, including only aged and physically disabled 1915(c) waivers (excluding other populations such as intellectual/developmental disabilities).

AARP Public Policy Institute followed up with many states (contact with state officials, other stakeholders, and/or state-specific data reports) because of inconsistent or implausible data values. One or more adjustments were applied in 16 states. Adjustments to state estimates are listed below:

Delaware, Hawaii, New Mexico, Rhode Island, Tennessee, Vermont (1115 waiver states, 2017 numbers are plausible but there is a significant undercount of users in 2014)—2014 data are estimated using an assumption of the same user balance (ratio of HCBS to nursing home users) as in 2017.

Arizona—2017 total HCBS users are estimated from 2014 data, based on an increase of 12.9% since 2014. Rate of increase from analysis of state reports for adults (ages 22+) receiving care in the community. https://www.azahcccs.gov/Resources/Reports/federal.html.

California—Because of overlap of these service types with the state's 1115 waiver, personal care and CFC were not included in the calculation for data year 2017. For 2014, an 1115 count was estimated assuming the same rate of growth seen in personal care services, and this was substituted for the personal care services count in the calculation.

District of Columbia—2015 data (provided by state Medicaid agency) used instead of 2014 for baseline calculation.

Iowa, South Dakota—2013 home health user counts were used (instead of 2014 and 2017) for calculating both baseline (2014) are current (2017) values.

Massachusetts—2014 total HCBS users are estimated 2017 data, based on an increase of 13.1% between 2014 and 2017. Rate of increase from analysis of data provided to AARP by state Medicaid agency.

Oregon—2017 data do not include CFC in the calculation. It appears that CFC recipients are also being counted as 1915(c) users, including both in the equation would produce a significant over count.

Texas—2014 data are estimated to have the same user balance (ratio of HCBS to nursing home users) as in 2017.

Utah—2014 aged/disabled 1915(c) waiver count of 2349 substituted. Data from CMS 372 report. https://www.medicaid.gov/sites/default/files/2019-12/cms-372-report-2015.pdf.

Washington—Because of overlap of these service types with CFC, personal care and aged/disabled 1915(c) waivers were not included in the calculation for data year 2017.

Numerator data sources:
Centers for Medicare & Medicaid Services, Medicare & Medicaid Statistical Supplement, 2005 through 2013 editions. "Table 13.25 - Medicaid Persons Served (Beneficiaries), by Type of Service and Area of Residence: Fiscal Year 2011" in the 2013 edition (previous editions may have different table numbering). Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Archives/MMSS.

Kaiser Family Foundation, State Health Facts, Distribution of Certified Nursing Facility Residents by Primary Payer Source, https://www.kff.org/other/state-indicator/distribution-of-certified-nursing-facilities-by-primary-payer-source/.

Kaiser Family Foundation, Medicaid Home and Community-Based Services Enrollment and Spending (April 2019), downloaded from https://www.kff.org/medicaid/issue-brief/medicaid-home-and-community-based-services-enrollment-and-spending in May 2019.

Kaiser Family Foundation, Medicaid Home and Community-Based Services: Results From a 50-State Survey of Enrollment, Spending, and Program Policies (January 2018), downloaded from http://files.kff.org/attachment/Report-Medicaid-Home-and-Community-Based-Services in May 2019.

Denominator data source:
US Census Bureau, ACS, American Community Survey (Washington, DC: US Census Bureau, 2013-2018), data table C18106: SEX BY AGE BY SELF-CARE DIFFICULTY, available at https://data.census.gov/cedsci/.

6 ADRC/No Wrong Door Functions (Composite Indicator, scale 0 – 100%):

This composite indicator comprises functional assessment scores from a voluntary, self-reported survey fielded by AARP for each state's Aging and Disability Resource Center/No Wrong Door (ADRC/NWD) System. Assessments rated states' progress toward developing NWD Systems using 41 criteria across 5 dimensions:

1 State Governance and Administration (10 criteria)
2. Populations (5 criteria)
3. Public Outreach and Coordination with Key Referral Sources (8 criteria)
4 Person-Centered Counseling (9 criteria)
5. Streamlined Eligibility for Public Programs (9 criteria)

States were awarded a point value on the functional status of each criterion. Each criterion received a maximum of 3 points, ranging from 0 (not in place) to 3 (fully operational statewide). Criteria that were informed by more than one question were scored based on the average of the individual questions.

State scores were summed across all criteria to a total of 123 possible points from these functionality criteria. Scores are listed in the *LTSS Scorecard* as a percentage of total possible points, rounded to the nearest whole percent.

List of 41 criteria by function and number of questions for each criterion:

I State Governance and Administration (10 criteria)

1. Governor and/or State Legislature's Support to Develop NWD System (1 question)
2. Multistate Agency Coordinating Body (1 question)
3. Formal Assessment of Access Programs and Functions (1 question)
4. Multiyear Plan to Implement NWD System (1 question)
5. External Stakeholder Involvement (1 question)
6. State Funding (1 question)
7. Designation of Entities (1 question)
8. Continuous Quality Improvement (3 questions)
9. Staff Capacity (2 questions)
10. Information Technology (2 questions)

II Populations (5 criteria)

1. Older Adult Population (1 question)
2. People with Physical Disabilities (1 question)
3. People with Intellectual and Developmental Disabilities (1 question)
4. People with Mental Illness and Behavioral Health Needs (1 question)
5. Family Caregiver Population (1 question)

III Public Outreach and Coordination with Key Referral Sources (8 criteria)

1. Outreach and Marketing Plan (1 question)
2. Searchable Website and 1-800 Phone Number (2 questions)
3. Information and Referral and State Health Insurance Assistance Program (SHIP) (2 questions)
4. Section Q – Local Contact Agencies (1 question)
5. Transitions – Hospitals or Rehab Facilities to Facilitate Transition to Home (1 question)
6. Transitions – Youth (1 question)
7. Veterans Administration (VA) Medical Centers to Provide Veteran-Directed HCBS (1 question)
8. Statewide Reach (1 question)

IV Person-Centered Counseling (PCC) (9 criteria)

1. Standards are Used to Define PCC (1 question)
2. Management Supports PCC and Planning (1 question)
3. Basic Competencies to Conduct Person-Centered Planning (1 question)
4. Specialized Competencies to Conduct Person-Centered Planning (4 questions)
5. Established Protocols for Developing Person-Centered Plans (1 question)
6. Variety of Organizations to Serve Different LTSS Populations (1 question)
7. Future Planning Needs and Private Pay (2 questions)
8. Follow-up (1 question)
9. Statewide Reach (1 question)

V Streamlined Eligibility for Public Programs (9 criteria)

1. Improving Efficiencies (1 question)
2. NWD Protocols (1 question)
3. Application Assistance (1 question)
4. Tracking Procedures (1 question)
5. Ease of Access (2 questions)
6. Targeting People Who Are High Risk of Institutionalization (1 question)
7. Diversion Protocol is in Place (2 questions)
8. Presumptive Eligibility (1 question from a different survey source)
9. Statewide Reach (1 question)

AARP PPI, ADRC/No Wrong Door state survey conducted in collaboration with The Lewin Group and US Administration for Community Living" (unpublished, Washington, DC: AARP Public Policy Institute, 2019). Baseline 2016 data are from 2016 and come from the same source.

7 Percentage of Medicaid- and State-Funded LTSS Spending Going to HCBS for Older People and Adults with Physical Disabilities:

The percentage of Medicaid LTSS spending for older people and adults with physical disabilities (defined as nursing homes, personal care, aged/disabled waivers, home health, private duty nursing, and other programs used primarily by older people and adults with physical disabilities) going to HCBS. State-funded services are also included where possible; these expenditures are small nationally (about 1% of Medicaid) but significant for some states. Medicaid data are from IBM Watson Health analysis of CMS data and include managed care spending.

The most current data year is 2016 and the reference data year is 2013, where possible. Several adjustments were necessary due to issues with data quality and completeness. 2014 was used for Alaska, California, Idaho, and Kansas. Oregon's 2016 expenditures for Community First Choice (CFC) were allocated according to historical patterns with 41% of CFC spending being for older adults and people with physical disabilities and 59% for other populations (including people with intellectual/developmental disabilities).

The baseline data year is 2013, where possible. Several adjustments were necessary due to issues with data quality and completeness. New Jersey "HCBS Unspecified AD" spending (managed care) was taken from the previous annual report in this series. New Mexico uses 2014 as a base year. Oregon's CFC expenditures are allocated 41% to older adults and people with physical disabilities and 59% for other populations, as above.

State-funded HCBS data are from 2018 (current year) and 2014 (reference year). During the most recent data collection, errors in previous 2014 data were noted in certain states, and corrected by others. As a result, for 8 states, 2014 state-funded LTSS spending estimates were interpolated by averaging the current data collection (2018 data) and 2011 data collected for the 2014 State *LTSS Scorecard*: Arizona, the District of Columbia, Idaho, Illinois, Louisiana, Massachusetts,

North Carolina, and Oklahoma. For Maine, the reference year state funded expenditures is set equal to the current (2017/2018) spending.

IBM Watson Health (2018). *Medicaid Expenditures for Long-Term Services and Supports in 2016*, IBM Watson Health, Cambridge, MA,

https://www.medicaid.gov/sites/default/files/2019-12/ltssexpenditures2016.pdf

AARP PPI and ADvancing States (2019) LTSS Economic Survey (unpublished).

AARP PPI (2016). *LTSS State Scorecard* Survey (unpublished).

8 Estimated Percentage of Medicaid Aged/Disabled LTSS Users Receiving HCBS:

This measure is an estimate, among older people and people with physical disabilities who received Medicaid LTSS during the year, of the percentage that received services in their home or community (as opposed to a nursing home). Because of changes in data availability, this measure is not comparable to previous *Scorecards*, in which the balance of **new** users receiving HCBS was calculated.

The data used for this indicator are the estimated number of HCBS users $EHCBS_{state,year}$ and nursing home users $ENH_{state,year}$ in the numerator of indicator 5: **Estimated Medicaid LTSS users per 100 population with ADL disability** above. Please see that indicator write-up for the details of estimating $EHCBS_{state,year}$ and $ENH_{state,year}$.

This indicator value is calculated as

$$\%HCBS = \frac{EHCBS_{state,year}}{EHCBS_{state,year} + ENH_{state,year}}$$

In additional to the adjustments detailed in the description of indicator 5, reference year data (2014) were not included for Delaware, Hawaii, New Mexico, Rhode Island, Tennessee, Texas, and Vermont due to incomplete data or a lack of comparability to current data.

Estimates are AARP Public Policy Institute calculations based primarily on:

Centers for Medicare & Medicaid Services, Medicare & Medicaid Statistical Supplement, 2005 through 2013 editions. "Table 13.25 - Medicaid Persons Served (Beneficiaries), by Type of Service and Area of Residence: Fiscal Year 2011" in the 2013 edition (previous editions may have different table numbering). Available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Archives/MMSS.

Kaiser Family Foundation, State Health Facts, Distribution of Certified Nursing Facility Residents by Primary Payer Source, https://www.kff.org/other/state-indicator/distribution-of-certified-nursing-facilities-by-primary-payer-source/.

Kaiser Family Foundation, Medicaid Home and Community-Based Services Enrollment and Spending (April 2019), downloaded from https://www.kff.org/medicaid/issue-brief/medicaid-home-and-community-based-services-enrollment-and-spending in May 2019.

Kaiser Family Foundation, Medicaid Home and Community-Based Services: Results From a 50-State Survey of Enrollment, Spending, and Program Policies (January 2018), downloaded from http://files.kff.org/attachment/Report-Medicaid-Home-and-Community-Based-Services in May 2019.

9 Number of People Self-Directing Services per 1,000 Population with Disabilities:

This is the number of people receiving self-directed services per 1,000 people with any disability in the state. Note that not all people with disabilities have LTSS needs.

The number of people receiving self-directed services is from the National Inventory of Self-Directed Programs in the United States 2019 survey data. Data for the inventory were collected from April to August 2019. Sources of data included state Medicaid waiver information, information from Financial Management Services providers, and telephone interviews with self-directed LTSS program administrators.

The number of people with disabilities is from the 2018 *American Community Survey*.

Applied Self-Direction, "National Inventory of Publicly Funded Self-Directed Long-Term Services and Supports Programs in the United States Survey" (unpublished, Boston, MA: Applied Self-Direction, 2019).

US Census Bureau, ACS, *American Community Survey* (Washington, DC: US Census Bureau, 2018). Census population data (all ages) from 2018 American Community Survey 1-Year Estimates, Table B18101, Sex by Age by Disability Status, available at https://data.census.gov/cedsci/.

10 Home Health and Personal Care Aides per 100 Population Ages 18+ with an ADL Disability:

This is the number of personal care, nursing, psychiatric, and home health aide direct care workers currently in the workforce per 100 population ages 18+ with an ADL. For 2013-2017, aides are those with occupation code 4610 (personal care aide) or 3600 (nursing, psychiatric, or home health aide) and industry code 8170 (home health care services), 8370 (social services), or 9290 (private households), and who worked in the last 12 months. For 2018, the occupation codes were updated to 3601 (home health aide), 3602 (personal care aide), 3603 (nursing assistant), or 3605 (orderlies and psychiatric aides).

Current year data are from the 2016, 2017, and 2018 *American Community Survey, Public Use Microdata Sample* and baseline data from 2013, 2014, and 2015 are from the same source. Denominator data also from the *American Community Survey*, via American FactFinder.

The supply to population ratio was calculated for each year, and this ratio was averaged across the three "current years" and three "reference years" to create the current and baseline indicator values.

US Census Bureau, ACS PUMS, *American Community Survey Public Use Microdata Sample* (Washington, DC: US Census Bureau, (2013–2018), https://www.census.gov/programs-surveys/acs/data/pums.html.

US Census Bureau, ACS, *American Community Survey* (Washington, DC: US Census Bureau, 2013-2018), data table C18106: SEX BY AGE BY SELF-CARE DIFFICULTY, available at https://data.census.gov/cedsci/.

11 Assisted Living and Residential Care Units per 1,000 Population Ages 75+:

This is the number of assisted living and residential care units per 1,000 population ages 75+. Assisted living and residential care units are taken from two National Center for Health Statistics (NCHS) surveys. To be eligible for inclusion in these studies, a residential care community must have been licensed, registered, listed, certified, or otherwise regulated by the state to

- Provide room and board with at least two meals a day, around-the -clock on-site supervision;
- Help with personal care such as bathing and dressing or health-related services such as medication management;
- Have four or more licensed, certified, or registered beds;
- Have at least one resident currently living in the community; and
- Serve a predominantly adult population.

Excluded were residential care communities licensed to exclusively serve individuals with severe mental illness or intellectual disability/developmental disability. Nursing homes were also excluded.

Data for the current-year 2016 and baseline 2014 assisted living and residential care units are from the *National Study of Long-Term Care Providers Survey*.

For 2016, no estimates were presented for the District of Columbia because the data did not meet confidentiality or reliability standards for NCHS. A 2015 capacity of 814 beds - data previously collected by AARP (unpublished) - was used for calculating the indicator value for DC.

Both 2014 and 2016 data for Connecticut and Iowa are not reported in the *Scorecard*. Connecticut's licensing structure for assisted living does not permit a unit count. The vast majority of Iowa's assisted living / residential care facilities were categorically ineligible for the *National Study of Long-Term Care Providers* (NSLTCP) due to the operational definition used in the survey.

2014 baseline data for Hawaii and Wyoming are treated as missing in the *Scorecard* because of concerns that change in supply over time from 2014 to 2016 was due to a change in the composition of the sampling frame, and not to an actual change in the number of units. For both states, the two years of NCHS data are very far apart in magnitude, and further investigation, including alternate data sources, could not resolve the observed differences.

Because publicly reported assisted living and residential care capacity is rounded to the nearest hundred, the capacity per 1,000 people ages 75+ was calculated by NCHS and reported rounded to the nearest whole number.

Population data for 2016 (current year) are from the US Census Bureau Population Estimates, 2017 vintage. Baseline 2014 population data are from the same source, 2015 vintage.

NCHS (2016, 2019). Analysis based on data from the 2014 and 2016 *National Survey of Residential Care Facilities* (unpublished).

NCHS, *National Study of Long-Term Care Providers* (Hyattsville, MD: National Center for Health Statistics, 2014, 2016), https://www.cdc.gov/nchs/nsltcp/.

US Census Bureau, *Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States: April 1, 2010 to July 1, 2017* (Washington, DC: US Census Bureau, 2018), https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html.

12 Adult Day Services Total Licensed Capacity per 10,000 Population Ages 65+

This is the maximum number of participants, per 10,000 population ages 65+, allowed at any one time at licensed adult day services centers in each state.

Adult day services capacity refers to the maximum number of participants allowed at an adult day services center location. The allowable daily capacity is usually determined by law or by fire code, but may also be a program decision. Adult day capacity data are from two National Study of Long-Term Care Providers (NSLTCP) surveys. To be eligible for inclusion in these surveys, all adult day services centers identified as adult day care, adult day services, or adult day health services centers and had to: 1) be included in the National Adult Day Services Association database; 2) be licensed or certified by the state to provide adult day services, or accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF); or authorized or otherwise set up to participate in Medicaid (Medicaid state plan, Medicaid waiver, or Medicaid managed care) or part of a Program of All-Inclusive Center for the Elderly (PACE); 3) have one or more average daily attendance of participants based on a typical week; and 4) have one or more participants enrolled at the center at the location at the time of the survey.

Data for current year 2016 and reference year 2014 total licensed adult day services capacity are from the *National Study of Long-Term Care Providers* survey. For 2016, no estimates for adult day services centers were presented for Delaware, the District of Columbia, West Virginia, and Wyoming, and for 2014, no estimates were presented for the District of Columbia, Idaho, Kansas, Utah, West Virginia, and Wyoming, because none of the estimates for these sectors meet confidentiality or reliability standards for NCHS.

For the *Scorecard*, the 2014 data was repeated for the 2016 indicator value for Delaware. All other states are treated as missing data.

Because publicly reported adult day services capacity data is rounded to the nearest hundred, the capacity per 10,000 people ages 65 and older was calculated by NCHS and reported rounded to the nearest whole number.

Population data for 2016 (current year) are from the US Census Bureau Population Estimates, 2017 vintage. Baseline 2014 population data are from the same source, 2015 vintage.

NCHS (2019). Analysis based on data from the 2014 and 2016 *National Study of Long-Term Care Providers* (unpublished).

NCHS, National Study of Long-Term Care Providers (Hyattsville, MD: National Center for Health Statistics, 2014, 2016), available at https://www.cdc.gov/nchs/nsltcp/nsltcp_webtables.htm.

US Census Bureau, Annual Estimate of the Resident Population for Selected Age Groups by Sex for the United States: April 1, 2010 to July 1, 2017 (Washington, DC: US Census Bureau, 2017, https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html.

13 Subsidized Housing Opportunities (Place-Based and Vouchers) as a Percentage of All Housing Units:

This is the number of place-based subsidized housing units and the number of authorized federal housing choice vouchers, as a percentage of all housing units in the state.

State-level housing choice voucher data are from the Center for Budget and Policy Priorities (CBPP) reports, all authorized vouchers. State-level data for place-based units are from the National Housing Preservation Database (NHPD), total units of any subsidy type. Total housing units are from the American Community Survey, via American FactFinder. Current year (2018) and baseline (2015) available from same sources.

NHPD (2016, 2019). AARP Public Policy Institute analysis of National Housing Preservation Database, downloaded 9/14/2016 and 6/6/2019. The NHPD pulls from multiple other sources with varying update frequencies. At the time that baseline and current data were downloaded, most sources were updated through 2015 and 2017.

CBPP (2015, 2017). *Housing Vouchers* (Washington, DC: Center on Budget and Policy Priorities, 2015, 2017), http://www.cbpp.org/topics/housing-vouchers.

US Census Bureau, ACS, *American Community Survey* (Washington, DC: US Census Bureau, 2015, 2018), data table B25001 available at US Census Bureau, https://data.census.gov/cedsci/.

14 Rate of Employment for Adults with ADL Disability Ages 18 to 64 Relative to Rate of Employment for Adults without ADL Disability Ages 18 to 64:

This is the relative rate of employment (full or part time) for people ages 18 to 64 with a self-care difficulty (difficulty dressing or bathing; a reasonable approximation to ADL disability) compared with people ages 18 to 64 without a self-care difficulty. Employment rate is calculated as the percentage of all people who are employed, including those who

are not in the labor force, as many people with disabilities are not in the labor force even though they may have the skills and desire to work.

The ratio of employment rate for adults with ADL disability to adults without ADL disability was calculated for each year, and this ratio was averaged across the three "current years" and three "reference years" to create the current and baseline indicator values.

Current year 2016-2018 data are from 2016, 2017, and 2018 and come from the *American Community Survey,* US Census Bureau. Baseline 2013-2015 are from 2013, 2014, and 2015 from the same source.

US Census Bureau, ACS, *American Community Survey* (Washington, DC: US Census Bureau, 2013- 2015, 2016-2018), data table B18120, available at US Census Bureau, https://data.census.gov/cedsci/.

15 Percentage of Long-Stay, High-Risk Nursing Home Residents with Pressure Sores:

Percentage of long-stay, high-risk nursing home residents impaired in bed mobility or transfer, comatose, or suffering malnutrition who have pressure sores (stage 2–4 or unstageable) on target assessment.

Current year, four quarter average Q1 – Q4, 2018 data from CMS Minimum Data Set (MDS) 3.0 for Nursing Homes. Data includes stage 2–4 and three unstageable pressure ulcer conditions. Unstageable pressure sores may be open or closed wounds that are completely covered with eschar (hard, black, dead tissue) or a non-removable dressing or device, making them difficult to diagnosis. Prior year CMS data, reported in previous *Scorecards*, did not include unstageable pressure ulcers.

CMS, MDS 3.0 (n.d.). Centers for Medicare & Medicaid Services, *Minimum Data Set, Quality Measure QM453,* Q1 – Q4, 2018, accessed on Nursing Home Compare in August 2018. Baltimore, MD: US Department of Health & Human Services, https://data.medicare.gov/data/archives/nursing-home-compare.

16 Percentage of Long-Stay Nursing Home Residents who are Receiving an Antipsychotic Medication:

The percentage of long-stay nursing home residents, defined as 100 or more cumulative days in the nursing facility, who are receiving antipsychotic medication on target assessment. Criteria exclude nursing home residents with a diagnosis of schizophrenia, Tourette's syndrome, and Huntington's disease.

Current year, four quarter average Q1 – Q4, 2018 , data from CMS Minimum Data Set (MDS) 3.0 for Nursing Homes. Baseline, four quarter average Q2 – Q4, 2015 and Q1, 2016, data from same source.

CMS, MDS 3.0 (n.d.). Centers for Medicare & Medicaid Services, *Minimum Data Set, Quality Measure QM419*, Q1 – Q4, 2018, accessed on Nursing Home Compare in August 2019 and Q2 – Q4, 2015 and Q1, 2016, accessed on Nursing Home Compare in September 2016. Baltimore, MD: US Department of Health & Human Services, https://data.medicare.gov/data/archives/nursing-home-compare.

17 HCBS Quality Cross-State Benchmarking Capability:

This indicator is constructed from state adoption of four tools that relate to HCBS quality measurement and assurance, or quality of life for people with LTSS needs:

- NCI-AD
- HCBS CAHPS
- BRFSS Emotional Support and Life Satisfaction Module
- Statewide NCQA Accreditation

Scoring Algorithm:

- NCI-AD
  1.2 points for any participation
  1.6 points for sample size >500 (greatest sample size of last two published annual reports)
  2.0 points for sample size >800
  2.5 points for sample size >1200
- HCBS CAHPS
  1.0 point for using within the past 2 years
  1.5 points for current/last year

If state is doing both NCI-AD and HCBS CAHPS, the CAHPS credit is reduced by 1.0 because of substitution effect between the tools (a state using one tool robustly is better than using both tools at a minimum level). A state using HBCS CAHPS within the last year would still get 0.5 points of credit for greater frequency of use. For example, Kansas reported using CAHPS in 2019, and therefore earned 1.5 points of credit. However, because the state already received credit for NCI-AD, they are only awarded 0.5 points for HCBS CAHPS instead of the full 1.5 points. Similar -1.0 point adjustments were made to Mississippi, New Jersey, and Pennsylvania.

- BRFSS ES/QOL Module
  0.6 points for 1 year fielding module 2015-17
  0.8 points for 2 years
  1.0 point for 3 years
- NCQA Statewide
  1.0 point for case management for LTSS
  or
  1.0 point for LTSS distinction required

Data sources:
NCI-AD: https://nci-ad.org/states/, https://nci-ad.org/resources/reports/.

HCBS CAHPS: AARP Public Policy Institute and National Association of States United for Aging and Disabilities, "Long-Term Services and Supports Economic Survey" (unpublished, Washington, DC: AARP PPI and NASUAD, 2018). Data validated by CMS (email correspondence, July 2019).

NCQA Statewide: Email correspondence, June 2019. Currently updated data available at: https://www.ncqa.org/public-policy/work-with-states-map/.

BRFSS: https://www.cdc.gov/brfss/questionnaires/modules/category2015.htm, https://www.cdc.gov/brfss/questionnaires/modules/category2016.htm and https://www.cdc.gov/brfss/questionnaires/modules/category2017.htm

18 Supporting Working Caregivers (maximum possible score 17.0):

This indicator is constructed along six policies:

Family Medical Leave. This policy evaluates the extent to which states exceed the federal Family Medical Leave Act (FMLA) requirements for covered employers, covered employee eligibility, covered relationships, and length of leave allowed.

Scoring: States received scores for the degree to which they exceeded federal FMLA requirements up to a total of 4.0 possible points as follows:

- 1.0 point for states exceeding federal FMLA for covered employers with 15 or fewer employees and 0.5 points for employers with 16 - 30 employees
- 1.0 point for states exceeding federal FMLA for covered eligibility (time with employer) of less than 1,000 hours, 6 months of work, or no minimum work requirement and 0.5 points for 1,000 hours over a 12-month period
- 0.25 points each (maximum of 1.0 point) for states exceeding federal FMLA for definition of family member (covered relationships) that includes (a) parent-in-law, (b) sibling, (c) grandparent, and (d) grandparent-in-law
- 1.0 point for states exceeding federal FMLA for allowing 16 weeks over a 2-year period and 0.5 points of 12–15 weeks over a 2-year period

Current-year 2018 data from *Raising Expectations: A State-by-State Analysis of Laws That Help Working Family Caregivers* and AARP Public Policy Institute independent research to verify status of laws in 2019. Baseline 2016 data from *Expecting Better for All Working Families: A Special Section of the Fourth Edition of Expecting Better* and legislative updates are from *National Partnership for Women & Families Work& Family Policy Database*, and US Department of Labor, *Wage and Hour Division: Federal vs. State Family and Medical Leave Laws.*

NPWF (2018). *Raising Expectations: A State-by-State Analysis of Laws That Help Working Family Caregivers* (Washington, DC: National Partnership for Women & Families, 2018), http://www.nationalpartnership.org/our-work/resources/workplace/raising-expectations-2018.pdf.

NPWF (2016) *Expecting Better for All Working Families: A Special Section of the Fourth Edition of Expecting Better* and *National Partnership for Women & Families Work & Family Policy Database* (Washington, DC: National Partnership for Women & Families, 2016), http://www.nationalpartnership.org/research-library/work-family/expecting-better-2016.pdf and http://www.nationalpartnership.org/issues/work-family/work-family-policy-database/.

US Department of Labor, *Wage and Hour Division: Federal vs. State Family and Medical Leave Laws* (Washington, DC: US Department of Labor, 2016) http://www.dol.gov/whd/state/fmla/.

Mandatory Paid Family Leave and Sick Days. These policies evaluate the extent to which states offer additional benefits beyond FMLA to family caregivers, including requirements that employers provide paid family leave and mandate the provision of paid sick days. The mandatory paid family leave policy evaluates statewide requirements for covered employers, covered relationships, and length of leave allowed. The mandatory paid sick days policy evaluates statewide requirements for covered employers and number of sick days allowed.

Scoring: States received up to 4.0 possible points for statewide paid family leave and up to 3.0 points for mandatory paid sick days leave as follows:

Mandatory Paid Family Leave

- 1.0 point for statewide laws mandating paid family leave and 0.5 points if enacted statewide law is not effective until after June 2020
- 1.0 point for statewide laws mandating paid family leave for covered employers with 15 or fewer employees, 0.5 points for employers with 16 - 30 employees, and one-half credit if statewide laws do not become effective until after June 2020
- 0.25 points each (maximum of 1.0 point) for statewide laws mandating paid family leave for definition of family member (covered relationships) that includes (a) parent-in-law, (b) sibling, (c) grandparent, and (d) grandparent-in-law, and one-half credit if statewide laws do not become effective until after June 2020
- 1.0 point for statewide laws mandating paid family leave for allowing 10 or more weeks of paid leave, 0.5 points for less than 10 weeks of paid leave, and one-half credit if statewide laws do not become effective until after June 2020.

Mandatory Paid Sick Days

- 1.0 point for statewide laws mandating paid sick days or paid personal time off and 0.5 points if statewide laws do not become effective until after June 2020
- 1.0 point for statewide laws mandating paid sick days or paid personal time off for covered employers with less than 10 employees, 0.5 points for employers with 10 - 49 employees, and one-half credit if statewide laws do not become effective until after June 2020
- 1.0 point for statewide laws mandating paid sick days or paid personal time off for allowing 40 or more hours of accrued annual leave, 0.5 points from less than 40 hours of accrued annual leave, and one-half credit if statewide laws do not become effective until after June 2020.

Current-year 2018 data from *Raising Expectations: A State-by-State Analysis of Laws That Help Working Family Caregivers* and AARP Public Policy Institute internal communications with State Advocacy & Strategy Integration and independent research to verify status of laws in 2019. Baseline 2016 data from *Expecting Better for All Working Families: A Special Section of the Fourth Edition of Expecting Better.*

NPWF (2018). *Raising Expectations: A State-by-State Analysis of Laws That Help Working Family Caregivers* (Washington, DC: National Partnership for Women & Families, 2018), http://www.nationalpartnership.org/our-work/resources/workplace/raising-expectations-2018.pdf.

NPWF (2016). *Expecting Better for All Working Families: A Special Section of the Fourth Edition of Expecting Better* and *National Partnership for Women & Families Work & Family Policy Database* (Washington, DC: National Partnership for Women & Families, 2016), http://www.nationalpartnership.org/research-library/work-family/expecting-better-2016.pdf.

Flexible Use of Sick Leave. This policy evaluates the extent to which states and localities require private sector employers to have workplace benefits that allow employees to use a portion of accrued sick time for purposes beyond their own illness, including family caregiving. The flexible use of sick leave policy evaluates state and local legislation for covered employers, covered relationships, and number of days allowed.

Scoring: States received up to 3.0 points for flexible use of sick leave as follows:

- 1.0 point for state or local laws requiring flexible use of sick leave for covered employers with 15 or fewer employees, 0.5 points for employers with 16 - 30 employees, and one-half credit if state or local laws do not become effective until after June 2020
- 0.25 points each (maximum of 1.0 point) for state or local laws requiring flexible use of sick leave for definition of *family member* (covered relationships) that includes (a) parent-in-law, (b) sibling, (c) grandparent, and (d) grandparent-in-law, and one-half credit if state or local laws do not become effective until after June 2020
- 1.0 point for state or local laws requiring 10 or more days of flexible use of sick leave, 0.5 points for less than 10 days, and one-half credit if legislation does not become effective until after June 2020.

Current-year 2018 data from *Raising Expectations: A State-by-State Analysis of Laws That Help Working Family Caregivers* and AARP Public Policy Institute internal communications with State Advocacy & Strategy Integration and independent research to verify status of laws in 2019. Baseline 2016 data *from Expecting Better for All Working Families: A Special Section of the Fourth Edition of Expecting Better*.

NPWF (2018). *Raising Expectations: A State-by-State Analysis of Laws That Help Working Family Caregivers* (Washington, DC: National Partnership for Women & Families, 2018), http://www.nationalpartnership.org/our-work/resources/workplace/raising-expectations-2018.pdf.

NPWF (2016). *Expecting Better for All Working Families: A Special Section of the Fourth Edition of Expecting Better* (Washington, DC: National Partnership for Women & Families, 2016), http://www.nationalpartnership.org/research-library/work-family/expecting-better-2016.pdf.

Unemployment Insurance. This policy evaluated the extent to which state unemployment insurance laws or regulations address "good cause" for job loss due to an illness or disability of a member of the individual's immediate family.

Scoring: States received 1.0 point if unemployment insurance laws or regulations include illness or disability of a member of the individual's immediate family as "good cause" for voluntarily leaving a job.

Current-year 2019 data obtained from communications with Richard McHugh, formerly with the National Employment Law Project. Baseline 2016 data are from *Access to Unemployment Insurance Benefits for Family Caregivers: An Analysis of State Rules and Practices*.

Richard McHugh unpublished internal communications, 2019.

AARP PPI (2015). *Access to Unemployment Insurance Benefits for Family Caregivers: An Analysis of State Rules and Practices*. Washington, DC: AARP Public Policy Institute, http://www.longtermscorecard.org/publications/access-to-unemployment-insurance-benefits-for-family-caregivers.

State Policies that Protect Family Caregivers from Employment Discrimination:

The extent to which a state (or locality) law expressly includes family responsibilities, including care provided to aging parents or ill or disabled spouses of family members, as a protected classification in the context that prohibits discrimination against employees who have family responsibilities.

Scoring: 2.0 points for statewide laws with defined policy prohibiting discrimination and 1.0 point if statewide but undefined familial status or family responsibility policy. 1.0 point for states with one or more locality laws with a defined policy prohibiting discrimination and 0.5 points if locality law does not define familial status or family responsibility.

Current-year 2019 data are from Center for WorkLife Law (WLL) at the University of California, Hastings College of the Law, legal analysis. Baseline 2014 data are from WLL at the University of California, Hastings College of the Law, *Work Life Law: State Law/Legislation Tracking* from AARP Public Policy Institute.

WLL, legal analysis (unpublished, San Francisco, CA: Center for WorkLife Law at the University of California, Hastings College of the Law, 2019).

WLL, WorkLife Law: *State Law/Legislation Tracking (*San Francisco, CA: Center for WorkLife Law at the University of California, Hastings College of the Law, 2014), https://worklifelaw.org/publications/FRD-Tracker-June-2014.pdf /.

19 Person- and Family-Centered Care (maximum possible score 5.5):

This indicator is constructed along three policies:

State Policies on Financial Protection for Spouses of Medicaid Beneficiaries who Receive HCBS:

This policy evaluated the extent to which the state Minimum Maintenance of Needs Allowance (MMNA) permits the community spouse to retain the federal maximum income allowance and asset resource protections, and whether spouses of HCBS waiver recipients receive the full level of income and asset protection afforded to spouses of nursing home residents.

Scoring: States received scores for income and asset protections up to a total of 2.0 possible points as follows:

- 1.0 point for states where the MMNA federal *maximum* income allowance of $3,160.50 is the state *minimum* income allowance protection, 0.5 points for states that permit the full range between the federal minimum $2,113.75 and federal maximum $3,160.50 income allowance protection. Midrange values have computed scores: (0.5*(X + X) -2113.75)/(3160.5-2113.75).
- 1.0 point for states where the MMNA federal maximum asset resource protection of $126,420 is the minimum standard, and a weighted computation score for states that use an amount above the federal *minimum* $25,284 asset resource protection: (X - $25,284)/ ($126,420 - $25,284).

Current-year 2019 state policies on financial protection for spouses of Medicaid beneficiaries who receive HCBS from Krause Financial Services (KFS), *State-Specific Medicaid Resources*, state data last updated Q1, 2019 through Q3, 2019 and AARP Public Policy Institute independent research on statutes for Medicaid HCBS waiver recipients receiving full income and asset protection. Baseline 2016 data are from the same source for Q4, 2015 through Q2, 2016.

KFS, *State-Specific Medicaid Resources* (De Pere, WI: Krauss Financial Services, 2015-16, 2019), https://www.medicaidannuity.com/resources/state-resources/.

State Assessment of Family Caregiver Needs. This policy addresses the extent to which a state conducts an assessment of family caregivers for their own needs when an older adult or adult with physical disabilities for whom they are caring is being assessed for one or more LTSS programs. Programs for which the caregiver assessment tool is used included: (1) 1915(c); (2) 1115 demonstration; (3) Medicaid state plan personal care services; (4) 1915(i); (5) 1915(j); (6) Medicaid state plan (k)—Community First Choice; (7) National Family Caregiver Support Program (OAA); (8) state-funded family caregiver support program; (9) state-funded HCBS; and (10) other.

Scoring: 1.0 point if a caregiver assessment is used in at least 1 of the 10 programs listed above for older adults and/or adults with physical disabilities for a maximum of 1.0 point. States are awarded 0.3 points for each additional program (up to 5 programs) beyond the first program linked to an assessment for a maximum of 1.5 points. Total allowable points states can be awarded for this component is 2.5 points.

Current year 2019 data from the LTSS Economic Survey, conducted jointly by the AARP Public Policy Institute and ADvancing States (unpublished). Baseline 2016 data from the AARP Public Policy Institute *LTSS State Scorecard* Survey (unpublished).

AARP PPI and ADvancing States, "LTSS Economic Survey" (unpublished, Washington, DC: AARP Public Policy Institute and Chrystal City, VA: ADvancing States, 2018-2019).

AARP PPI, "*LTSS State Scorecard* Survey" (unpublished, Washington, DC: AARP PPI, 2016).

CARE Act. States that passed Caregiver Advise, Record, Enable (CARE) Act legislation and Bill is signed into law. The CARE Act helps family caregivers from the moment their loved ones go into the hospital to when they return home. The CARE Act requires hospitals to: (1) Record the name of the family caregiver on the medical record of a loved one; (2) Inform the family caregivers when the patient is to be discharged; and (3) Provide the family caregiver with education and instruction of the medical tasks he or she will need to perform for the patient at home.

Scoring: States that pass CARE Act legislation and had a Bill signed into law received 1.0 point.

Current year 2019 data obtained from AARP State Advocacy & Strategy Integration internal communications. Baseline 2016 data are from the same source.

AARP State Advocacy & Strategy Integration unpublished internal communications, 2016, 2019.

20 Nurse Delegation and Scope of Practice: (maximum possible score 5.0):

This indicator is constructed with two policies:

Number of Health Maintenance Tasks Able to be Delegated to LTSS Workers (out of 16 tasks):

The number of 16 tasks that can be performed by a direct care aide through delegation by a registered nurse:

Medication Administration	**Tube Feeding and Gastric Care**
1. Oral medication	10. Gastrostomy tube feeding
2. PRN medication	11. Administer enema
3. Pre-filled insulin/insulin pen	**Bladder Regimen and Skin/Appliance Care**
4. Draw up insulin	12. Perform intermittent catheterization
5. Other injectable medication	13. Perform ostomy care including skin care and changing appliance
6. Glucometer testing	**Respiratory Care**
7. Medication through tubes	14. Perform nebulizer treatment
8. Insertion of suppositories	15. Administer oxygen therapy
9. Eye/ear drops	16. Perform ventilator respiratory care

Scoring: States received 0.25 points for each of the 16 health maintenance tasks that can be delegated by a registered nurse to an LTSS direct care worker for a total of 4.0 points.

Current-year 2019 data collected from AARP Public Policy Institute survey on nurse delegation in home settings. 2016 data was repeated for three states (Hawaii, Indiana, and Nevada) that did not respond to the 2019 survey on nurse

delegation. Baseline 2016 data from the AARP Public Policy Institute 2016 survey on nurse delegation in home settings. AARP interpreted 2016 state Board of Nursing regulations for twelve states that did not respond to the survey on nurse delegation (Delaware, District of Columbia, Indiana, Kentucky, Louisiana, Michigan, Mississippi, Montana, New Mexico, Oklahoma, Texas, and Utah). Due to data limitations, 2013 data was repeated in 2016 for South Carolina.

AARP PPI, "Survey on Nurse Delegation in Home Settings" (unpublished, Washington, DC: AARP Public Policy Institute, 2016, 2019).

Nurse Practitioner Scope of Practice: This policy addresses the extent to which state practice and licensure laws permit a nurse practitioner (NP) to be able to practice to the fullest extent of his or her education and training. Scope of practice includes three levels of authority: (a) Under full practice authority, the NP is permitted to evaluate patients, diagnose, order, and interpret diagnostic tests, initiate and manage treatments, and prescribe medications; (b) Reduced practice requires a collaborative practice agreement with a physician specifying the scope of practice allowed; and (c) Restricted practice requires a physician to oversee all care provided by the NP.

Scoring: States that permit full scope of practice received 1.0 point, states that permit reduced scope of practice received 0.5 points, and states that have restricted practice received 0 points.

Current year 2019 data from AARP Public Policy Institute analysis of nurse practitioner state practices, American Association of Nurse Practitioners, *Nurse Practitioner State Practice Environment*. Baseline 2016 data from same source.

American Association of Nurse Practitioners (AANP), *Nurse Practitioner State Practice Environment* (Austin, TX: American Association of Nurse Practitioners, 2016, 2019), https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment.

21 Transportation Policies (maximum possible score 1.0):

Transportation policies that support family caregivers include volunteer driver policies.

Volunteer driver polices (current year 2019, baseline 2015-2016): Protection from insurance cancelation, or unreasonable or unfair if the state had a policy.

Scoring: States with volunteer driver policies received 1.0 point, and states that did not have a policy received 0 points.

Jana Lynott (AARP, Public Policy Institute), Johanna Zmud, Gretchen Stoeltje, Todd Hansen, Tina Geiselbrecht, Chris Simek, Ben Ettelman (Texas A&M Transportation Institute), and Wendy Fox-Grage, *Volunteer Driver Insurance in the Age of Ridehailing* (Washington, DC: AARP Public Policy Institute, publication forthcoming).

ITN America/AARP PPI (2016 analysis of data from ITN America, 50 state Policy Project, http://policy.itnamerica.org/?page_id=2881.

22 Percentage of Nursing Home Residents with Low Care Needs:

This is the percentage of nursing home residents ages 65+ who met the criteria of having low care needs. Low care status is met if a resident does not require physical assistance in any of the four late-loss ADLs (bed mobility, transferring, using the toilet, and eating) and is not classified in either the "Special Rehab" or "Clinically Complex" Resource Utilization Group (RUG-IV). Low care status may apply to a resident who is also classified in either of the lowest 2 of the 44 RUG-IV groups. Analysis of 2017 MDS 3.0 state-level care data as reported in LTCFocUS.org, by V. Mor at Brown University.

As of February 2020, data for 2016 and 2017 for this measure on LTCFocUS.org are not consistent with previous years, mostly likely due to a change in the details of the calculation.

Brown University (2017). Changing Long Term Care in America Project at Brown University funded in part by the National Institute on Aging (1P01AG027296). Providence, RI: Brown University School of Public Health, http://ltcfocus.org/.

23 Percentage of Home Health Patients with a Hospital Admission:

This is the percentage of home health stays for patients who have a Medicare claim for an unplanned admission to an acute care hospital during the 60 days following the start of the home health stay.

Current year 2017 national and state-level data for how often home health patients had to be admitted to the hospital are from CMS, Home Health Compare, Data Archive, 2018 Annual Files, for January – December 2017. Baseline 2015 data are from 2015 Annual Files from the same source for January – December 2014.

Prior *Scorecards* used a different measure of home health hospital admissions that is no longer being calculated or reported.

CMS, Home Health Compare, Data Archive, (Baltimore, MD: US Department of Health & Human Services, archive dates 10/8/2015 and 10/24/2018), https://data.medicare.gov/data/archives/home-health-compare.

24 Percentage of Long-Stay Nursing Home Residents Hospitalized within a Six-Month Period:

This is the percent of long-stay residents (residing in a nursing home for at least 90 consecutive days) who were ever hospitalized within six months of baseline assessment. Residents were excluded if they did not have continuous Medicare fee-for-service coverage for the six month evaluation period.

The study population was identified using data from MDS 3.0, which captures data on nursing home resident assessments, and Master Beneficiary Summary File, Part A-Medicare Inpatient Claims data between January 1, 2016 and December 31, 2016 (current year); and January 1, 2014 and December 31, 2014 (baseline year.)

The national percentage was not provided in the source data. The US rate was estimated by the average of state rates, weighted by the total nursing home population in each state.

Brown University (2014, 2016). Changing Long-Term Care in America Project at Brown University funded in part by the National Institute on Aging (1P01AG027296). Providence, RI: Brown University School of Public Health, http://ltcfocus.org/.

25 Percentage of Nursing Home Residents with One or More Potentially Burdensome Transitions at End of Life:

This is the percentage of nursing home decedents who had at least one potentially burdensome transition at end of life. A potentially burdensome transition is defined as:

Any transfer in the last 3 days of life;

A lack of continuity of a nursing home before and after a hospitalization in the last 120 days of life (i.e., going from nursing home A to the hospital and then to nursing home B);

Three or more hospitalizations in the last 90 days of life;

Two or more hospitalizations for dehydration in the last 120 days of life;

Two or more hospitalizations for pneumonia in 120 days; and

Two or more hospitalizations for septicemia in the last 120 days of life.

This definition and the details of the data analysis differ slightly from the definition used in previous *Scorecards*. The study population was identified using data from MDS 3.0, Medicare Beneficiary Summary File, Medicare Medpar records, which captures data on nursing home resident assessments, and Medicare claims data between January 1, 2016 to December 31, 2016 (current year) and January 1, 2013 to December 31, 2013 (baseline year). Subject eligibility criteria included the following: (1) insured by Medicare fee-for-service; (2) a resident of a nursing home within 120 days prior to death; and (3) ages 66+.

Brown University (2013, 2016). Changing Long-Term Care in America Project at Brown University funded in part by the National Institute on Aging (1P01AG027296). Providence, RI: Brown University School of Public Health. http://ltcfocus.org/.

26 Percentage of Short-Stay Residents Who Were Successfully Discharged to the Community:

This is a claims-based outcome measure of the proportion of Medicare beneficiaries, ages 18+, who successfully discharged to the community from a post-acute care (PAC) skilled nursing facility (SNF) and had no unplanned rehospitalizations and no death in the 31 days following discharge. Community is defined as home or self-care, with or without home health services, based on Patient Discharge Status Codes 01, 06, 81, and 86 on the Medicare FFS claim.

Only PAC stays that are preceded by a short-term acute care stay in the 30 days prior to the PAC admission date are included in the measure. Stays ending in transfers to the same level of care are excluded.

Previous *Scorecards* used two measures of transition to and from a nursing home, designed by AARP and Mathematica, and calculated by Mathematica. We are replacing these with a single publicly reported measure in order to align with data that are more readily available and enable comparison to other time periods and levels of analysis (facilities, counties, etc).

Data are from Skilled Nursing Facility Quality Reporting Program, Medicare Fee-for-Service Claims data, 4/1/2017 – 3/31/2018, file date 2/1/2019.

CMS, Medicare Fee-for-Service Claims (2019). Centers for Medicare & Medicaid Services, *Medicare Fee-for-Service Claims QM 523,* 4/1/2017 – 3/31/2018, file date 2/1/2019, accessed on Nursing Home Compare in July 2019. Baltimore, MD: US Department of Health & Human Services. https://data.medicare.gov/data/nursing-home-compare?sort=relevance&tag=quality%20measures.

Exhibit B5 Detailed Indicator Data: Supporting Working Caregivers (State and Local Policy-Level Details)

States and Localities with Laws that Protect Family Caregivers from Employment Discrimination

The information provided below includes states that received points for having statewide or local laws that protect family caregivers from employment discrimination. States received points for the extent to which a state (or locality) law expressly includes family responsibilities, including care provided to aging parents or family members with an illness or disability, as a protected classification in the context that prohibits discrimination against employees who have family responsibilities.

In the *2020 LTSS State Scorecard*, states with laws that expressly prohibit employment discrimination against family caregivers receive 2.0 points. States with one or more localities that have laws that protect working family caregivers receive 0.60 points. State and local laws that do not expressly define their key term leave room to interpret those laws to protect family caregivers from employment discrimination. States receive 1.0 point for statewide laws with undefined key terms; 0.30 points are given to states with one or more localities with laws having undefined key terms.

Information also includes a list of localities for each state that received points for localities that enacted local legislation and a summary of state and local laws that define key terms—*family responsibilities, family status, familial status*, and *caregiver*—that can protect working family caregivers of older people and adults with disabilities from employment discrimination.

Arizona (0.30 points)

- Local law: Buckey, Tolleson—Local laws do not define familial status.

California (0.60 points)

- Local law: San Francisco—Caregiver is defined to include care for a parent of the employee who is age 65 or older and other adult family members who have serious health conditions. Family is defined as related by blood or marriage, and includes spouse, partner, parent, sibling, and grandparent. Caregiver coverage includes caregivers of own parents over age 65 and adult family members who have a serious health condition.

Colorado (0.30 points)

- Local law: Crested Butte, Telluride—Local laws do not define familial status.

Connecticut (1.00 point)

- Statewide law—Law does not define family responsibility.

Delaware (2.00 points)

- Statewide law—Family responsibility is defined as caring for family members who would be covered under the federal Family Medical Leave Act (FMLA), so siblings, in-laws, grandparents, and unmarried partners are not included. Caregiver coverage includes caregivers of own spouse and own parent and children with a serious health condition.

District of Columbia (2.00 points)

- Districtwide law—Family responsibilities is defined as contributing to the support of a person in a dependent relationship. City regulations clarify that the person may be related by blood, legal custody, or marriage, or may be someone who shares a residence and maintains a domestic partnership. Caregiver coverage includes caregivers for a spouse and adult family members, including own parent.

Florida (0.60 points)

- Local law: Monroe County—Familial status means the status of "…living alone or in any familial relationship whatsoever, including, but not limited to, living with a

partner… , and of living with one or more dependents, whether minor or disabled children or parents." Caregiver coverage includes caregivers of adult family members.

Illinois (0.60 points)

- Local laws: Champaign, Urbana—Family responsibilities is defined as contributing to the support of a person in a dependent relationship. Caregiver coverage includes caregivers of dependent family members, including own parent and adult family members.

Indiana (0.30 points)

- Local laws: Valparaiso, Zionsville—Local laws do not define familial status.

Iowa (0.60 points)

- Local law: Grinnell—Familial status is defined as living with minor children or living with and caring for another adult with physical or mental disabilities. Caregiver coverage includes caregivers of adults with disabilities who reside in the same home as the caregiver.

Kansas (0.60 points)

- Local law: Mission—Familial status is defined as adults who are spouses, parents, and children, and "persons who are presently residing together or have resided together in the past." Caregiver coverage includes caregivers of people who have certain family relationships, including own parent and adult family members.

Kentucky (0.30 points)

- Local law: Paducah—Local law does not define familial status.

Maine (0.30 points)

- Local laws: Bangor, Orano—Local laws do not define family status.

Maryland (0.60 points)

- Local law: Montgomery County—Family responsibilities is defined as being financially or legally responsible for the support or care of a person. Caregiver coverage includes caregivers of others, including own parents and adult family members.

Michigan (0.60 points)

- Local laws: Adrian, Albion, Ann Arbor, Battle Creek, Canton Charter Township, Farmington Hills, Fenton, Howell, Jackson, Kalamazoo, Lansing, Marquette, Mount Pleasant, Oshtemo, Portage, Royal Oak, Trenton, Ypsilanti—Local laws define family status and family responsibilities. Caregiver coverage includes caregivers of family members, including own parents and adult family members.

New Jersey (0.60 points)

- Local law: East Orange—Family status is defined as being in a family, which means a spouse, sibling, parent, child, or other near relative who lives with the employee, and a nonrelative under certain circumstances. Caregiver coverage includes caregivers of family members, including own parents and adult family members, who live together.

New Mexico (0.30 points)

- Local law: Angel Fire—Local law does not define familial status.

New York (0.60 points)

- Local law: New York City—Caregiver status is defined as providing direct and ongoing care for a care recipient, which is defined as a person with a disability who is a covered relative or who lives with the employee and relies on the employee for medical care or the needs of daily living. Covered relatives include spouse, partner, parent, sibling, grandparent, parents of the employee's spouse or partner, or any other individual in a familial relationship with the employee. Caregiver coverage includes caregivers of family members, including own parents and adult family members, and others who live with the employee and who have a disability and rely on the employee for care.

Ohio (0.30 points)

- Local laws: Bowling Green, Kent, New Carlisle, Olmsted Falls, St. Clairsville—Local laws do not define familial status.

Oklahoma (0.30 points)

- Local laws: Mounds, Norman, Okmulgee—Local laws do not define familial or family status.

Oregon (0.30 points)

- Local laws: Beaverton, Corvallis, Hillsboro, Salem, Springfield, Benton County, Multnomah County—Local laws do not define familial status.

Pennsylvania (0.60 points)

- Local law: Philadelphia—Familial status is defined as providing care or support to a family member. Family members include spouses, partners, parents, grandparents, siblings, and in-laws. Caregiver coverage includes caregivers of family members, including own parents and adult family members.

Texas (0.30 points)

- Local law: Fulton—Local law does not define familial status.

Wisconsin (0.60 points)

- Local laws: De Pere, Racine—Family status is defined as a household containing one or more minor or adult relatives (note: this definition may apply to housing, but no other definition is provided for employment). Caregiver coverage includes caregivers of adult relatives, including own parents and adult family members, who live together.

The Extent to Which States Exceeded Federal Requirements under the Family and Medical Leave Act

The information provided below includes states that exceeded federal Family and Medical Leave Act (FMLA) requirements for covered employers, covered employee eligibility, length of leave, and type of leave allowed. States received points for the degree to which they exceeded the federal FMLA requirements, up to a total of 4.0 possible points, as follows:

Covered employers:

15 or fewer employees (1.0 point) |16 to 30 employees (0.50 points)

Covered employee eligibility (time with employer):

Less than 1,000 hours or 6 months of work with no minimum hours (1.0 point) | 1,000 hours over a 12-month work period (0.50 points)

Type of leave (covered "family member" relationships):

Parent-in-law | Sibling | Grandparent | Grandparent-in-law (0.25 points each, up to a total of 1.0 point)

Length of leave:

16 weeks over 2 years (1.0 point) | 12 to 15 weeks over 2 years (0.50 points)

Connecticut (1.75 points)

- Time with employer (0.50 points)—1,000 hours over a 12-month work period
- Covered relationships (0.25 points)—Parent-in-law
- Length of leave (1.0 point)—16 weeks of leave over a 24-month period

District of Columbia (3.00 points)

- Covered employers (0.50 points)—20 or more employees
- Time with employer (0.50 points)—1,000 hours over a 12-month work period
- Covered relationships (1.0 point)—Parent-in-law, sibling, grandparent, grand-parent-in-law

- Length of leave (1.0 point)—16 weeks of leave over a 24-month period

Hawaii (2.00 points)

- Time with employer (1.0 point)—More than 6 consecutive months of service with employer
- Covered relationships (1.0 point)—Parent-in-law, sibling, grandparent, grandparent-in-law

Maine (1.25 points)

- Covered employers (1.0 point)—15 or more employees
- Covered relationships (0.25 points)—Sibling

Minnesota (0.50 points)

- Covered relationships (0.50 points)—Sibling, grandparent

New Jersey (1.75 points)

- Covered employers (0.50 points)—30 or more employees
- Time with employer (0.50 points)—1,000 hours over a 12-month work period
- Covered relationships (0.75 point)—Parent-in-law, sibling, grandparent

Oregon (2.00 points)

- Covered employers (0.50 points)—25 or more employees
- Time with employer (1.0 point)—900 hours of service (36 weeks, minimum 25 hours per week)
- Covered relationships (0.50 points)—Parent-in-law, grandparent

Rhode Island (0.50 points)

- Length of leave (0.50 points)—13 weeks of leave over a 2-year period

Vermont (1.25 points)

- Covered employers (1.0 point)—15 or more employees
- Covered relationships (0.25 points)—Parent-in-law

Wisconsin (0.75 points)

- Time with employer (0.50 points)— 1,000 hours over a 12-month work period
- Covered relationships (0.25 points)—Parent-in-law

The Extent to Which States Offer Mandatory Paid Family Leave

The information provided below includes states that received points for extending benefits beyond FMLA to family caregivers. States received points for the extent to which state laws require employers to provide mandatory paid family leave, up to a total of 4.0 possible points, as follows:

Statewide paid family leave law:

Statewide law enacted and effective (1.0 point) | ½ credit if statewide law enacted but not effective until after 6/2020 (0.50 points)

Covered employers:

15 or fewer employees (1.0 point) | ½ credit if law not effective until after 6/2020 (0.50 points) | 16 to 30 employees (0.50 points) | ½ credit if law not effective until after 6/2020 (0.25 points)

Type of leave (covered "family member" relationships):

Parent-in-law | Sibling | Grandparent | Grandparent-in-law (0.25 points each, up to a total of 1.0 point) | ½ credit if law not effective until after 6/2020 (0.125 to 0.50 points)

Length of leave:

10 or more weeks of leave (1.0 point) | ½ credit if law not effective until after 6/2020 (0.50 points) | less than 10 weeks (0.50 points) | ½ credit if law not effective until after 6/2020 (0.25 points)

California (3.25 points)

- Statewide law (1.0 point)—Effective
- Covered employers (1.0 point)—All private-sector employers
- Covered relationships (0.75 points)—Parent-in-law, sibling, grandparent
- Length of leave (0.50 points)—8 weeks of leave

Connecticut (2.00 points)

- Statewide law (0.50 points)—Law enacted (becomes effective 1/1/21)
- Covered employers (0.50 points)—All private-sector employers (law effective 1/1/21)
- Covered relationships (0.50 points)—Parent-in-law, sibling, grandparent, grandparent-in-law (law effective 1/1/21)
- Length of leave (0.50 points)—Up to 12 weeks of leave (law effective 1/1/21)

District of Columbia (3.50 points)

- Statewide law (1.0 point)—Effective
- Covered employers (1.0 point)—All private-sector employers
- Covered relationships (1.0 point)—Parent-in-law, sibling, grandparent, grandparent-in-law
- Length of leave (0.50 points)— 6 weeks of leave

Massachusetts (3.25 points)

- Statewide law (1.0 point)—Effective
- Covered employers (0.50 points)—25 or more employees
- Covered relationships (0.75 points)—Parent-in-law, sibling, grandparent
- Length of leave (1.0 point)—12 weeks of leave

New Jersey (2.50 points)

- Statewide law (1.0 point)—Effective
- Covered employers (0.50 points)—30 or more employees
- Length of leave (1.0 point)—12 weeks of leave

New York (3.50 points)

- Statewide law (1.0 point)—Effective
- Covered employers (1.0 point)—All private-sector employers
- Covered relationships (0.50 points)—Parent-in-law, grandparent
- Length of leave (1.0 point)—10 weeks of leave

Oregon (1.50 points)

- Statewide law (0.50 points)—Law enacted (becomes effective 2023)
- Covered employers (0.25 points)—25 or more employees (law effective 2023)
- Covered relationships (0.25 points)—Parent-in-law, sibling (law effective 2023)
- Length of leave (0.50 points)—12 weeks of leave (law effective 2023)

Rhode Island (2.75 points)

- Statewide law (1.0 point)—Effective
- Covered employers (1.0 point)—All private-sector employers
- Covered relationships (0.25 points)—Grandparent
- Length of leave (0.50 points)—4 weeks of leave

Washington (3.50 points)

- Statewide law (1.0 point)—Effective
- Covered employers (1.0 point)—All private-sector employers
- Covered relationships (0.50 points)—Sibling, grandparent
- Length of leave (1.0 point)—12 weeks of leave

The Extent to Which States Offer Mandatory Paid Sick Days

The information provided below includes states that received points for extending benefits beyond FMLA to family caregivers. States received points for the extent to which state laws require employers to provide mandatory paid sick days, up to a total of 3.0 possible points, as follows:

Statewide paid sick leave law:

Statewide law enacted and effective (1.0 point) | ½ credit if statewide law enacted but not effective until after 6/2020 (0.50 points)

Covered employers:

Fewer than 10 employees (1.0 point) | ½ credit if law not effective until after 6/2020 (0.50 points) | 10 to 49 employees (0.50 points) | ½ credit if law not effective until after 6/2020 (0.25 points)

Amount of annual accrued leave:

40 or more hours of leave (1.0 point) | ½ credit if law not effective until after 6/2020 (0.50 points) | Less than 40 hours (0.50 points) | ½ credit if law not effective until after 6/2020 (0.25 points)

Arizona (2.00 points)

- Statewide law (1.0 point)—Effective
- Covered employers (0.50 points)—15 or more employees
- Amount of annual accrued leave (0.50 points)—Less than 40 hours of leave

California (2.50 points)

- Statewide law (1.0 point)—Effective
- Covered employers (1.0 point)—Any number of employees
- Amount of annual accrued leave (0.50 points)—Less than 40 hours of leave

Connecticut (2.00 points)

- Statewide law (1.0 point)—Effective
- Covered employers (0 points)—50 or more employees
- Amount of annual accrued leave (1.0 point)—40 or more hours of leave

District of Columbia (2.00 points)

- Statewide law (1.0 point)—Effective
- Covered employers (0.50 points)—25 or more employees
- Amount of annual accrued leave (0.50 points)—Less than 40 hours of leave

Illinois (2.00 points)

- Statewide law (0 points)—Not statewide
- Covered employers (1.0 point)—Any number of employees
- Amount of annual accrued leave (1.0 point)—40 or more hours of leave

Maine (1.50 points)

- Statewide law (0.50 points)—Enacted "paid personal time off" (law effective 1/1/21)
- Covered employers (0.50 points)—10 or more employees (law effective 1/1/21)
- Amount of annual accrued leave (0.50 points)—40 or more hours of leave (law effective 1/1/21)

Maryland (2.50 points)

- Statewide law (1.0 point)—Effective
- Covered employers (0.50 points)—15 or more employees
- Amount of annual accrued leave (1.0 point)—40 or more hours of leave

Massachusetts (2.50 points)

- Statewide law (1.0 point)—Effective
- Covered employers (0.50 points)—11 or more employees
- Amount of annual accrued leave (1.0 point)—40 or more hours of leave

Michigan (2.00 points)

- Statewide law (1.0 point)—Effective
- Covered employers (0 points)—50 or more employees
- Amount of annual accrued leave (1.0 point)—40 or more hours of leave

Minnesota (2.00 points)

- Statewide law (0 points)—Not statewide
- Covered employers (1.0 point)—Fewer than 10 employees
- Amount of annual accrued leave (1.0 point)—40 or more hours of leave

Nevada (2.00 points)

- Statewide law (1.0 point)—Effective
- Covered employers (0 points)—50 or more employees
- Amount of annual accrued leave (1.0 point)—40 or more hours of leave

New Jersey (3.00 points)

- Statewide law (1.0 point)—Effective
- Covered employers (1.0 point)—Any number of employees
- Amount of annual accrued leave (1.0 point)—40 or more hours of leave

New Mexico (1.50 points)

- Statewide law (0 points)—Not statewide
- Covered employers (1.0 point)—Fewer than 10 employees
- Amount of annual accrued leave (0.50 points)—Less than 40 hours of leave

New York (2.00 points)

- Statewide law (0 points)—Not statewide
- Covered employers (1.0 point)—5 or more employees
- Amount of annual accrued leave (1.0 point)—40 or more hours of leave

Oregon (2.50 points)

- Statewide law (1.0 point)—Effective
- Covered employers (0.50 points)—10 or more employees
- Amount of annual accrued leave (1.0 point)—40 or more hours of leave

Pennsylvania (1.50 points)

- Statewide law (0 points)—Not statewide
- Covered employers (0.50 points)—10 or more employees
- Amount of annual accrued leave (1.0 point)—Up to 40 hours of leave

Rhode Island (2.50 points)

- Statewide law (1.0 point)—Effective
- Covered employers (0.50 points)—18 or more employees
- Amount of annual accrued leave (1.0 point)—40 or more hours of leave

Texas (1.50 points)

- Statewide law (0 points)—Not statewide
- Covered employers (0.50 points)—15 or more employees
- Amount of annual accrued leave (1.0 point)—40 or more hours of leave

Vermont (3.00 points)

- Statewide law (1.0 point)—Effective
- Covered employers (1.0 point)—Any number of employees
- Amount of annual accrued leave (1.0 point)—40 or more hours of leave

Washington (3.00 points)

- Statewide law (1.0 point)—Effective
- Covered employers (1.0 point)—Any number of employees
- Amount of annual accrued leave (1.0 point)—40 or more hours of leave

The Extent to Which States Offer Flexible Use of Sick Time

The information provided below includes states that received points for extending benefits beyond FMLA to family caregivers. States received points for the extent to which state laws require employers to provide flexible use of sick time, up to a total of 3.0 possible points, as follows:

Covered employers:
15 or fewer employees (1.0 point) | 16 to 30 employees (0.50 points)

Type of leave (covered "family member" relationships):

Parent-in-law | Sibling | Grandparent | Grandparent-in-law (0.25 points each, up to a total of 1.0 point)

Amount of available time:

10 or more days of available time (1.0 point) | Less than 10 days (0.50 points)

Arizona (2.25 points)

- Covered employers (1.0 point)—15 or more employees
- Covered relationships (0.75 points)—Parent-in-law, sibling, grandparent
- Amount of available time (0.50 points)—Less than 10 days

California (2.25 points)

- Covered employers (1.0 point)—Any number of employees
- Covered relationships (0.75 points)—Parent-in-law, sibling, grandparent
- Amount of available time (0.50 points)—Less than 10 days

Connecticut (1.00 point)

- Covered employers (0 points)—75 or more employees
- Covered relationships (0 points)—Not applicable
- Amount of available time (1.0 point)—10 or more days

District of Columbia (2.00 points)

- Covered employers (0.50 points)—25 or more employees
- Covered relationships (1.0 point)—Parent-in-law, sibling, grandparent, grandparent-in-law
- Amount of available time (0.50 points)—Less than 10 days

Georgia (1.25 points)

- Covered employers (0.50 points)—25 or more employees
- Covered relationships (0.25 points)—Grandparent
- Amount of available time (0.50 points)—Less than 10 days

Hawaii (2.00 points)

- Covered employers (0 points)—100 or more employees
- Covered relationships (1.0 point)—Parent-in-law, sibling, grandparent, grandparent-in-law
- Amount of available time (1.0 point)—10 or more days

Illinois (2.25 points)

- Covered employers (1.0 point)—Any number of employees
- Covered relationships (0.75 points)—Parent-in-law, sibling, grandparent
- Amount of available time (0.50 points)—Less than 10 days

Maine (1.00 points)

- Covered employers (0.50 points)—25 or more employees
- Covered relationships (0 points)—Not applicable
- Amount of available time (0.50 points)—Less than 10 days

Maryland (2.00 points)

- Covered employers (1.0 point)—15 or more employees
- Covered relationships (0 points)—Not applicable
- Amount of available time (1.0 point)—10 or more days

Massachusetts (1.75 points)

- Covered employers (1.0 point)—Any number of employees
- Covered relationships (0.25 points)—Parent-in-law
- Amount of available time (0.50 points)—Less than 10 days

Michigan (1.00 point)

- Covered employers (0 points)—50 or more employees
- Covered relationships (0.50 points)—Sibling, grandparent
- Amount of available time (0.50 points)—Less than 10 days

Minnesota (2.25 points)

- Covered employers (0.50 points)—21 or more employees
- Covered relationships (0.75 points)—Parent-in-law, sibling, grandparent
- Amount of available time (1.0 point)—10 or more days

New Jersey (2.00 points)

- Covered employers (1.0 point)—Any number of employees
- Covered relationships (0.50 points)—Sibling, grandparent
- Amount of available time (0.50 points)—Less than 10 days

New Mexico (3.00 points)

- Covered employers (1.0 point)—Any number of employees
- Covered relationships (1.0 point)—Parent-in-law, sibling, grandparent, grandparent-in-law
- Amount of available time (1.0 point)—10 or more days

New York (2.00 points)

- Covered employers (1.0 point)—5 or more employees (law enacted only in New York City and Westchester County)
- Covered relationships (0.50 points)—Sibling, grandparent
- Amount of available time (0.50 points)—Less than 10 days

Oregon (2.00 points)

- Covered employers (1.0 point)—10 or more employees
- Covered relationships (0.50 points)—Parent-in-law, grandparent
- Amount of available time (0.50 points)—Less than 10 days

Rhode Island (1.75 points)

- Covered employers (0.50 point)—18 or more employees
- Covered relationships (0.75 points)—Parent-in-law, sibling, grandparent
- Amount of available time (0.50 points)—Less than 10 days

Vermont (2.25 points)

- Covered employers (1.0 point)—Any number of employees
- Covered relationships (0.75 points)—Parent-in-law, sibling, grandparent
- Amount of available time (0.50 points)—Less than 10 days

Washington (2.75 points)

- Covered employers (1.0 point)—Any number of employees
- Covered relationships (0.75 points)—Parent-in-law, sibling, grandparent
- Amount of available time (1.0 point)—10 days or more

Wisconsin (1.25 points)

- Covered employers (0 points)—50 or more employees
- Covered relationships (0.25 points)—Parent-in-law
- Amount of available time (1.0 point)—10 days or more

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