Balancing Incentive Program

October 7, 2011
Friday Morning Collaborative

With support from The SCAN Foundation, NCOA leads a coalition of national aging and disability organizations working to protect and strengthen Home and Community-Based Services.

For more information about The SCAN Foundation visit: www.TheSCANFoundation.org
Friday Morning Collaborative

- AARP
- Alliance for Retired Americans
- American Network of Community Options and Resources
- Association of University Centers on Disabilities
- Alzheimer’s Association
- Balezon Center for Mental Health Law
- Easter Seals
- Families USA
- Jewish Federations of North America
- Leading Age
- Lutheran Services in America
- National Alliance for Caregiving
- National Association of Area Agencies on Aging
- National Association for Home Care and Hospice
- National Committee to Preserve Social Security and Medicare
- National Council on Aging
- National Council on Independent Living
- National Consumer Voice for Quality Long-Term Care
- National Disability Rights Network
- National Senior Citizens Law Center
- Paralyzed Veterans of America
- Paraprofessional Healthcare Institute
- Service Employees International Union
- The Arc/United Cerebral Palsy
- United Spinal Association
- Volunteers of America
Webinar Overview

- Introduction
  - Joe Caldwell, National Council on Aging

- Speakers
  - Anne Montgomery (Senator Kohl)
  - Janel George (Senator Cantwell)
  - Effie George (CMS Disabled and Elderly Health Programs)
  - David Braddock (Coleman Institute for Cognitive Disabilities, University of Colorado)
  - Enid Kassner (AARP Public Policy Institute)

- Questions and Answers
  - 15 - 20 minutes

- Closing Remarks
All Lines Will Be Muted During the Call
To Ask A Question Use the Chat Feature
Anne Montgomery
Senate Special Committee on Aging
Senator Kohl

Janel George
Senator Cantwell
Balancing Incentive Program
Section 10202
of the Affordable Care Act

EFFIE R. GEORGE, PH.D.

DISABLED & ELDERLY HEALTH PROGRAMS
GROUP, CMCS
Balancing Incentive Program

- Goal – increase access to non-institutionally based Medicaid Services and implement key structural reforms
- States must reach benchmarks of either 2 or 5% by the end of the program
- CMS is accepting applications from States immediately through August 1, 2014
- Enhanced FMAP available until September 30, 2015 or until total program funding of $3 billion dollars is expended
- State Medicaid Agencies must apply
Balancing Incentive Program

- Eligibility – States who submit an application and spend less than 50% on HCBS
- States may submit expenditure data on total Medicaid expenditures on LTSS as of FY 2009 to be reviewed on case by case basis
- States may not apply based on expenditures by target population(s)
- Funding available for community-based LTSS
Balancing Incentive Program

- Financial Incentives – 2 or 5% on eligible HCBS provided under the following Medicaid program authorities:
  - HCBS under 1915 (c) or (d) or under an 1115 Waiver;
  - State plan home health;
  - State plan personal care services;
  - The Program of All-Inclusive Care for the Elderly (PACE);
  - Home and community care services defined under Section 1929(a);
  - Self-directed personal assistance services in 1915 (j),
  - services provided under 1915(i),
  - private duty nursing authorized under Section 1905 (a)(8) (provided in home and community-based settings only)
  - Affordable Care Act, Section 2703, State Option to Provide Health Homes for Enrollees with Chronic Conditions
  - Affordable Care Act, Section 2401, 1915(k) - Community First Choice (CFC) Option.
Balancing Incentive Program

- **Structural Changes:**
  - No Wrong Door/Single Entry Point system,
  - conflict-free case management, and
  - core assessment instruments

- And data reporting requirements

- A User Manual and technical assistance will be available
Balancing Incentive Program

- Opportunities for collaboration and coordination
  - Community First Choice (CFC),
  - Health Home,
  - Money Follows the Person (MFP), and
  - Aging and Disability Resource Centers (ADRCs)
Resources

• Balancing Incentive Program Guidance:
  http://www.cms.gov/SMDL/SMD/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1252041&intNumPerPage=10

• Questions or comments:
  Balancing-Incentive-Program@cms.hhs.gov
BALANCING INCENTIVES: DISABILITY LONG-TERM CARE SYSTEMS

David Braddock, Ph.D., Associate Vice President, University of Colorado Professor and Executive Director, Coleman Institute for Cognitive Disabilities

Balancing Incentives Payments Webinar Washington, DC October 7, 2011

Presentation © 2011 David Braddock
I. CURRENT TRENDS IN SERVICES TO PEOPLE WITH DISABILITIES IN THE U.S.

II. CHARACTERISTICS OF ECONOMIC UNCERTAINTY IN THE STATES
I. OVERVIEW OF DISABILITY IN THE U.S.: 2010

TOTAL: 56.05 MILLION PERSONS

Source: Braddock, D., Coleman Institute, University of Colorado, 2010; estimated from U.S. Census Bureau, American Community Survey (2010).
U.S. DISABILITY SPENDING: 1997-08 ($ BILLIONS)

Average annual growth rate: 3%

Source: Braddock (2011), University of Colorado School of Medicine.
Figure 1
Public Spending for Disability in 2008

- **Health Care**: $158.3 Billion (26%)
- **Long Term Care**: $190.2 Billion (31%)
- **Special Education**: $86.7 Billion (14%)
- **Income Maintenance**: $183.5 Billion (30%)

Total: $618.7 Billion

Source: Braddock (2011), University of Colorado School of Medicine, Department of Psychiatry.
COGNITIVE/MH DISABILITY IN THE U.S.: 2010

Intellectual Disability 4.88 Million
Alzheimer’s 4.63 Million
Stroke .80 Million
Severe, Persistent Mental Illness 6.58 Million

TOTAL: 23.1 MILLION PERSONS

Source: Braddock, D., Coleman Institute, University of Colorado, 2010.
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**Source**: Braddock, D., University of Colorado School of Medicine, Department of Psychiatry, 2011.
United States

Billions of 2008 Dollars (Federal-State)

- Intellectual Disability
- Physical Disability
- Mental Health

Fiscal Year

Source: Braddock (2011), University of Colorado School of Medicine.
## 2008 Long-Term Care I/DD Spending: % Community

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**Source:** Braddock, D., University of Colorado School of Medicine, Department of Psychiatry, 2011.
## 2008 LONG-TERM CARE MENTAL HEALTH SPENDING: % COMMUNITY

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**Source:** Braddock, D., University of Colorado School of Medicine, Department of Psychiatry, 2011.
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**Source:** Braddock, D., University of Colorado School of Medicine, Department of Psychiatry, 2011.

**UNITED STATES** 22%
• STRUCTURE AND FINANCING OF I/DD SERVICES IN THE UNITED STATES
Daily Census of State I/DD Institutions in the U.S., 1848-2006

STATES WITHOUT STATE-OPERATED I/DD INSTITUTIONS

1. DISTRICT OF COLUMBIA (1991)
2. NEW HAMPSHIRE (1991)
3. VERMONT (1993)
4. RHODE ISLAND (1994)
5. ALASKA (1997)
6. NEW MEXICO (1997)
7. WEST VIRGINIA (1998)
8. HAWAII (1999)
9. MAINE (1999)
10. MICHIGAN (2009)
11. OREGON (2009)
12. ALABAMA (2012)

Utilization Rate: 194 per 100,000

PERCENT OF TOTAL OUT-OF-HOME I/DD PLACEMENTS IN SETTINGS FOR 6 OR FEWER PERSONS, 2009

I/DD MEDICAID MONEY IN THE STATES? 20% IS IN NEW YORK

An Outsize Share

One in five Medicaid dollars for developmental disabilities is spent in New York, where providers have become adept at exploiting funding formulas.

Source: The State of the States in Developmental Disabilities 2011, University of Colorado Department of Psychiatry

NY Times, August 2, 2011
### ESTIMATED PERCENT OF I/DD CAREGIVING FAMILIES RECEIVING STATE I/DD AGENCY SUPPORT, 2009

- **THE HCBS WAIVER FINANCES 58% OF FAMILY SUPPORT SPENDING IN THE U.S.**

**Source:** Braddock, D., State of the States in Developmental Disabilities, 2011.
• ECONOMIC UNCERTAINTY IN THE STATES
• DURING 2006, 2008 AND 2009, AGGREGATE PUBLIC NATIONWIDE I/DD SPENDING GREW BY THE SMALLEST AMOUNTS WE HAVE OBSERVED IN 32 YEARS.

ANNUAL % CHANGE IN INFLATION-ADJUSTED SPENDING: 1978-09

## INFLATION-ADJUSTED CHANGE IN I/DD SPENDING IN THE STATES, 2008-09:

### 23 REDUCTIONS

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<th>% Change</th>
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### Source:
WHICH STATES ARE CONFIDENT ABOUT THE U.S. ECONOMY TODAY?

Least Pessimistic

Most Pessimistic

A TALE OF FOUR RECESSIONS: 1979-2012 GENERAL FUND

Source: National Governors Association and National Association of State Budget Officers (Spring 2011)
79-10 "actual" state expenditure; 2011 "estimated" 2012 "recommended."
DECADE OF STATE BUDGET SHORTFALLS

Fiscal Year


Billions of Dollars

($300) ($250) ($200) ($150) ($100) ($50) $0 ($50) ($100) ($150) ($200) ($250) ($300)

Last Recession
March-Nov. 2001

"Great Recession"
Dec. 2007- June 2009

Source: Center on Budget and Policy Priorities (June 2011); National Bureau of Economic Research (2010).
# STATE BUDGET SHORTFALLS

## 42 STATES PROJECT BUDGET GAPS FOR FY 2012

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<th>State</th>
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<th>State</th>
<th>Percent of 2012 State Budget</th>
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**Source:** McNichol, Oliff, & Johnson, *Center on Budget and Policy Priorities*, June 17, 2011.
STATE TAX REVENUE FELL 2008 Q2 – 2009 Q2—REBOUNDED 2009 Q3 -- 2011 Q2

BOUNCING BACK? SALES TAX REVENUE INCREASES IN 47 STATES

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</tbody>
</table>

% CHANGE IN STATE TAX REVENUE JANUARY-MARCH QUARTER, 2010 TO 2011 (Revised)

STATE OF THE STATES, STATE OF THE NATION: 2011

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Raising Expectations

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

Enid Kassner
Director, Independent Living/Long-Term Services and Supports
AARP Public Policy Institute

October 7, 2011
Presentation to the Friday Morning Collaborative
Background

- Concise performance tool to put LTSS policies and programs in context and prompt dialogue.
- First attempt to use a multidimensional approach to comprehensively measure state LTSS system performance overall and across diverse areas of performance.
- Differs from analyses that examine a single aspect of states’ LTSS systems.
- Developed over two years: feasibility, vision, measures.
Expert Advisors

- Lisa Alecxih
- Brian Burwell
- Penny Feldman
- Lynn Friss Feinberg
- Melissa Hulbert
- Rosalie Kane
- Ruth Katz
- James Knickman
- Harriet Komisar
- Joseph Lugo
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  - Terry Moore
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  - D.E.B. Potter
  - Jean Accius
    - Kathy Apple
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  - Steve Eiken
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  - Sabrina How
  - Gail Hunt
  - Bob Kafka
  - Kathy Kelly
  - Thomas Lawless
  - Kevin Mahoney
  - Suzanne Mintz
  - Herb Sanderson
  - Mark Sciegaj
  - Nancy Spector
  - Shawn Terrell
  - Nancy Thaler
  - Heather Young
Goals

• Raise the national level of performance for LTSS.

• Help states:
  • Assess their systems of long-term services and supports (LTSS);
  • Target areas for improvement;
  • Provide a foundational set of baseline indicators to measure progress; and
  • Engage public and private sectors.
Characteristics of a High-Performing LTSS System

• Affordability and Access
• Choice of Setting and Provider
• Quality of Life and Quality of Care
• Support for Family Caregivers
• Effective Transitions and Organization of Care

• The first four characteristics map to dimensions and indicators.
Framework for Assessing LTSS System Performance

High-Performing LTSS System

is composed of five characteristics

Affordability and Access
Choice of Setting and Provider
Quality of Life and Quality of Care
Support for Family Caregivers
Effective Transitions and Organization of Care

that are approximated in the Scorecard, where data are available, by dimensions along which LTSS performance can be measured, each of which is constructed from individual indicators that are interpretable and show variation across states

Source: State Long-Term Services and Supports Scorecard, 2011.
In a high-performing LTSS system, consumers are able to easily find and afford the services they need and there is a safety net for those who cannot afford services.

**Affordability and Access** include:

- The relative affordability of private-pay LTSS;
- The proportion of individuals with private long-term care insurance;
- The reach of the Medicaid safety net and the Medicaid LTSS safety net to people with disabilities who have modest incomes; and
- The ease of navigating the LTSS system.
In a high-performing LTSS system, a person- and family-centered approach to LTSS places high value on allowing consumers to exercise choice and control over where they receive services and who provides them.

**Choice of Setting and Provider** includes:

- The balance between institutional services and HCBS;
- The extent of participant direction;
- The facilitation of consumer choice in publicly funded LTSS programs; and
- The supply and availability of alternatives to nursing homes.
Dimension: Quality of Life and Quality of Care

In a high-performing LTSS system, services maximize positive outcomes and consumers are treated with respect. Personal preferences are honored when possible.

Quality of Life and Quality of Care include:

- Level of support, life satisfaction, and employment of people with disabilities living in the community; and
- Indicators of quality in nursing homes and in home health services.
Dimension: Support for Family Caregivers

In a high-performing LTSS system, the needs of family caregivers are assessed and addressed so that they can continue in their caregiving role without being overburdened.

Support for Family Caregivers includes:

- Level of support reported by caregivers;
- Legal and system supports provided by the states; and
- The extent to which registered nurses are able to delegate health maintenance tasks to non-family members, which can significantly ease burdens on family caregivers.
Dimensions & Indicators

- Four dimensions are represented in the Scorecard.
- Each dimension is comprised of 3-9 indicators for a total of 25 foundational indicators (existing and new).
- Criteria for indicators:
  - Important and meaningful, conceptually valid, easy to interpret with clear directionality; and
  - Must be available for all states and updated regularly.
State Scorecard Summary of LTSS System Performance Across Dimensions

Source: State Long-Term Services and Supports Scorecard, 2011.
State Ranking on Overall LTSS System Performance

Source: State Long-Term Services and Supports Scorecard, 2011.
Two Ways to Use the Scorecard

Printed Report

Website
www.longtermscorecard.org

- Content:
  - Full Report
  - Executive Summary
  - Chart Pack
  - State Fact Sheets
  - State-by-State Interactive Comparisons
  - Podcast
  - Methodology
  - Archived Webcast
Data Challenges

• Data are not always available to measure the characteristics of a high-performing system.
  – Data may be missing entirely
  – Available but defined or collected differently across states
  – May not have clear directionality or scale
  – May require additional resources to analyze

• Strategies to address data gaps.
  – Process measures when outcomes not available
  – Original data collection
  – Combining multiple data sources
  – Composite indicators
Data Gaps

- Effective Transitions and Organization of Care
- Coordination with Medical Services, Supportive Housing, and Transportation
- Consumer-Based Measure of Availability of Services
- Performance Metrics for ADRC/SEP/Tools and Programs
- Degree of Consumer Direction
- HCBS Quality Measures
- LTSS Consumer Experience Measures
- Caregiver Respite
Innovative Approaches

• Safety Net Coverage
  – (used) Medicaid coverage for low-income pop. with disabilities
  – (used) Medicaid LTSS utilization for low-income PWD
  – (not used) Percent of population at risk for needing LTSS theoretically meeting functional/financial eligibility

• Consumer Direction
  – NRCPDS survey of consumer direction programs
    • Written form and follow-up phone interview
  – (used) percentage of PWD consumer-directing services
  – (not used) degree of consumer direction allowed
Innovative Approaches

• Composite Indicators
  - (used) ADRC/single entry point functionality
  - (used) Tools and programs to facilitate consumer choice
  - (used) System supports for caregivers
  - (not used) Quality monitoring

• Nurse Delegation
  - Original data collection with NCSBN
  - Data obtained for 46 states
  - Identification of 16 critical health maintenance tasks that could be performed (with training) by direct-care workers
Components of the Composite Indicator

- Presumptive Eligibility;
- Uniform Assessment;
- Money Follows the Person and other nursing facility transition programs; and
- Options counseling.
High-Level Findings

• Leading states often do well in multiple dimensions—but all have far to go to achieve the vision.
  • Rankings compare states to each other, not to the ideal.
  • No state scored in the top quartile across all 25 indicators.

• Wide variation exists within dimensions and indicators.

• States can target opportunities to improve and look to other states for paths to higher performance.

• Poverty and high rates of disability present challenges.
  • Even with these challenges, the lowest ranking states scored in the top quartile for at least one indicator.
High-Level Findings

- The cost of LTSS is unaffordable for middle-income families.

- State Medicaid policies dramatically affect consumer choice and affordability.

- Support for family caregivers goes hand in hand with other dimensions of high performance.

- Better data are needed to assess state LTSS system performance.
Role of Public Policy

Public policy plays an important role in LTSS systems by establishing:

- Who is eligible for assistance;
- What services are provided;
- How quality is monitored; and
- The ways in which family caregivers are supported.
Examples of Public Policy Actions

States can improve their performance by enacting public policies that:

• Assess and address family caregiver needs;
• Improve Medicaid balancing by adopting key provisions of the Affordable Care Act;
• Enhance consumer choice through administrative tools and structures such as streamlined eligibility and system navigation;
• Reduce reliance on nursing homes by taking advantage of programs such as Money Follows the Person; and
• Expand nurse delegation of health maintenance tasks.
State Variation: Measures of Medicaid LTSS Balance

Percent

- Best state
- Top 5 states average
- All states median
- Bottom 5 states average
- Lowest state

Percent of Medicaid and state-funded LTSS spending going to HCBS:
- New Mexico: 64%
- Washington: 60%
- Minnesota: 30%
- Oregon: 13%
- Alaska: 11%

Percent of new Medicaid LTSS users first receiving services in the community:
- Minnesota: 83%
- Michigan: 77%
- Alaska: 50%
- New Mexico: 26%
- California: 22%

Top 5 states
1. New Mexico
2. Washington
3. Minnesota
4. Oregon
5. Alaska

Note: HCBS = Home and Community-Based Services.
Source: State Long-Term Services and Supports Scorecard, 2011.
How the Affordable Care Act Can Help States Move Toward A High-Performing System Of Long-Term Services and Supports
# Impact of Improved Performance

## National Cumulative Impact if All States Achieved Top State Rates

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-Income PWD with Medicaid</td>
<td>667,171</td>
<td>more low- or moderate-income (&lt; 250% poverty) adults age 21+ with ADL disabilities would be covered by Medicaid.</td>
</tr>
<tr>
<td>Medicaid LTSS Balance: New Users</td>
<td>201,531</td>
<td>more new users of Medicaid LTSS would first receive services in home and community settings.</td>
</tr>
<tr>
<td>Nursing Home Hospital Admissions</td>
<td>120,602</td>
<td>unnecessary hospitalizations of people in nursing homes would be avoided. ($1.3 billion saved.)</td>
</tr>
<tr>
<td>Nursing Home Low Care</td>
<td>163,441</td>
<td>nursing home residents with low care needs would instead be able to receive LTSS in the community.</td>
</tr>
</tbody>
</table>

Notes: PWD = People With Disabilities; ADL = Activities of Daily Living.  
Source: State Long-Term Services and Supports Scorecard, 2011.
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Enid Kassner
Director, Independent Living/Long-Term Services and Supports
AARP Public Policy Institute

ekassner@aarp.org
Balancing Incentive Program

A Win-Win for States and Advocates
## Eligibility for Balancing Incentive Program

<table>
<thead>
<tr>
<th>State</th>
<th>% HCBS</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Mexico</td>
<td>83.2%</td>
</tr>
<tr>
<td>Oregon</td>
<td>72.3%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>67.9%</td>
</tr>
<tr>
<td>Arizona</td>
<td>69.3%</td>
</tr>
<tr>
<td>Vermont</td>
<td>64.9%</td>
</tr>
<tr>
<td>Alaska</td>
<td>62.7%</td>
</tr>
<tr>
<td>Washington State</td>
<td>62.1%</td>
</tr>
<tr>
<td>Colorado</td>
<td>58.1%</td>
</tr>
<tr>
<td>California</td>
<td>55.2%</td>
</tr>
<tr>
<td>Kansas</td>
<td>54.7%</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>52.1%</td>
</tr>
<tr>
<td>Wyoming</td>
<td>50.8%</td>
</tr>
<tr>
<td>Washington DC</td>
<td>50.3%</td>
</tr>
<tr>
<td>Maine</td>
<td>49.1%</td>
</tr>
<tr>
<td>Montana</td>
<td>47.2%</td>
</tr>
<tr>
<td>Texas</td>
<td>46.9%</td>
</tr>
<tr>
<td>New York</td>
<td>46.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State</th>
<th>% HCBS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idaho</td>
<td>46.2%</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>46.0%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>44.8%</td>
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<tr>
<td>Connecticut</td>
<td>44.1%</td>
</tr>
<tr>
<td>Utah</td>
<td>43.9%</td>
</tr>
<tr>
<td>North Carolina</td>
<td>42.9%</td>
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<tr>
<td>Hawaii</td>
<td>42.7%</td>
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<tr>
<td>Virginia</td>
<td>42.5%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>42.4%</td>
</tr>
<tr>
<td>Nevada</td>
<td>41.6%</td>
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<tr>
<td>Oklahoma</td>
<td>41.5%</td>
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<tr>
<td>New Hampshire</td>
<td>40.7%</td>
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<tr>
<td>Missouri</td>
<td>40.7%</td>
</tr>
<tr>
<td>South Dakota</td>
<td>40.5%</td>
</tr>
<tr>
<td>West Virginia</td>
<td>40.0%</td>
</tr>
<tr>
<td>Iowa</td>
<td>39.8%</td>
</tr>
<tr>
<td>Nebraska</td>
<td>38.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State</th>
<th>% HCBS</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Carolina</td>
<td>38.4%</td>
</tr>
<tr>
<td>Georgia</td>
<td>37.4%</td>
</tr>
<tr>
<td>Maryland</td>
<td>36.8%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>36.4%</td>
</tr>
<tr>
<td>Delaware</td>
<td>35.2%</td>
</tr>
<tr>
<td>Florida</td>
<td>34.2%</td>
</tr>
<tr>
<td>Michigan</td>
<td>33.0%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>33.0%</td>
</tr>
<tr>
<td>Ohio</td>
<td>32.5%</td>
</tr>
<tr>
<td>Kentucky</td>
<td>31.1%</td>
</tr>
<tr>
<td>Indiana</td>
<td>30.6%</td>
</tr>
<tr>
<td>Arkansas</td>
<td>29.8%</td>
</tr>
<tr>
<td>Alabama</td>
<td>29.7%</td>
</tr>
<tr>
<td>North Dakota</td>
<td>28.9%</td>
</tr>
<tr>
<td>Illinois</td>
<td>27.8%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>26.0%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>14.4%</td>
</tr>
</tbody>
</table>

Based on Appendix C of CMS Application
Yellow = 2% FMAP    Red = 5% FMAP
Rough Estimates

<table>
<thead>
<tr>
<th>State</th>
<th>FMAP Increase for HCBS</th>
<th>Additional FMAP $ (2011-2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York</td>
<td>2%</td>
<td>$815 million</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>2%</td>
<td>$179 million</td>
</tr>
<tr>
<td>Ohio</td>
<td>2%</td>
<td>$144 million</td>
</tr>
<tr>
<td>Virginia</td>
<td>2%</td>
<td>$70 million</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>2%</td>
<td>$43 million</td>
</tr>
<tr>
<td>Mississippi</td>
<td>5%</td>
<td>$36 million</td>
</tr>
</tbody>
</table>
To Ask A Question Please Use the Chat Function
Continue the Conversation Online

Join to discuss what you learned today!

www.NCOACrossroads.org/HCBS

• New online community!
• Join advocates nationwide to protect HCBS
• Easily share ideas and resources
• Access additional information and materials on block grants and spending caps.
• Access archives of previous webinars on state budgets and cost-effectiveness of HCBS.
Thank You

- You will receive a follow up e-mail next week with links to the archived recording of the webinar and additional resources.

- Please share with other advocates in your state.

- Please complete a short survey to give us feedback and suggestions for future webinars.