3/22/2016
Keystone Policy Center
Strategic Action Planning Group on Aging
DRAFT Literature Review – Part 2 of 5

Questions:

2. What states and regions have conducted aging studies since 2000?

State/Region	Date	Title	Summary/Key Recommendations
Alaska	2/2016	Alaska Commission on Aging FY 2015 Annual Report: Healthy Aging in Alaska – Alaska's Road Map to Successful Aging *44 pages - Skimmed*	• AK has the fastest growing population of people age 65 and older in the nation for six consecutive years and is projected to more than double by 2042 before declining. • AK's Roadmap to Address Alzheimer's Disease and Related Dementias is AK's first state plan that provides a comprehensive and coordinated approach to address the multiple and complex challenges that dementia presents in order to improve the quality of life (QOL) for Alaskans and their caregivers impacted by this condition. ○ Strategies include public education, potential State Medicaid Plan Amendments, identification of resources for people to remain in their own homes for as long as possible, quality standards for assisted living, dementia-care training and in-home respite care • Caregiving often exerts a heavy emotional, physical, and financial toll that puts family caregivers at risk, particularly those caring for loved ones with dementia. The cost of healthcare for caregivers in AK in 2014 was $27 million higher than for Alaskans who are not caregivers. Caregivers commonly experience mental health problems, especially depression. They also experience poorer physical health than non-caregivers and financial hardship due to caregiving demands. ○ Legislative recommendations include providing continued funding for Family Caregiver Support programs • States that invest more money in core senior services (such as home-delivered meal programs) spend less on higher cost health care for their elderly residents. ○ Legislative recommendations include maintaining funding for Nutrition, Transportation and Support Services

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			• Comparing SFY2010 to SFY2014, there has been a 110% increase in the total number of reports of harm received by Adult Protective Services (APS) regarding vulnerable adults and almost a four-fold increase (382%) in those involving seniors/elders. ○ Legislative recommendations include reforming AK's Power of Attorney law in order to provide improved protection of seniors from financial exploitation • The Senior Citizen Housing Development Fund (SCHDF), administered by Alaska Housing Finance Corporation (AHFC), is the one and only senior housing grant fund in AK. Since 1995, AHFC has competitively awarded SCHDF funds to nonprofit organizations and regional housing authorities to expand rental housing opportunities for AK seniors, providing financial support to fund more than 70 senior housing projects statewide with approximately 1,420 residential units.

Alaska	1/2011	Long-Term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2010-2030	• Long-term forecast of Medicaid program enrollment, utilization and spending from 2010 to 2030 (based on the Medicaid program as it currently exists with adjustments for some provisions of the ACA)
			• It is estimated that an additional 32,000 individuals will become eligible, and may enroll in Medicaid in 2014. The $220 million price tag for these individuals will be paid for entirely with federal funds.
			  ○ In 2017 the costs for these newly eligible individuals will start to be shifted to the state. The federal share will be 95% in 2017, 94% in 2018, and 93% in 2019.
			  ○ Starting in 2020, 90% of the costs for the newly-eligible enrollees will be paid by the federal government.
			  ○ By 2030, population growth will add another 3,000 individuals to the rolls, and the costs for the 35,000 newly-eligible individuals will cost a total of $570 million, with federal funds paying for $520 million and state general funds paying the remaining $50 million.

Arkansas	11/2014	Special Report Summary – Arkansas Department of Human Services (DHS): Community First Choice Option (CFCO)	This report provides an overview of the Home- and Community-Based (HCB) programs currently in place in the State. The level of risk associated with these programs was also discussed. Information regarding the proposed Community First Choice Option (CFCO) program was provided as well. DHS management's projections of HCB expenditures and

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		28 pages - Skimmed	calculated savings related to CFCO implementation were presented. Possible additional costs related to woodwork expenses (costs realized if implementation of CFCO entices some individuals who were already eligible for services to apply for CFCO) and loss of state revenue from reduced quality assurance fees collected from nursing homes and provider fees collected from intermediate care facilities were noted. Finally, the report provided a series of specific questions from members of the General Assembly and answers provided by DHS. • DHS projections indicate that, over the next 12 years, CFCO implementation would save the State $365.5 million compared to the cost of maintaining the status quo and $924.5 million compared to Olmstead enforcement.
Arkansas	12/2012	Choices in Living for Arkansans with Long-Term Care Needs Arkansas' Long-Term Care System: Planning for the Future *52 pages – Read Introduction*	The report lays out a number of policy recommendations to continue progress toward AR's goal of balancing the LTSS system through enhancing community-based services. **Priority Recommendations Requiring Executive and/or Legislative Action:** • Increase reimbursement rates for Personal Care, Targeted Case Management and selected ElderChoices services. Incorporate pay for performance (P4P) standards tied to reimbursement. • Dedicate $8,000,000 in General Improvement Funds for the development of affordable private assisted living facilities. • "Repurpose" unused or unoccupied nursing home (NH) beds by promoting nontraditional "Home-Style" facilities such as those found in the GreenHouse™ or similar small house models. • Use a portion of the $500,000 appropriated to Division of Medical Services (DMS) for "fast track" to include transition services, case management and other costs for individuals in institutions wishing to return to the community. • Amend ElderChoices and Alternatives 1915 (c) Medicaid waivers to include transition services allowed under current federal regulations. • Create an internal workgroup within DHS to determine which Money Follows the Person (MFP) Demonstration Services should be incorporated into Medicaid State Plan or waivers.

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			• Restructure the Governor's Integrated Services Taskforce to advise DHS on the implementation of this plan. • Proceed with piloting Service Options Using Resources in Community Environments (SOURCE), an enhanced case management program, in four counties. • Develop a DHS strategic plan to meet the HCBS needs of Arkansans with Traumatic Brain Injuries (TBI), including the feasibility of developing a TBI Medicaid waiver. • Review LTC Financing options (and organizational system design) to identify models that will enable the state to meet the future increase in demand for LTC services, including global budget, managed care and integrated service models, while improving care coordination and reducing the fragmentation of the LTC system. • Improve the use of technology in the delivery of HCBS. As a part of this initiative, an Information Technology Plan, which will facilitate access to HCBS and support quality improvement and quality assurance activities, will be developed and funded. • Develop performance standards to measure the progress made in balancing the state's LTC system. Additional recommendations: • Create a work group to address the LTC application process to ensure consumer choice and timely processing of LTC applications. • Coordinate with Partners in Planning (PIP) to make healthy aging a reality in AR through statewide interdisciplinary coordination and collaboration. • Develop models that integrate acute and chronic care. • Implement Administration on Aging (AOA) NH diversion programs. • Improve access to LTC information and assistance. • Educate consumers and families regarding LTC financing options. • Review Medicaid LTC functional eligibility criteria and procedures. • Improve Hospital Discharge Planning Process. • Enhance support services for informal caregivers. • Increase focus on health promotion and prevention interventions to reduce future need for LTC services. • Support Quality Improvement/Assurance Initiatives. • "Rightsizing" the NH industry/Addressing the Changing role of the NH industry

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			• Explore use of common functional assessment and care planning instruments in order to reduce the completion of duplicative assessments.
Arkansas	7/2011	Medicaid Savings Resulted when Community Health Workers Matched Those with Needs to Home and Community Care *9 pages – Read entirely*	• In 2005, AR Medicaid, with support from the Robert Wood Johnson Foundation (RWJF), funded the Tri-County Rural Health Network, a community-based nonprofit organization, to implement the Community Connector Program in a three-year (2005–08), three-county demonstration. • The program sought community health workers (CHWs) with at least a high school education, strong leadership skills, knowledge of the targeted communities, and ability to maintain a good relationship with the residents. • The CHWs identified Medicaid-eligible elderly and younger adults with physical disabilities who had potential unmet LTC needs. • CHWs screened the identified individuals for unmet LTC needs using self-reported characteristics and AR Medicaid's criteria for NH admission • People identified as being eligible for Medicaid but not enrolled were first referred to Medicaid for enrollment. Those identified as having unmet LTC needs were informed of available LTC options, including available HCBS, then connected to agencies offering such services. • CHWs followed up with those who were referred to agencies for services, and provided assistance to those having difficulty navigating the system. • The Community Connector Program screened 2,122 adults for their LTC needs in 2005–08. Among these, 69% were found to be in need of services. Of these 1,473 people, records for 63% of them were matched with records of Medicaid beneficiaries. • Annual Medicaid spending for program participants averaged $16,074 per person during the year before program participation. It increased to $19,174 per person during the last year of participation, resulting in an unadjusted increase of 19.3% over study period. In the matched comparison group, annual spending averaged $15,559 during the preprogram year and increased to $20,224 per person during the last year of participation, resulting in an unadjusted increase of 30% over the study period.

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			• Overall, spending on home health services and HCBS increased significantly in the intervention group relative to the comparison group, while spending on NH services increased significantly in the comparison group relative to the intervention group. • **Overall, the Community Connector Program produced total estimated savings of $3.5 million in Medicaid expenditures for 919 program participants during the demonstration period.** During this same period, the program incurred $896,000 in operational expenses, resulting in a net savings of $2.6 million for the Medicaid program, or a return on investment (ROI) of $2.92 per dollar invested in the program. • The Community Connector Program is the first US initiative designed to test a mechanism of identifying priority populations with unmet LTC needs, using the knowledge and skills of CHWs, and enabling people to gain access to HCBS. • This study suggests that CHWs can help states cost-effectively direct HCB LTC services to disabled and elderly residents who face elevated risks of entering NHs, particularly among underserved populations such as blacks and residents of rural areas.
California	2/2016	California Secure Choice Market Analysis, Feasibility Study and Program Design Consultant Services (Non-IT Services) RFP No. CSCRSIB03-14: Final Report to the California Secure Retirement Savings Investment Board *523 pages – Read first 16 pages (Executive Summary)*	<u>The key findings are the following:</u> 1. About 6.8 million workers are potentially eligible for the CA Secure Choice Retirement Savings Program. 2. Likely participation rates (70-90%) are sufficiently high to enable the Program to achieve broad coverage well above the minimum threshold for financial sustainability. 3. Eligible participants in CA are equally comfortable with a 3% or 5% contribution rate. The majority of likely participants are also comfortable with auto-escalation in 1% increments up to 10%. 4. To start, the program should offer a default investment option consisting of a diversified portfolio with LT growth potential and the choice to opt into a low-risk investment. 5. The Program launch should include a concerted public education campaign focused on workers and small businesses. **Financial Feasibility**

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			1. The Secure Choice Program is financially viable and self-sustaining even under adverse conditions with poor investment returns and high opt-outs rates. 2. Total fees to participants need not exceed 1% of invested assets and such fees can decline to significantly lower levels after the first 5 years of operation, making the Program very attractive for savers. 3. Under the conservative assumptions of the Baseline Scenario, with a default contribution rate of 5% and an opt-out rate of 25%, the Program achieves significant scale by the first year of operation with 1.6 million participants and over US $3 billion in assets. It also achieves operational breakeven by the fourth year of operation. 4. Even under the adverse conditions of the Pessimistic Scenario, program expenses fall below 1% of program assets by the fifth year of operation. The funding gap rises to a still manageable US $129 million representing 2.7% of program assets by Year 2, 1.7% by Year 3, 1.2% by Year 4 and 0.9% by Year 5. 5. The sensitivity analysis performed demonstrated that financing requirements and program expense ratios are very sensitive to the default contribution rate, but the opt-out rate has a small to moderate impact below 50% and even extreme opt-out rates exceeding 80% do not materially impact the financial sustainability of the Program. 6. Because most Program operating expenses consist of employee and employer per unit costs, employer-level participation rates do not meaningfully impact Program financial feasibility. <u>Key recommendations</u> **Financial Feasibility** 1. Structure the California Secure Choice Program along the lines of the Baseline Scenario in terms of the default contribution rate (5%) and a record-keeper direct service model. 2. Make provisions for obtaining startup financing through a line of credit or loan (best option), through vendor financing (less attractive option), through higher fees to participants (undesirable option) or as a combination of the above.
California	1/2016	California Secure Choice Retirement Savings Program: Legislative Criteria	In 2012, SB 1234 and SB 923 laid the groundwork for the CA Secure Choice Retirement Savings Investment Program by authorizing a feasibility study and market analysis. The

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		Must be Met Before Planning Can Proceed *3 pages – Read entirely*	program, for private sector employees, would be funded by an automatic payroll deduction. If implemented, the program would create a state-run retirement savings plan for private employees that includes automatic enrollment with an opt-out provision for an estimated 6.3 million CA workers whose employers do not currently offer a retirement savings program. Private employers with five or more employees would be required to provide access to and make payroll deductions for retirement accounts offered through the program. Certain federal approvals must be granted in order for the program to go forward. The board must be assured by the Internal Revenue Service and the U.S. Department of Labor (DOL) in advance to request that contributions made by employees be on a pre-tax basis, and that no part of the program is subject to the Employee Retirement Income Security Act of 1974 (ERISA). Secure Choice may proceed only if the following criteria are met: • Retirement accounts must qualify for the favorable federal tax treatment ordinarily granted Individual Retirement Accounts (IRAs) under the federal Internal Revenue Code. • The program must not be considered an employee benefit plan under ERISA. • The program must create no liability for the state or for employers. The study is anticipated to be final and recommendations made to the board in early 2016.
California	10/2013	Long-Term Care Integration (LTCI) Strategic Plan for San Francisco *208 pages - Skimmed*	**RECOMMENDATIONS:** CA has established the Cal MediConnect Pilot Project, which focuses on individuals who are full benefit Medicare and Medi-Cal beneficiaries ("dual eligibles"). The three-year project will combine all health services (medical, BH, HCBS, and LTSS) into a single benefit package, which will be delivered through a coordinated system. A capitated payment model will be used to provide both Medicare and Medi-Cal benefits through the state's existing network of Medi-Cal Health Plans. This pilot project will initially launch in 2014 with eight approved demonstration counties.

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			Expansion from the original eight counties cannot begin without Legislative approval. The state's goal is to expand to eight additional demonstration counties (which may include San Francisco), with full statewide implementation to begin after that. Since additional legislation is needed, the most likely timeframe for CCI expansion to San Francisco is 2016.
California	12/2012	Medicaid and Medicare Spending on Acute, Post-Acute and Long-Term Services and Supports in California *37 pages – Read Introduction and Discussion Sections*	The report presents findings on Medicaid and Medicare spending by creating a dataset that links Medicare claims, Medi-Cal claims, and Medi-Cal assessment data for recipients of LTSS in CA. To assist policymakers in targeting programmatic interventions and better identifying opportunities for cost containment, this report describes the categories of services with high and low relative costs. Specifically, the report shows Medi-Cal and Medicare spending on LTSS beneficiaries in three categories: acute and other medical care, post-acute care, and LTSS. This multi-year project's key findings were: ○ Total Medi-Cal LTSS spending per recipient was $14,445 in 2008. ○ LTSS spending on people who are dually eligible for Medicare and Medicaid coverage was $15,541, compared with $10,950 for Medi-Cal-only recipients (a 42% difference). ○ Spending on acute and other medical care was the largest category of spending for LTSS recipients in 2008, with average per capita spending at $29,220. • Medicare paid 83% of this total. • About 52% of all LTSS spending was for HCBS, and per recipient spending on NFs was 3x higher than for HCBS ($32,406 for nursing facility care versus $9,129 for HCBS). ○ **The study concludes that the high investment in HCBS in California is a promising foundation upon which to increase HCBS further to potentially reduce institutional services and avoidable hospitalizations.**
California	8/2012	Can a Publicly Sponsored Retirement Plan for Private Sector Workers Guarantee Benefits at No Risk to the State?	**HIGHLIGHTS** The CA legislature is currently considering SB 1234, a bill that would create the CA Secure Choice Retirement Savings Trust—a state-sponsored retirement plan for private sector workers who lack access to a workplace plan. Although the plan would technically be a

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		24 pages - Skimmed	defined-contribution (DC) program based on an individual retirement account (IRA) platform, assets would be managed in a pooled fund and workers would be guaranteed a rate of return on their contributions, insured by private underwriters rather than the state. This Policy Brief broadly assesses the feasibility of such a plan by analyzing the private cost of guarantees, probable investment returns simulated through a hypothetical pension investment portfolio, and the long-term funded status of a hypothetical pension plan given conservative assumptions. 1. Experts agree that while government is in the best position to insure DC plans, the private financial market can also insure benefit guarantees—for a price. The question is how much insurance is optimal in terms of costs and benefits. 2. Based on a hypothetical conservative portfolio split 50/50 between equities and bonds/treasuries, a publicly sponsored retirement plan is likely to generate an average annual real rate of return over the long term of 5% real (i.e., after inflation), with very little risk of the rate dropping below 2.3% over a 30-year period, or below 2.9% over a 50-year period. 3. Results from a plan model based on conservative assumptions indicate that a hypothetical state-sponsored retirement plan with a modest minimum return guarantee would be fully funded or over-funded during its first 40 years of operation.
California	7/2010	Aging in Pace: The Case for California Expansion *25 pages - Skimmed*	The Program of All-Inclusive Care for the Elderly (PACE) is a model of care that enables frail elders to live independently in their communities. Designed as an alternative to nursing homes, PACE started in San Francisco as an adult day center almost 40 years ago; it has since evolved into a national program offering a full continuum of coordinated care and services for seniors who qualify to receive care in a NH.

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			PACE has grown slowly in CA due to high start-up costs, limited pool of sponsors who can afford to start a program, CA's weakened financial system and a complex regulatory environment. Recommendations: 1. Rethink the legislative and regulatory process a. Accelerate PACE review process b. Remove requirements for an adult day health care license c. Default to federal PACE regulations to simplify different federal/state reporting requirements 2. Marketing Strategies 3. Attract Foundations 4. Revamp PACE a. Co-locate PACE services in housing b. Share resources and risk among partner organizations
California	11/2009	Home and Community-Based Long-Term Care: Recommendations to Improve Access for California *330 pages – Read Executive Summary and Recommendations Sections*	This report presents results of the financing study of the California Community Choices program, funded by a five year grant from CMS to increase access to HCBS. The recommendations presented address Medicaid's institutional bias and will result in more cost-effective management of the LTC system. They address policies, laws, regulations, rates and fiscal incentives that impact access to HCBS. **Reduce institutional bias** 1. Establish the philosophy and legislative intent 2. Develop a strategic plan **Balanced long-term care systems** Short-term recommendations 3. Add a special income level eligibility group 4. Increase the home maintenance income exemption 5. Maintain the Supplemental Security Income(SSI)/State Supplement Program (SSP) Medi-Cal eligibility status

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			6. Adopt a case mix reimbursement system for NFs 7. Establish a NF occupancy provision 8. Convert the labor driven operating allocation to an incentive to promote discharge planning or increased QOC 9. Review Department of Developmental Services regional centers rates for nonresidential services 10. Conduct a study of need for waiver expansion <u>Medium range recommendations</u> 11. Establish a statewide institutional transition program 12. Reinvest savings from institutional care in HCBS 13. Promote diversion through preadmission screening/options counseling about community alternatives through SEPs and aging and disability resource connections and by working with hospitals 14. Expand coverage of residential options statewide to offer more service alternatives for older adults 15. Increase the use of provider fees for HBCS providers 16. Explore converting a portion of SSP payment to provide services in residential settings 17. Create a temporary rental assistance housing subsidy 18. Allow presumptive Medi-Cal eligibility for HCBS waiver applicants 19. Develop HCBS that addresses individuals with mental illness 20. Create rate and other incentives to reduce nursing facility capacity <u>Longer-Term Recommendations</u> 21. Create a Department of LTSS 22. Create SEPs to access services for aged and disabled beneficiaries 23. Co-locate Medi-Cal financial eligibility workers in SEPs/ADRCs 24. Create a united LTC budget

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			25. Create a standardized structure for HCBS based on the acuity of the person receiving series 26. Create incentives for HCBS through managed long-term care and capitation 27. Create financing strategies that improve the balance between community and institutional services 28. Develop a LTC database
Connecticut	7/2015	An Annual Report Prepared by Connecticut's Legislative Commission on Aging, Pursuant to Public Act 13-109 to the Connecticut General Assembly's Committees on Aging, Housing, Human Services and Transportation *28 pages - Skimmed*	The Commission on Aging has identified seven areas through which community leaders and their partners can influence community livability: planning and zoning, public spaces and buildings, housing, transportation, health services, social services, and community engagement. For each area, we provide ideas, inspiration and resources, including a document that we created for community leaders that provides a comprehensive list of potential strategies on shaping community livability. Next steps in the Commission's livable communities initiative are outlined below: **Continue Research Analysis and Formulation of Public Policy Strategies.** The Legislative Commission will continue to analyze the findings of the comprehensive survey conducted earlier this year to learn what CT residents have to say about how communities can best prepare to support residents across the lifespan. **Embed a Lifespan Lens in Statewide, Regional and Local Planning.** In 2013, the Legislative Commission shepherded legislation, suggesting that municipal plans of conservation and development include planning for older adults and individuals with disabilities to remain in their homes and communities. The Legislative Commission will continue to influence efforts by the state, regional and local planning community to embed a lifespan lens in community design, building and financing. **Promote Policies that Consider Non-Motorized Transportation and Sustain, Coordinate and Grow Fixed-Route and Demand-Responsive Transportation Options.** The Legislative Commission will continue to collaborate with transportation stakeholders to build on CT's successes and promote funding for and implementation of complete streets policies to accommodate all transportation users. The Legislative Commission will

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			also inform changes to transportation financing policy to support the continued coordination, growth and need for enhancing the convenience and quality of fixed-route and demand-responsive transportation options. **Integrate Older Adults into Economic Development Strategies.** The Legislative Commission will work to ensure that older adults are integrated into economic development strategies, both to signal their critical economic value in the workforce, as caregivers and as consumers, among other roles, as well as to help both the public and private sectors respond with more services to this growing market segment. **Develop Wide-Ranging Strategies to Support Rural and Suburban Environments, As Well As Urban Centers.** The majority of CT's older adults are aging in suburban and rural environments. Shaping livability warrants consideration for every CT resident, regardless of the type of community in which that resident lives. **Foster Diversity, Equity and Inclusion.** Continue to support the commitment of every CT community to foster diversity, equity and inclusion. **Continue Executing our Legislative Charge.** The Legislative Commission on Aging will continue recognizing innovations, ideas and best practices for shaping livability across the state; strategically expanding and sustaining diverse partnerships across multiple sectors; convening statewide and regional forums on livability; identifying funding opportunities for communities; providing technical assistance to CT communities; and identifying and advancing policy solutions that incentivize and inspire the creation of livable communities.
Connecticut	3/2015	The Age-Inclusivity of New Haven and Connecticut	CT has already recognized the urgency to begin planning for aging communities, passing a state law called An Act Concerning Livable Communities, which became effective July 1, 2013. The law empowered CT's Legislative Commission on Aging to spearhead

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		43 pages – Read Background and Information Chapter	Connecticut for Livable Communities, a statewide initiative that convenes and supports local and regional efforts to shape more livable communities for residents of all ages. The Legislative Commission on Aging is a non-partisan public policy and research office of the General Assembly. Among many efforts, in September 2014, they convened over 50 experts representing more than 30 stakeholder organizations to discuss a framework for measuring and assessing livability in Connecticut. They referenced the World Health Organization's (WHO) progress in creating indicators to measure community livability. They have also used the WHO's domains to inform the creation of their own framework for looking at issues of livability. Statewide, a number of indicators and standards are used to evaluate an area's age-inclusiveness, or livability. CT's Legislative Commission on Aging is required annually to report on the progress of its livable communities initiative to the CT legislature. As part of its statutory charge, the Commission on Aging also maintains a website, (www.livablect.org) that provides information and resources to municipalities, including a list of assessments that community leaders may wish to use in determining their readiness to support an aging population. Consistent with the WHO's evolving framework, CT's Legislative Commission on Aging has identified the following domains, or areas of intervention for community leaders and their partners: • planning and zoning • public spaces and buildings • housing • transportation • community engagement (which includes support and connectivity, civic engagement, and opportunities for both employment and recreation) • health services • social services

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Connecticut	12/2012	Home Care at a Glance: SFY 2010 annual Report to the Legislature *60 pages – Skimmed*	This report provides an assessment of the CT Home Care Program for Elders (CHCPE), a state-funded HCBS program and Medicaid waiver for older people with LTSS needs living in the community. **A hypothetical cost-effectiveness model computes annual savings of nearly $107 million compared with serving participants in a NF.** • The model takes into consideration the expense of waiver services, skilled nursing, home health, Older Age Assistance services, administrative costs, and back-filling of empty NH beds that would not occur if the CHCPE program did not exist. • In addition to expenditures for services, the analysis includes demographic and social characteristics of participants, enrollment trends, admissions and discharges, and health status indicators. Appendices include a program history, authorizing legislation, and results of a customer satisfaction survey.
Florida	7/2009	Florida's State Profile Tool	This document describes the factors that have shaped FL's LTC system and its rebalancing efforts. This includes the LTC delivery systems currently in place for the frail elderly population, people with I/DD, people with physical disabilities and chronic diseases and people with MI and substance abuse (SA) problems. For each population group, this report presents information on the range of available HCBS as well as any known gaps in coverage. Population forecasts made by the State Data Center on Aging at the University of South Florida indicate a continuing high demand for LTC by the frail elderly. • By 2030, the population over age 85 is forecast to increase to 22.13% of the population age 65 and older (3.45% of the total state population). • The greater percentage of the 85+ population among the aged is expected to be accompanied by a corresponding increase in the demand for LTC services. Despite very real funding shortfalls across the state, funding for HCBS for elders has received the support of political leaders as evidenced by a net increase in funds for

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			Medicaid waivers. But continued increases in funding remain uncertain. Individuals who do not qualify for Medicaid are on waiting lists or are assisted by programs exclusively funded by the state. The cost to provide the increasing need for services exceeds available state funds, and subsequently many participants receive only a few hundred dollars' worth of services per year or remain on waitlists. As the population ages and service demand increases, FL will be challenged to adequately meet this demand. As with many states, the further shifting of funding from institutional care to HCBS programs faces fiscal challenges. However, FL will continue to advocate for increased funding for HCBS for these populations for whom HCBS have been shown to be cost effective alternatives to institutionalization. The reforms necessary to balance institutional and alternative LTC services to FL's growing consumer populations will require significant additional resources, sustained advocacy and political leadership.
Maine	2015	Supports & Services for Older Adults with Developmental Disabilities and Dementia in Maine *36 pages – Skimmed to last chapter then read*	**Recommendations:** 1. I**ncrease awareness of dementia and developmental disabilities among:** • **Persons with Disabilities and Families:** Increased understanding of risks will allow individuals and families to more effectively plan for their futures, access the most appropriate services and more effectively advocate for themselves. • **State agency personnel:** ME is one of a handful of states that are at the forefront in developing systems to meet the unique and often challenging needs of aging adults with DD who develop dementia. Raising the visibility of the issues is the first step and needs to take place within both the DD and the aging networks of services. • **Elected representatives:** ME has a history of addressing the needs of aging adults with dementia in the general population. However, there is little awareness among policymakers of the unique needs of aging adults with DD generally or those with dementia specifically. Ensuring adequate and fair allocation of scarce state and federal funds is imperative to meeting the support needs of these individuals. • **Developmental Disability Providers:** Currently, there are individual providers who are delivering effective person centered supports for individuals with dementia, as well as providers who are not dementia-capable at all. Lack of

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			coordinated regional or statewide planning and collaboration limits access to quality evidence based services and may increase costs. • **Health and Long Term Care Professionals**: Inadequate awareness of the impact of dementia among health care providers can result in significant challenges to persons with DD accessing appropriate health care. 2. **Increase Integration of Services and Supports:** Historically, aging and DD services have existed in effective silos. While there have been recent efforts at the state and federal level to increase integration of disability related services and supports across the lifespan, effective collaboration is still too often dependent upon the commitment of individuals rather than planned integration of knowledge, services and support. Individuals and families impacted by DD and dementia should receive quality, consistent, coordinated support however they access the system. Integration of services and supports will require the involvement of: • **State Agencies**: primarily the Office of Aging and Disability Services, but also including other agencies where families access systemic care, such as MaineCare Services and income-based supports; • **The Aging Network**: including the Aging and Disability Resource Centers, the Area Agencies on Aging and service providers; • **Developmental Disability and Aging service providers; Health Care Providers; Other Advocacy Organizations**: such as Maine Council on Aging, American Association of Retired Persons, the Alzheimer's Association, etc.; and • **Research and Education Entities**: such as the Maine Center on Aging. **3. Expand Systemic Capacity** **Workforce Development**: Increase the availability of elder services providers able to address DD and dementia capable developmental services providers • **Southern Maine Agency on Aging Dementia Grant**: The Southern ME AAA has received a large federal grant to develop services for adults with dementia and has specifically included adults with DD in the proposal. • **DSP Online Training Module on Developmental Disabilities and Dementia:** The Muskie School of Public Service has developed the ME Personal and Home Care

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			Assistance Training Program targeting personal and home care assistance workers, including Direct Support Professionals. **Enhance Family Support Services**: including education, referral and diagnosis, clinical supports, and respite. **Specialized Group Homes for Dementia Care.** As dementia progresses, specialized care (including hospice and nursing supports) is needed. As awareness of the unique needs of adults with DD and dementia become more prevalent it can be anticipated that agencies will recognize specialized dementia care as a necessity and devote resources to the development of one or more small purpose group homes designed specifically for dementia. 4. **Adopt Evidence Based Screening Practices:** The National Task Group has developed an easy to administer screening instrument called the Early Detection Screen for Dementia for early detection screening of those adults with a DD who are suspected of, or may be, showing early signs of mild cognitive impairment or dementia. It is recommended that this instrument be used on an annual or as indicated basis with adults with Down syndrome beginning with age 40, and with other at-risk persons with I/DD when suspected of experiencing cognitive change. It was designed to be used to detect 'cognitive impairment' among adults with intellectual disabilities as preparation for the annual wellness visit requirement under the ACA. It can also be used to identify those individuals with dementia-like symptoms whose function and behavior are the results of other causes (such as thyroid disorders, medication interactions, depression, etc.). **5. Improve Data** **Impact of dementia among family caregivers:** To preclude institutional placements and to support families with continued caregiving state level research needs to be conducted on the impact of dementia upon family caregiving. The onset of dementia in their adult children will tax the ability of these families to continue to provide care.

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			Impact of dementia among people with developmental disabilities receiving services and supports: Little is known about how many persons with dementia are currently receiving Developmental Services, nor are accurate estimates available about how many will need services in the future. Accurate data on the number of adults currently in the system with dementia as well as projections on future numbers is vital to assuring adequate and fair distribution of scarce state financial resources. Improved data will also allow for better regional or statewide coordination of supports for low incidence needs.
Maine	11/2014	Final Report of the Commission to Continue the Study of Long-Term Care Facilities *62 pages – Read Executive Summary*	The Commission met four times and developed the following specific recommendations: 1. Convene a technical work group to examine rate setting 2. Develop a policy for complex-needs patients 3. Convene a work group to develop P4P models with new funding 4. Provide a financial picture of the NF industry 5. Provide a history of the combination of the health care provider tax and General Fund contributions to MaineCare seed funding. 6. Seek assistance to improve options for pursuing unpaid cost of care. 7. Restore crossover payments to NFs. 8. Include continuing education for direct care staff in direct care costs. 9. Lower the threshold for occupancy adjustments. 10. Initiate a ME-focused time study to reflect staff time with patients with dementia. 11. Develop a critical access NF designation. 12. Develop a procedure when bed rights are relocated. 13. Review recommendations in the Center for LTC Reform. 14. Support the ME Aging Initiative. 15. Support DHHS's comprehensive planning for the continuum of care. 16. Increase the personal needs allowance.
Maine	3/2009	A Cross System Profile of Maine's Long Term Support System: A New View of Maine's Long Term Services and Supports and the People Served	This study provides a profile of LTSS for several groups of recipients including older adults and adults with disabilities. Besides descriptive information, the profile includes demographic and utilization data, administration and management information, and key components associated with balancing an LTSS system. The purpose of the report is to

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		152 pages – Read Introduction	establish a baseline for developing policy goals for LTSS; thus, it does not report on cost savings.
Maryland	2013	Maryland Department of Aging Operating Budget Data *21 pages – Skimmed*	Updated annually, these budget documents provide an analysis of performance trends of the department, including trends for the number of seniors receiving various HCBS, funding for services, and the percentage of those in need actually served. The analysis also compares the annual cost per senior for the Older Adults Waiver, NH care, and other community-based services, as well as the number served with these programs versus the number on the waiting list. The document also looks at trends in the Guardianship program, complaints to the Ombudsman, and employment and training for seniors programs. The department considers community-based services to be a cost effective investment for the state because many of the people who received HCBS would have required NH services if the HCBS were not available. The cost of NHs is more than double the cost of the Medicaid HCBS Waiver for Older Adults, which is the most expensive community-based service offered by the aging department.
Maryland	3/2004	Maryland Nursing Home Consumer Satisfaction Recommendations – Final Report *42 pages – Skimmed except for Section 6.0*	This report provides an overview of key information on NH satisfaction surveys and recommendations that can assist Maryland with implementing state legislation requiring public reporting of NH QOC and resident satisfaction. The report focuses on the availability of NH consumer satisfaction surveys; future reports will address survey methodology and implementation issues. There are several activities that will help to further guide the selection of a consumer satisfaction survey. 1. Determine if there are unique, state-specific issues that MD must address in its satisfaction data collection and resulting public reporting. Such issues need to be explored with the various stakeholders, including LTC industry representatives, individual facilities, consumer groups, regulators, payors and

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			others. Questions to ask of survey developers include, but are not limited to, the following: a. What is the required sample size and response rate for public reporting? b. Can additional domains/items be added? - Does the developer have a valid set to offer? c. What is the recommended sampling frame for the instrument? d. What response rates have been obtained during implementation of the survey, on average? e. Are there licensing fees, copyright issues, data ownership issues or other issues and costs associated with the selection of one of the candidate proprietary satisfaction surveys? 2. Understand the potential impact of a mandated data collection effort on MD NFs. Explore the experience, from the NF's point of view, with various survey-associated processes (e.g., interviewer-administered surveys, mail surveys, obtaining consent to complete surveys, compiling lists of family member names and addresses for survey contractors). 3. Examine issues associated with the public reporting of consumer satisfaction (sampling issues, survey response rates and other survey implementation issues).
Massachusetts	11/2010	Securing the Future: Report of the Massachusetts Long-Term Care Financing Advisory Committee	This report provides the policy framework of the state's Long-Term Care Financing Advisory Committee. It lays out options to achieve the goal of universal access to LTSS coverage in the state using affordable and sustainable financing mechanisms. The report describes strategies for short- to long-term timeframes. The Advisory Committee's recommended core financing strategies (each consists of a set of discrete recommendations): 1. Increase utilization of private LTSS financing mechanisms • Implement National Association of Insurance Commissioners (NAIC) model legislation that will provide for better regulation of LTSS insurance • Promote life insurance with LTSS options • Promote group coverage of LTSS insurance and portability of that coverage

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			• Develop a LTC Partnership Program that provides protection from impoverishment for individuals who purchase LTSS insurance if they eventually become eligible for Medicaid • Promote the use of other private LTSS financing mechanisms, such as reverse mortgages, annuities, and LTSS savings account 2. Expand MassHealth coverage to achieve equity in access to LTSS • Expand access to a limited package of community-based LTSS to a targeted group of adults under age 65 with disabilities and self-care needs • Expand access to a comprehensive package of community-based LTSS to a targeted group of adults under age 65 with disabilities and self-care needs • Expand eligibility for MassHealth coverage for LTSS for elders over age 65 3. Promote the use of social insurance programs that allow all people to prepare for financing their LTSS needs • Educate employers and employees about CLASS and consider promoting their participation in the program if warranted. • If other strategies do not achieve the goal of universal access to basic LTSS coverage, design and implement a state-sponsored individual contribution program that provides universal access to basic LTSS coverage for all Massachusetts residents. Private insurance and MassHealth could supplement this coverage for individuals with very high LTSS needs. The researchers conclude that with implementation of the recommended reforms, individual and caregiver out-of-pocket expenses for LTSS would be reduced from 38% of the total cost to 15% by 2030. The cost for the state would be reduced from 21% to 17% of LTSS care, for a difference of nearly $1 billion.
Massachusetts	4/2009	Long-Term Supports in Massachusetts: A Profile of Service Users	The authors provide a comprehensive review of the populations needing LTSS in MA and project future demand. The report summarizes system capacity, an assessment of unmet LTSS needs, and gaps in access to MA's LTSS system.

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		59 pages - Skimmed	This report served to inform the work of the Massachusetts Long-Term Care Financing Advisory Committee.
Michigan	6/2009	Michigan Profile of Publicly Funded Long-Term Care Services *107 pages – Skimmed and Read Appendix C*	The Department of Community Health (DCH) Office of Long-term Care Supports and Services (OLTCSS) contracted with the Michigan Public Health Institute to develop a profile of the state's LTC system. The OLTCSS subsequently contracted with key stakeholders to further develop the content and framing of the profile. The profile represents an analysis of MI's publicly-funded LTC system. The information provided was collected through interviews with many MI government employees, advocates, and stakeholders involved in the system. Appendix C focused on The Michigan Medicaid Long-Term Care Task Force, which met between June 2004 and May 2005. It was charged to examine the LTC system and make recommendations to improve quality, expand the reach of HCBS, and reduce barriers to an efficient and effective continuum of LTC services in MI. The task force recommended the following policy changes: 1. Require and implement person-centered planning practices throughout the LTC continuum and honor the individual's preferences, choices, and abilities. 2. Improve access by establishing money follows the person (MFP) principles that allow individuals to determine, through an informed choice process, where and how their LTC benefits will be used. 3. Designate locally or regionally-based SEP agencies for consumers of LTC and mandate that applicants for Medicaid funded LTC go through the SPE to apply for services. 4. Strengthen the array of LTC services and supports by removing limits on the settings served by MI Choice waiver services and expanding the list of funded services. 5. Support, implement, and sustain prevention activities through (1) community health principles, (2) caregiver support, and (3) injury control, chronic care management, and palliative care programs that enhance the QOL, provide person-centered outcomes, and delay or prevent entry into the LTC system.

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			6. Promote meaningful consumer participation and education in the LTC system by establishing a LTC Commission and informing the public about the available array of options. 7. Establish a new Quality Management System for all LTC programs that includes a consumer advocate and a Long-Term Care Administration that would be responsible for the coordination of policy and practice of LTC. 8. Build and sustain culturally competent, highly valued, competitively compensated and knowledgeable LTC workforce teams that provide high quality care within a supportive environment and are responsive to consumer needs and choices. 9. Adopt financing structures that maximize resources, promote consumer incentives, and decrease fraud. The goal of these recommendations is to create an integrated system that appears seamless to the consumer, yet takes maximum advantage of the variety of LTC programs at the local, state, and federal levels. Specific recommendations for reducing barriers to an efficient and effective LTC system include expanding eligibility criteria, creating reimbursement mechanisms based on the acuity level of the consumer, and centralizing supports coordination in the SEP. Citizens will be better informed, involved, and prepared for their LTC needs through public education, participation in statewide and local commissions, and through financial incentives. The state will be better organized by centralizing its LTC planning and administration functions, which are currently scattered across departments.
Minnesota	10/2013	Status of Long-Term Services and Supports: Adult Mental Health, Aging and Adult Services, Children's Mental Health Disability Services, Nursing Facility Rates and Policy – Legislative Report *41 pages - Skimmed*	This report summarizes the status of LTSS for older adults, people with disabilities, children and youth with mental health conditions, and adults living with MI through calendar year 2012. It was developed in response to a legislative mandate (M.S. 144A.351) to biennially update the legislature on the effects of legislative initiatives to "rebalance" the state's LTSS system. Recommendations Related to Home and Community-Based Services: **Better Individual Outcomes** • Increased flexibility to better meet the needs of each individual • Increased stability in the community

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			• Better-informed individual decision-making about LTSS options • Promotion of person-centered planning and self-determination – life-long planning as well as to mitigate a crisis situation. • Improved transitions between settings and programs, preventing avoidable health crises • Recognize and address the social determinants of health care need and cost **Right Service at the Right Time** • Low-cost, high-impact services reach people earlier • Decreased reliance on more costly services • Access to home and community-based services, not institutional care, is the **Entitlement** • Ensuring the Future of Long-Term Services and Supports • Increased sustainability of the long-term services and supports system • Increased efficiency in the use of public long-term services and supports resources DHS prepares a forecast of expenditures in its major programs twice each year. It aims to forecast caseloads and expenditures given current state and federal law at the time of publication. Expenditures for LTC facilities are projected to continue to decrease through state fiscal year 2017. Meanwhile the number of recipients and dollar payments for waivers and home care services are projected to increase over the next five years.
Minnesota	6/2012	Population Accountability: Getting from Talk to Action *1 pages – Read entirely*	1. Over the past five years, LTC funding for seniors has averaged a net annual increase of 1.5%, with NF funding decreasing at an average of 1.7% and HCBS increasing at a rate of 8.2%. 2. In 2011, overall LTC funding was $1.13 billion, with $696 million for seniors in institutional settings and $438 million for seniors in HCBS programs. 3. Over the next five years, overall LTC funding is expected to increase at an average rate of 1.3% per year. This slowed growth is due, in part, to changes in the NF Level of Care criteria which is expected to lower caseloads in NFs and across the Elderly Waiver and Alternative Care programs.

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			4. The costs of providing LTC services is increasingly driven by the rising cost of retaining LTC workers and operating programs, and cost of living increases. 5. The growing use of more expensive HCBS options such as assisted or customized living is a major cost driver of LTC services for seniors. 6. The rising cost of providing LTC services will be difficult to sustain. The cost to retain LTC workers and operate programs will continue to rise especially as the demand for workers increases at a time when the supply of workers becomes more limited. 7. As seniors live longer, there will be an increasing number age 85 and older who require and need publicly-funded LTC services. 8. The demand for more intensive and expensive models of care (providing 24-hour per day coverage) will increase as the number of family members available to provide care diminishes.
Minnesota	2/2011	The Long Run has Become the Short Run: Budget Implications of Demographic Change *26 pages – Read entirely*	MN currently supplements the biennial budget forecast for years currently under consideration with planning estimates of revenues and expenditures for the following biennium. Legislative leaders have requested a somewhat longer overview of the likely path that state expenditures and revenues may follow over the next decade as the state ages. This report provides some of the additional information needed for policymakers seeking to incorporate longer term considerations into the budget development process. **2013 to 2020 – Remainder of the Decade** 1. The population 65 and older will rise rapidly, increasing as much this decade as in the past four combined. 2. The workforce will experience sluggish growth as more people retire and the working-age population grows slowly. Economic growth will slow unless there are substantial gains in per worker productivity. 3. Slower workforce growth could improve opportunities for workers, or employers will resort more to alternatives to hiring such as labor-saving devices, downsizing, and moving to labor markets with more qualified labor. The match between the skill sets of available workers and the requirements of employers will be crucial in determining how employers react to the shifts in the labor market. 4. Total personal income growth will slow as more people retire and their incomes become more dependent on SS and pensions.

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			5. State government will face chronic structural deficits and adjustments will be needed to balance the budget. This perennial crisis will be produced by slower revenue growth coupled with increasing pressure on expenditures for major state programs such as health care and education. 6. Health-care costs will play a major role in future state budget challenges. Health-care costs for government employees will also contribute to strain on public expenditures. 7. Retirements in health care professions, coupled with long-run inadequate numbers of graduates from medical and nursing schools, will create a growing problem in the provision of health services. 8. Most of MN's population increase this decade will be minority persons, with most of the increase under age 30. With the overall number of graduates expected to decline, this could exacerbate the mismatch between the needs of employers and the skill sets of young workers. 9. Household growth will return to pre-recession levels of 20,000 to 25,000 per year by 2013 or 2014, but the types of household will change. Families with children under age 18 will grow at a much slower pace, at approximately a third of the rate of growth over the past five decades. Most of the growth in households will be among older married couples who have empty-nested and among older people living alone. These trends have implications for construction, school financing, and delivery of social services. 10. Most of the increase in 65 and older population in MN during the 2010s will occur in the Twin Cities metro area, especially in the suburban counties. 11. An increasing number of rural counties will experience chronic natural decrease (more deaths than births) and long-run population decline. **Beyond 2020, Toward 2060** Long-run forecasts should always be view skeptically. That said, there are some things that are fairly predictable. 1. The decade of the 2020s will see an even greater increase in the 65 and older population than the 2010s. From 2010 to 2030, MN will add nearly 600,000 people age 65 and older. By 2030, the biggest increases in the 65 and older population will

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			be over. After 2030, the elderly population will grow at a much slower rate as the Baby Boom effect plays itself out. 2. LTC will be a challenging issue as the leading edge of the Baby Boom Generation moves into its late 70s in the 2020s. 3. Aging of the population, coupled with rising energy prices, may contribute to a movement back to the central cities or inner-ring suburbs at the expense of suburbs built from 1990 to 2008. 4. Population growth in most of the world is expected to decline. Slower worldwide population growth could reduce immigration, dampening population growth in the U.S. and MN. However, differences in economic opportunity in different countries will still produce substantial amounts of international migration. 5. Worldwide aging and rising income will increase the demand for higher quality food, while continued population increases will place increasing demand on basic food items. These trends will combine to place upward pressure on commodity prices, most notably food and energy. Any adverse crop events in critical agriculture areas will place even more upward pressure on commodity prices. This may improve MN's competitive position. 6. Many of the fastest growing areas of the nation today are in water deficit areas. This includes both the Southwest as well as the Southeast regions of the nation. Unless a disruptive technology alters the current course, growth in many of the states in these regions will be constrained by 2020. MN, with a more ample supply of water, will be in a more competitive position for economic and population growth, but only if water resources are carefully preserved and managed.
New Mexico	5/2014	Aging and Long-Term Services Department Resource Allocation, Cost, Availability and Effectiveness of Aging Network *50 pages – Read Executive Summary*	This evaluation focused on the oversight of the aging network, fund management, system efficiency, and strategic planning to meet the needs of the increased population. **KEY RECOMMENDATIONS** **The Legislature should:** • Consult with the Department prior to proposing specific service and location capital outlay to ensure the program has the infrastructure, staffing, and operational budget to support the project.

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			Aging and Long-Term Services Department (ALTSD) should: • Take action to resolve external audit findings by implementing systems which correct findings and prevent future occurrences. • Assess departmental contracts with AAAs and administrative code to determine if the department should recall any portions of the scope of work to ensure ALTSD maintains appropriate control of the aging system. • Work with local governmental entities to determine the feasibility of a minimum threshold for local contributions through cash or in-kind donations. • Review formulas from other states to evaluate if there are opportunities to improve NM's Intrastate Funding Formula for federal funds and the disbursement of state general fund allocations to better target resources. • Act as the lead in solicitation of funding from local government entities. • Work with NM Department of Transportation to develop strategies where grant applicants most in need are considered a priority for funding and investigate options on how procurement code and grant requirements can be met in lieu of upfront match payments. • Create gateway criteria in prioritization system in the capital outlay process that will not allow an application to proceed for ranking if the applicant is not in compliance with Executive Order 2013-006 and if the applicant cannot demonstrate that they can provide for the ongoing operations and maintenance of the facility. • Track service outcomes and report them as performance measures to give a better idea of the aging network's capacity and its adequacy in meeting the needs of the senior population. • Create standardize training manuals and provide more direct training to providers to help them understand all aspects of the aging network system. • Work with the LFC and other partners to develop a strategy for a longitudinal analysis of aging network data.
New York	2011	New York State Plan on Aging	This State Plan on Aging outlines the goals, objectives and strategies that are sensitive to the needs and wants as expressed by older New Yorkers. The State Plan: • Articulates measurable outcomes that can be achieved given the Agency's present resources.

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		134 pages – Read Introduction and Goals, Objectives, Strategies and Expected Outcomes sections	• Outlines strategies to increase the availability of information and assistance, support opportunities for volunteerism and civic engagement, promote health, protect consumer rights and assist people with obtaining needed benefits. • Focuses on developing and maintaining the ongoing partnerships necessary to support the ability of the Aging Network to address local needs. • Continues to build the foundation for a future in which every older New Yorker has the opportunity to enjoy wellness, longevity, and quality of life in strong, healthy communities. Goals include: 1. Empower older New Yorkers, their families, and other consumers to make informed decisions about, and be able to easily access, existing health and long-term care options 2. Enable Older New Yorkers to remain in their own homes with high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers 3. Empower older New Yorkers to stay active and healthy through Older Americans Act Services and the new prevention benefits under Medicare 4. Ensure the rights of older New Yorkers and prevent their abuse, neglect and exploitation 5. Refine current management and operational practices to achieve greater efficiency and an effective management structure throughout the Aging Network in New York State Objectives, strategies and outcomes are presented for each goal.
Ohio	6/2015	The Road to Balance: Two Decades of Progress in Providing Long-Term Services and Supports for Ohio's Older Population	Study Recommendations: • Given the projected demographic changes, OH must delay or avoid disability across the entire older population. This is particularly important for moderate and middle income elders who do not turn to Medicaid until they require NH care. Today more than half of older people with severe disability use LT services funded through the Medicaid program.

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		66 pages – Skimmed but Read Recommendations Section	• Use technology to assist older people with a disability to remain independent in the community. • Environmental adaptability can assist older people to remain independent in the community. Some of these types of changes could be extensive in scope, while others are relatively simple. For instance, the concept of visitability, a residence deliberately built to include universal design, has received considerable attention. • LT services will always rely on a caring and well-trained workforce. A strategy to recruit, train and retain the direct care workforce needs to be a priority of the state and the LT services industry. • The number of individuals below age 60 now using NHs in OH continues to be an important policy issue. For some of these individuals a short-term rehabilitation stay in a NF represents an appropriate use of the NH setting. Given that one-quarter of the under 60 group reports limited levels of disability, and more than one in five stay two years or more, it will be critical to better understand NH use for this group. • In the last two years OH has reduced the number of NH beds and improved the distribution of beds across counties. With an occupancy rate of 84% and a higher number of beds per population age 65 and older than the majority of states, OH still has room to lower its bed supply. Exploring models where beds could be banked for a 10-15 year time period, an approach used in other states, should be examined. • The LT services changes now underway in OH are dramatic. Initiatives such as MyCare (dual eligible) will alter the delivery system in fundamental ways. Making sure that a comprehensive quality monitoring and improvement system that includes a common assessment and outcome measure is used across the system to compare program effectiveness will be critical.
Ohio	2008	Livable Communities: Helping Older Ohioans Live Independent and Fulfilling Lives *5 pages – Read entirely*	The concept of livable communities is related to similar initiatives (“universal design,” “smart growth,” and “aging in place”) and incorporates certain elements of all. Basic recommendations include: • *Health Care:* Ensure a full range of health care facilities, from NHs to hospitals to outpatient and specialty clinics, is accessible to people of all ages and impairment levels. Increase and expand preventive health measures, such as vaccinations and screenings.

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			• *Housing:* Institute and expand tax relief & assistance programs and alter zoning laws to ease the development of mixed-use land in which apartment-type living accommodations could be built near shopping areas, health-care facilities and recreation areas. Encourage "universal design" ramps, stairless entrances, rails safety bars, expanded hallways, and better lighting. • *Transportation:* Emphasize the transportation/mobility needs of older persons and others with impairments. Ensure public transportation services – and special services for those with impairments – are linked to health care, shopping, cultural, educational and recreational destinations. • *Supportive Services:* Create a streamlined SEP for all services related to older persons. • *Recreational/Cultural/Educational Opportunities*: Link transportation systems to recreational, cultural and educational activities. Create partnerships between aging-service agencies and recreational/cultural administrators.
Ohio	2008	Ohio's Aging Workforce: Opportunities & Challenges for Ohio's Employers *13 pages - Skimmed*	OH has the 6th highest older population in the US, though OH is seventh among the 50 states in total state population. Over 22% of OH's population was age 55 or older in 2000. By 2020, that number is expected to increase to almost 30%. OH has had slower population growth than the nation as a result of net outmigration, which is expected to continue over the next few years. Understanding that it is in their best interest to attract and retain older workers – as well as smooth transfer of knowledge between senior and younger workers – many OH companies have developed programs and policies that should prove beneficial in this regard. For example: • Procter & Gamble (P&G) and Eli Lilly initiated establishing a contracting agency (YourEncore.com) with the intention of attracting retired research scientists, engineers, and product developers who are interested in working on a project-by-project basis. http://www-935.ibm.com/services/us/gbs/bus/pdf/ge510-4017-aging-workforce.pdf • AEP Ohio, a unit of American Electric Power, in 2004 recognized the aging of its work force and realized that it might be facing the loss of its knowledge base. A solution is the establishment of a mentorship program between senior and junior staff so there

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			will be a gradual transfer of knowledge and shared history. http://uaelp.pennnet.com/display_article/256346/34/ARTCL/none/none/1/the-agingworkforce-challenge/ Additional action steps and programs as listed below: • Special age diversity training • Employee discounts (drug benefits) • Phased retirement benefits • Developing 'Casual Worker Programs' to hire or re-employ workers with few benefits and no pension • Paid time-off bank (a number of paid days off employees can use for any reason) • Post-retirement employment • Flextime • Mentoring • Knowledge transfer programs • Internship programs for older workers • Eldercare benefit programs • Vocational planning for older workers • Partnerships with Institutes for Learning in Retirement (ILR) • Family/generational planning services to help employees prepare for later life • "Retiree Pools" of recently retired workers with skill sets and training to consult or fill in on short-term projects • Renaissance programs which provide peer and professional counseling for older workers • Pension contribution plans • Employee focus groups/surveys regarding older workers' needs and wants • Intergenerational programs (grandchildren on site) Older workers are often looking for flexible work schedules. Given a choice, they often choose part-time employment in order to balance work, leisure and family responsibilities. In addition, older workers are looking for work opportunities that involve social interaction, often preferring jobs involving contact with co-workers and

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			the public they serve. It is evident that in order to compete successfully in the market place, employers will do well to adjust their personnel practices to attract, recruit, and retain older workers, paying special attention to the needs and preferences - as well as the valuable experience - of an increasingly aging workforce.
Ohio	2005	Real Choices: A Caregiver Respite Strategy for the State of Ohio *41 pages – Read Executive Summary*	The purpose of Real Choices: A Caregiver Respite Strategy For The State of Ohio was to determine the feasibility of restructuring the PASSPORT program to achieve caregiver respite. The conceptual model illustrates respite is a strategy to help sustain caregiver activities and potentially keep care at home. Critical to respite strategy are the care receiver, caregiver, other support for the caregiver, and formal services. The report proposes a four component family-based respite strategy: (1) Defacto Respite; (2) Defacto Respite Plus; (3) Institutionalize Respite Strategy; and (4) Real Choices. Defacto respite has already been incorporated into PASSPORT. The three additional components introduce a family-based approach to service plan development, flexibility, and consumer-direction culminating in "Real Choices". "Real Choices" is a modest cash benefit or voucher program that is grounded in a systematic assessment of the primary caregivers needs. • Cash benefits to purchase goods and services will help offset the often higher cost of other services and/or for some enabling the caregiver to continue support of the care receiver.
Oklahoma	9/2005	Home and Community-Based Services in Oklahoma: A Systems Review *54 pages – Read Executive Summary, Introduction and Recommendations Sections*	The report has two sections: Section I contains an overview and trends observed in OK, a description of relevant characteristics of state long term care systems, findings from interviews with key informants and a review of related materials from OK, and promising practices gleaned from the experiences of other states. Section II contains recommendations for strengthening Oklahoma's long term care system based on findings and promising practices: • Organization: consolidation of LTC functions is the preferred model • Philosophy and Mission Statement included in statute and regulation

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			• Budgets for NH and HCBS should be linked to one another; "Money Follows the Person" is the second option • Reduce fragmentation by consolidating access functions currently performed by multiple agencies • Implement a pilot program to presume financial eligibility for Medicaid for individuals who are at risk of admission to a NH and are likely to be eligible when the full Medicaid financial application is completed and reviewed • Examine the array of services available and the circumstances that lead HCBS participants and others to enter NHs; gaps should be identified and strategies developed to fill them • Permit consumers to have more control over purchasing personal care and other supportive services • Strengthen quality management for LTC
Oregon	9/2014	Report and Recommendations of the Oregon Retirement Savings Task Force (Created and Tasked Pursuant to HB 3436 – 2013) *47 pages – Read Executive Summary and Recommendations*	The OR Retirement Savings Task Force finds that the national retirement savings crisis deeply affects far too many Oregonians. • According to a 2011 study by the OR State Treasury, roughly 45% of employed Oregonians do not have access to employer-sponsored retirement plans. • Of those who access employer-sponsored accounts or access retirement savings accounts on their own, many often do not save enough. • More than half of OR workers have less than $25,000 in retirement savings and more than a quarter have saved less than $1,000. While retirement security has historically been seen as a matter of personal responsibility, it is rapidly becoming a broad concern for policymakers. Widespread failure to save adequately for retirement will likely lead to increased burdens on costly social services. The Retirement Savings Task Force believes that the State should be a leader in addressing this crisis and recommends to the Oregon Legislature the creation of a retirement security program encompassing the following: Retirement Savings Plan Characteristics To overcome the challenges faced by Oregonians who want to save and prevent the potential strain on public resources resulting from inadequate saving rates, the Task

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			Force recommends developing and making available to all Oregonians lacking access to a retirement savings plan at their workplace with the following nine characteristics: 1. Employees should be automatically enrolled with the right to opt-out. Employees should be notified of and provided financial education about their enrollment upon employment. 2. Employees should have the opportunity to choose their initial and ongoing automatic contribution rates or rely on the default rates. The default rates for employee contributions should be automatically increased over time. 3. Defined contributions should be made from employee payroll deductions. Existing payroll systems should be used wherever possible to reduce costs. Persons who are self-employed or unemployed should also be able to make contributions. 4. The plan should meet the qualification requirements to receive federal and state tax deductions for the participants. 5. Employers should not be required to contribute to employee accounts. If possible, voluntary employer contribution arrangements on behalf of employees should be accepted. 6. Accounts should be individual and account information should be regularly reported to each participant. 7. Accounts should be portable, allowing savers to maintain their accounts from one job to the next and during periods of unemployment or self-employment. 8. Funds should be pooled and professionally managed to maximize returns for participants. 9. The costs to manage the accounts should be paid from employee payroll contributions and/or account earnings.

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			Program Governance and Management The Task Force recommends empanelling a state board responsible for sponsoring and overseeing the program outlined in these recommendations. Additional Program Components The Task Force acknowledges that more effort is needed to ensure all Oregonians have access to a retirement savings plan with the above characteristics. The Task Force recommends further investigation and analysis in the following areas: • Market Research • Small Business Outreach • Tax Credits and Other Incentives • Legal Guidance • Financial Literacy
Rhode Island	12/2011	An Independent Evaluation of Rhode Island's Global Waiver *43 pages – Read Executive Summary*	The Global Waiver advanced Rhode Island's strategic plan to rebalance the LTSS system initiated through RI's Real Choice Systems Transformation Grant which began in 2006. The following initiatives were included in the Global Waiver to help to rebalance the LTC system: • Changes to the clinical level of care policy and process including development of a • preventive level of care • Initial steps to address the needs of high cost utilizers • NH Diversion and Transition Projects • Promoting the availability of community based services as an alternative to NH Placement • Removing delegated authority from hospital discharge planners • Improving access to shared living arrangements To evaluate the impact of the Global Waiver on re-balancing the LTC system, Medicaid claims data for long term care services for state fiscal years (SFY) 2008 through 2010 were evaluated. • The Global Waiver was successful in re-balancing the LTC system resulting in the utilization of more appropriate LTC services.

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			• During the study period the average number of NH users fell by 3.0% from SFY08 to SFY10. • During this same period the average number of HCBS users rose by 9.5%. • These Global Waiver strategies clearly helped the state to re-balance the delivery of LTC services, resulting in savings of $35.7 million during the three year study period.
Utah	10/2015	Taking Care of Our Seniors: As Assessment of Utah's Aging Services *16 pages - Skimmed*	FINDINGS: • UT's senior population is growing rapidly. By 2030 UT's senior population will make up more than 13% of the state. • The vast majority of seniors want to age in place. Aging services make it more likely that seniors will be able to stay in their own homes. • More than 10% of UT seniors rely on nutrition programs like senior center meals and Meals on Wheels. • There are 336,000 caregivers in UT who provide 90% of the care for seniors. Less than 1% of caregivers use state or local support services. • Every county in the state has a waiting list for caregiver respite services because these services are inadequately funded. • Transportation services for seniors are scarce, especially in rural areas of the state, which impedes senior mobility and independence. • State programs like Alternatives that provide services such as household chores and personal care are critical for helping vulnerable seniors remain at home instead of entering residential facilities.
Utah	2013	New Trends in Housing for Utah's Aging Population *5 pages – Read entirely*	As Utahns age, three housing concerns consistently top the list— **Aging-in-Place** The opportunity to stay put and live in a familiar residence or community has many benefits, for individuals and neighborhoods including higher QOL and increased civic participation by older adults. The ability to do so may depend on conditions not typically found in suburban neighborhoods such as accessible public transit and a wider range of housing options. **Affordable Choices**

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			Housing affordability, often the first consideration for actual housing, is governed by neighborhood context as well as housing type. In addition to a wide range of housing options, an affordable community also consists of access to key amenities such as social services and transit options, and is the outcome of targeted policies and flexible zoning. **Availability of Housing Options** A wider range of housing options includes: • *Accessory Dwelling Unit (ADU)* An ADU is a housing unit attached to or situated alongside a single family dwelling. The ADU has its own entrance, kitchen, bedrooms, and bathroom. • Single Family Types • Small Facility Types (up to 12 residents) ○ Co-Housing Community ○ Green House Model ○ Group Home • Large Facility Types (13 or more residents) ○ Retirement Community ○ Life Care Community ○ Assisted Living Facility ○ Independent Living Facility ○ Congregate Housing ○ Nursing Home ○ Convalescent Home ○ Skilled Nursing Facility ○ Boarding Home Personal Care Facility ○ ADL Facility ○ Senior Apartments

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Vermont	6/2011	Vermont Choices for Care: Evaluation of Years 1-5 – Final Report *30 pages – Read Introduction and Conclusions and Recommendations Sections*	Overall, available data has indicated that Choices for Care (CFC) has been highly effective with HCBS participants. Even though consumers are overall very satisfied with the program, there are areas which allow for improvements: • **Information and Dissemination**: The Department of Disabilities, Aging and Independent Living (DAIL) provides many of its brochures, forms and manuals on-line. However, in order to proactively increase awareness of its programs and materials, DAIL can work with stakeholders to identify cross-promotional opportunities. • **Access:** DAIL can work with community organizations to increase knowledge of the financial process and eligibility criteria among elders, caregivers, adults with disabilities and professionals who work in the health care field. • **Experience of care**: DAIL has established that the CFC program will provide quality services which meet the needs of elders and adults with disabilities who need LTSS. Consequently, it is incumbent upon DAIL to ensure that all aspects of the CFC program function well. Even though the rate of resolution to problems and concerns indicates that this issue affect a small subset of the overall program, DAIL should work with the staff at all levels that interact with consumers in the specific programs. • **Effectiveness/Access**: There has been a gradual closure of NF beds. As more counties begin to provide more services which are community-based, DAIL has the opportunity to explore with stakeholders actions which can be taken by the state to incent NFs and others to develop community settings for elders and adults with disabilities. • **Consumer Quality of Life**: Throughout the duration of the CFC program, QOL measures for CFC consumers have always been less than those for the general population. Because these measures include indicators such as health outcomes, community integration, perception of safety and mobility, there are many avenues through which DAIL can act. • **Public Awareness**: DAIL is encouraged to review the recommendations provided in the Hospital Discharge Policy Brief and the Consumer Focus groups to determine any actions it can take to increase awareness of LTSS.

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Virginia	6/2009	Virginia State Profile Tool: An Assessment of Virginia's Long-Term Care System *145 pages – Read Executive Summary*	In federal fiscal year (FFY) 2007, CMS awarded grants to ten states under the Real Choice Systems Change program to develop profiles of their LTC delivery systems and participate in the process of developing national balancing indicators. The goal of the State Profile Tool (SPT) is to establish a template for states to assess their LTC systems with a focus on progress made in "rebalancing" from heavy reliance on institutional services to increased use of community-based services. Virginia's SPT examines the LTC delivery system for five target groups: older adults; adults with physical disabilities; people with intellectual and developmental disabilities; adults with mental illness; and children with disabilities. VA has undertaken numerous initiatives to enhance and reform the LTC system: some funded to a large extent by federal grants while others are funded primarily through state general funds. The Governor's Task Force on Health Reform, MFP Demonstration and Real Choice Systems Change grants, No Wrong Door (NWD), Own Your Future, Long-Term Care Partnership, and other initiatives are moving VA forward in creating a more balanced and sustainable system. In the September 2007, Health Reform Commission report, the LTC workgroup made the following five consensus recommendations: 1. Support and expand services for low-income LTC consumers; 2. Create accessible and affordable housing for LTC consumers; 3. Ensure consumers, caregivers, and families have adequate information about LTC services and encourage Virginians to plan for their LTC needs 4. Improve HCB options for all seniors and persons with disabilities; 5. Improve state and local coordination. The NWD initiative will improve the information older adults and people with disabilities receive about available supports, including LTC services. The initiative includes: • Development of Virginia Easy Access, a Web portal that started in August 2008 and connects users to many information sources related to the needs of older adults and people with disabilities (including but not limited to LTC).

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			• Facilitating secure connections among AAAs and providers using coordinated information, referral and access software called the NWD Tools. Ten of Virginia's 25 AAAs are implementing the NWD Tools in 2009. • Establishing a protocol for when 2-1-1 Virginia, the Commonwealth's human services information and referral telephone line, refers people to agencies that specialize in information and assistance for older adults and people with disabilities (e.g. AAAs, CSBs and CILs). In the past few years, VA has embarked on two initiatives designed to encourage people to plan for their LTC needs: • The Own Your Future (OYF) Campaign (OYF) is a joint federal-state LTC awareness campaign featuring a toolkit for individuals to help them plan for their LTC needs. • VA also started a Long Term Care Partnership (LTCP) in September of 2007. This collaborative program between state government and private insurers permits individuals to buy LTCI policies with asset protection. Individuals who buy Partnership-qualified policies may retain assets equal to the amount the policy pays out for LTC benefits if they eventually apply for Medicaid. • In addition, VA offers group LTCI policies to state employees and permits tax deductions to its citizens for the purchase of LTCI. VA residents can deduct 100% of the sum of all premiums paid for a LTCI policy in a given year, provided that no deductions have been taken for the taxpayer's LTCI on the federal income tax claim for the given tax year. • VA has one program specifically designed to support informal caregivers: the VDA Family Caregiver Support Program. In FY 2008, VA served over 2,000 caregivers with expenditures of $5.1 million. The Commonwealth also supports informal caregivers through services provided under HCBS waivers.
Washington	12/2014	The Joint Legislative Executive Committee on Aging and Disability Issues: 2014 Final Report *45 pages - Skimmed*	The Committee is responsible for identifying key strategic actions to prepare for the aging of Washington's population. The Committee has framed the following policy options in terms of timing for implementation (short-term is the 2015 session, mid-term is the 2016 session, and long-term is 2017 and beyond).

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			• Long Term Care Insurance Study. Contracted actuarial insurance industry study of options to finance LTCI for the citizens of WA, including options for public financing and public-private partnerships. *SHORT-TERM* • Use Savings from the Community First Choice Option (CFCO): Federal matching funds cover 56% of the cost of services under the CFCO, which is 6% higher than the current rate. Implementing the CFCO is projected to save roughly $80 million GF-State in 2015-17. The Legislature authorized DSHS to utilize roughly half the savings to provide services to clients with developmental disabilities. The Legislature also directed the JLEC on Aging/Disability to explore options for further investment in HCBS. The following reinvestment options have been identified by the JLEC as equally important: ▪ Family Caregiver Support Program ▪ Medicaid Rate Enhancements for Providers of LTSS ▪ Restoration of hours for Home Care Clients ▪ Pre-Medicaid Services ▪ Area Agencies on Aging Care Management Funding *SHORT-TERM* • Create a "Save Toward Retirement Today" (STaRT) State Retirement Savings Plan. Permits private employers and employees to participate in retirement plans administered by the WA State Department of Retirement Systems. Empowers the WA State Investment Board to invest the funds contributed by participating employers and employees to the Start Plan *MEDIUM* • Encourage residents to plan for their retirement using tools available to them in the private market. Encourage planning before retirement with an emphasis on what residents can do for themselves to achieve their own planned retirement, without relying on state action (e.g., through education campaigns) *MEDIUM*

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			• Similar to the private market retirement planning suggestion, develop strategies and policies that will incent individuals to plan ahead and get more involved with their own future LTC needs. This could be through insurance, savings programs, or other planning tools. *MEDIUM* • Elder Abuse Omnibus Bill. Criminal codes should be updated to include a crime of financial exploitation of an adult and a reduction in the intent standard for the felony criminal mistreatment statute. *SHORT-TERM* • Timely response to complaints must occur within the Residential Care Services Complaint Investigations and Complaint Resolution Unit Intake Staffing. *SHORT-TERM* • The regulation of CCRCs should be given attention by the Committee in 2015 interim. MEDIUM • End of life care planning, patient counseling, system improvement (like Oregon's) *SHORT-TERM* • Duals pilot and health homes. These programs provide comprehensive services in one place for the highest cost, highest risk populations and should continue. If these service models are proven effective through improved outcomes, additional federal funds may be leveraged through shared savings with Medicare. *SHORT-TERM* • The work of the Committee needs to be continued in a forum that includes state-level policy makers to consider LTC policies. This could be continuing the committee in its current format and specifying a number of meetings yearly with or without an end date in the statute. *SHORT-TERM*

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			• Comprehensive community-based solutions to issues facing the aging population must be considered, including transportation options, housing options, and the use of CHWs. The state must encourage community efforts to plan for the needs of aging populations by supporting local initiatives that promote independence or by removing barriers that inhibit local solutions. *MEDIUM/LONG-TERM* • Policy needs to consider ways that technology can complement or substitute for human caregivers to reduce costs while maintaining or improving the QOC. *MEDIUM* • Look for ways to partner with the Federal Government to redesign Medicaid programs to allow for different eligibility criteria with a goal of obtaining services earlier and delaying enrollment in the full Medicaid program. *SHORT-TERM* • Respite services and other supports for unpaid caregivers. The needs of unpaid caregivers must be met through respite services and other supports, including the exploration of using Residential Habilitation Centers (RHCs) where available. Currently respite and supports are provided to unpaid LTC caregivers through the Family Caregiver Support Program. Through this program, planned respite may be provided in the client's own home, or with a short stay in an adult family home or nursing home. *MEDIUM* • In-home Respite Providers. Remove barriers for part time respite providers and address the workforce needs (how to address the shortage of qualified workers). *SHORT-TERM* • Continue the work of the Alzheimer's Plan Work Group which was established through SSB 6124. *SHORT-TERM*

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			• As WA's population ages, the number of people who will need guardianship and information about assisted decision making options will grow significantly. The state needs to understand how the formal guardianship system, both public and private, can respond to this need in a way that maintains high standards and public confidence. *MEDIUM*
Wisconsin	11/2014	Improving Long-Term Care in Wisconsin *16 pages – Read entirely*	○ In fiscal year 2014, 40% of state Medicaid expenditures in WI were spent on LTC, even though only 7% of Medicaid enrollees were receiving LTC services. ○ About 15% of WI residents age 65 and over are in a NH, compared to the national average of 13%. WI is facing some challenges that will result in future growth in Medicaid long-term care expenditures. **Recommendations to Reform Long-Term Care.** Following are some recommendations to further manage the increasing cost of long term care while providing services to residents who truly need them. 1. At the federal level, allow states to establish their own home equity limits, or none at all, for Medicaid eligibility. The current minimum and maximum home equity exemptions of $543,000 and $814,000 are large enough that almost anybody who is asset rich and cash poor can qualify for Medicaid. Instead, state legislatures should be allowed to establish their own, lower home equity limits, based on the median home price in the state and the distribution of assets among the residents' income quintiles. 2. Allow Medicaid to require and support reverse mortgages as an alternative to asset recovery. One option that could replace asset recovery after the death of the institutionalized spouse would be to require the use of reverse mortgages before Medicaid kicks in. Reverse mortgages allow homeowners age 62 or older to borrow against their home equity and receive the money in the form of a steady stream of income (annuity), a lump sum payment or a line of credit they can draw on. This income could then be used to pay for LTC.

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			3. Phase out the public/private partnership, and replace it with a state income tax credit for the purchase of LTCI. Public/private partnership program participation has been marginal at best, and more popular with higher-income households, who are least likely to qualify for LTC through Medicaid to begin with. In order to provide a greater incentive for the purchase of LTCI across all income and wealth levels, offer a tax credit toward state income taxes that phases out with higher income levels. 4. Use home care in place of institutional care when possible. Through new programs under the ACA, states can provide statewide HCBS as an alternative to institutional care. The CFC Option program allows states to receive an additional 6% in FMAP. Eligible recipients are those with incomes up to 150% of the FPL or those with incomes over 150% of the FPL who would otherwise be eligible for Medicaid services in their state.
Wisconsin	12/2013	Wisconsin's Future Population: Projections for the State, Its Counties and Municipalities, 2010-2040 *28 pages – read entirely*	**State Projections, 2010 – 2040** • WI's population in 2040 is projected to be nearly 6,500,000, a gain of more than 800,000 people, or 14%, from 2010. • Each decade will be marked by specific demographic patterns: 2010 – 2020: ○ Net migration, after being slightly negative in the first five years, returns to a strong net gain in the latter half of the decade, matching the state's pattern of the 1990s. ○ Births remain well ahead of deaths, providing a solid component of natural increase to the state's population, accounting for more than two-thirds of the decade's gain. ○ The total population will grow more than 315,000, nearly equaling the 2000-2010 numeric growth of 323,000. 2020 – 2030: ○ Net migration will continue to be strongly positive, producing nearly one-half of the decade's increase in population.

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			○ The leading edge of the Baby Boom reaches age 80 in mid-decade. Even with improvements in life expectancy, the size of the "Boomer" cohort will lead to an inevitable increase in deaths. While the number of births will still grow, it will not keep pace with the rise in deaths, thus leading to a reduction in the natural increase component. ○ The total population will grow more than 370,000, the largest decadal change since the 1990s. <u>2030 – 2040:</u> ○ Deaths among the Boomers will continue to rise. The number of births will increase only slightly. Natural increase, while remaining positive, will decelerate rapidly. ○ Net migration is expected to also lose pace after 15 years of strong growth. ○ The total population will grow by 115,000 for the decade. • Across the full 30 years: ○ The preschool- and school-aged populations—ages 0 through 17—will decrease slightly from 1,339,500 in 2010 to 1,311,500 in 2015, then grow steadily to a peak of 1,390,000 in 2035. At 1,381,000 in 2040, this age group will have a net gain of 3.1% from the beginning to the end of the projection period. ○ The school-aged population alone—ages 5 through 17—will follow a similar pattern: decline from 981,000 in 2010 to 962,500 in 2015, then a gradual increase to 1,012,500 at 2035. At 1,007,500 in 2040, the net gain across the 30 years will be 2.7%. ○ The traditional working-age population—ages 18 through 64—will rise modestly from 3,570,000 in 2010 to 3,603,000 in 2020, then begin a slow decline during the 2020s and 2030s to 3,575,000 in 2040, resulting in a 0.1% increase across time. ○ The elderly population—age 65 and over—will increase rapidly in every five-year interval, from 777,500 in 2010 to 1,535,500 in 2040, nearly doubling in 30 years.

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			○ The very elderly population—age 85 and over—will rise steadily from 118,500 in 2010 to 145,500 in 2025, then nearly double to 283,500 in the following fifteen years. From 2010 to 2040, this age group will increase 140%. ○ The state's population of centenarians is expected to increase from approximately 1,200 in 2010 to 3,800 in 2040. ○ The shares of three broad age groups will change across the 30-year time span in this manner: --Ages 0-17: from 23% in 2010 to 21% in 2040 --Ages 18-64: from 63% in 2010 to 55% in 2040 --Ages 65 & over: from 14% in 2010 to 24% in 2040 ○ The state's median age is projected to rise from 38.4 years in 2010 to 42.4 in 2040. In comparison, the Census Bureau projects the national median will rise from 37.7 to 40.4 years across the same period. ○ Life expectancy at birth will rise from 77.3 years at 2010 to 81.5 years in 2040 for males and from 82.0 years at 2010 to 85.7 years in 2040 for females. WI's life expectancies will continue to outpace those predicted for the national population.
	2013	State Studies Find Home and Community-Based Services to be Cost-Effective *24 pages – Skimmed/used as reference to locate studies*	Collection of studies published between 2005 and 2012 including state-specific public studies, evaluations and fiscal analyses. The studies address the actual or potential state fiscal impact (or justification) of HCBS alternatives to nursing facility care or the fiscal impact of HCBS programs using state-specific data. These reports include both state-sponsored studies or analyses and studies prepared by external entities. The focus was to collect publicly released studies or analyses that were relied upon by state policymakers to make decisions about HCBS program policymaking. Major Findings: • Many states have evaluated publicly funded HCBS programs, resulting in this collection of 38 studies. The studies that evaluated the cost effectiveness of HCBS

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			supported Medicaid "balancing" and other efforts to move more resources toward HCBS rather than institutional care. • This bibliography shares both qualitative and quantitative analyses that were conducted in states over the past 8 years (most within the past 5 years). State policymakers (both surveyed state Medicaid directors and aging and disability directors) have used these studies to make informed decisions about LTSS. • Several of the reports are available online. • The studies consistently provide evidence of cost containment and a slower rate of spending growth as states have expanded HCBS. Although few studies document absolute cost savings, the studies consistently found much lower per-individual, average costs for HCBS compared with institutional care. Overall, the findings illustrate cost reductions by diverting and transitioning individuals from nursing home care to HCBS.
	7/2008	A Balancing Act: State Long-Term Care Reform *195 pages - Skimmed*	Paper examines the extent to which states have balanced the delivery of Medicaid-funded LTSS to people in their homes and in institutions. The primary focus is on older people and adults with physical disabilities separate from other LTC populations. Includes profiles of all 50 states plus District of Columbia, Puerto Rico and the Virgin Islands
Ontario, Canada	1/2013	Living Longer, Living Well Highlights and Key Recommendations from the Report Submitted to the Minister of Health and Long-Term Care and the Minister Responsible for Seniors on Recommendations to Inform a Senior Strategy for Ontario (document not available online) *20 pages - Skimmed*	Specific Key Recommendations were grouped under the following headings: • Promoting Health and Wellness • Strengthening Primary Care for Older Ontarians • Enhancing the Provision of Home and Community Care Services • Improving Acute Care for Elders • Enhancing Ontario's Long-Term Care Home Environments • Addressing the Specialized Needs of Older Ontarians

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			• Medications and Older Ontarians • Caring for Caregivers • Addressing Ageism and Elder Abuse • Addressing the Unique Needs of Older Aboriginal Peoples in Ontario • Supporting the Development of Elder-Friendly Communities • Necessary Enablers to Support a Seniors Strategy for Ontario • Establishing the Mandate • Implementing the Strategy