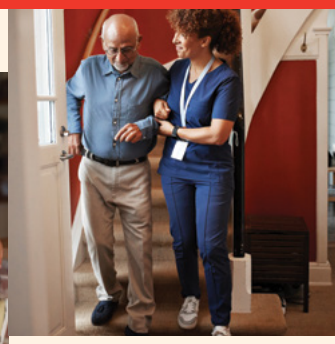
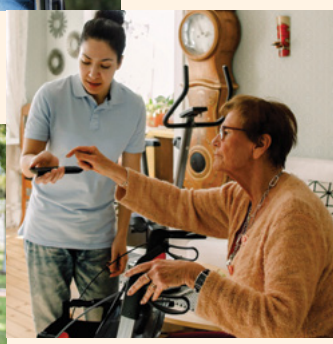
INNOVATION AND OPPORTUNITY:

A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers, 2023 Edition





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EXECUTIVE SUMMARY

Introduction

The 2023 LTSS State *Scorecard* (the *Scorecard*) is a compilation of state data and analysis based on a new vision of a high-performing state long-term services and supports (LTSS) system.[1] Released every three years, the *Scorecard* uses data from a wide range of sources to describe how state LTSS systems are performing. Our intention is to identify strengths and weaknesses in state systems to spark and inform the development of actionable solutions at the local, state, and national levels—solutions that respond in meaningful ways to individual preferences and family choices and care needs as well as to new pressures and challenges. We hope that it will help everyone who is part of these state systems to take action that will transform and modernize them.

This fifth edition of the *Scorecard* relies on indicators that have been tracked since the first *Scorecard* in 2011 to show trends over time. It also includes 20 new indicators and new ways of analyzing and displaying data to provide a more comprehensive picture of state performance. We made revisions to the five dimensions of high performance and organized states into performance tiers. All of these improvements are intended to offer states the clearest information we can about their performance as they rebuild and reimagine their LTSS systems going forward.

New Vision

This *Scorecard* is based on an updated vision of high-performing LTSS systems. That vision includes the following elements:

1. **Affordability and Access.** Consumers can easily find and afford services, with a meaningfully available safety net for those who cannot afford services. Safety net LTSS do not create disparities by income, race/ethnicity, or geography.

2. **Choice of Setting and Provider.** A person- and family-centered approach allows for consumer choice and control of services (including self-directed models). A well-trained and adequately paid workforce is available to provide LTSS. Home and community-based services (HCBS) are widely available. Provider choice fosters equity, and consumers across communities have access to a range of culturally competent services and supports.

3. **Safety and Quality.** Consumers are treated with respect and preferences are honored whenever possible, with services maximizing positive outcomes—including during and after care transitions. Residential facilities and HCBS settings are adequately staffed and are prepared for emergencies. Policy-, system-, and practice-level efforts reduce and/or prevent disparities in quality and outcomes.

1 "High-Performance Revisited: Examining Long-Term Services and Supports System Performance," Long-Term Services & Supports State Scorecard, November 10, 2022, https://www.longtermscorecard.org/publications/promising-practices/high-performance-revisited.

4. **Support for Family Caregivers.** Family caregivers are recognized and their needs are assessed and addressed, so they can receive the support they need to continue their essential roles. A robust LTSS workforce limits over-reliance on family caregivers. Family caregiver supports are culturally appropriate and accessible to all communities.

5. **Community Integration.** Consumers have access to a range of services and supports that facilitate LTSS, including safe and affordable housing. Communities are age friendly and supported by state Multisector Plans for Aging. Policy and programming that facilitate livable communities also drive equitable communities.

Equity in a High-Performing LTSS System

The new vision of a high-performing LTSS system centers on equity, which therefore will serve as a basis for the *Scorecard* now and going forward. With significant input from our advisors, we developed the following definition with regard to equity in LTSS:

> *Equity in a high-performing LTSS system means that high performance is shared across all groups, defined by race/ethnicity, gender identity, sexual orientation, age, disability status, and income, among others.*
>
> *States where every measured group does well will score highly, and states in which some groups perform poorly will score lower.*

We recognize that even an "average" LTSS experience may not be available to all communities—and that an LTSS system cannot be said to perform well unless it does so for everyone.

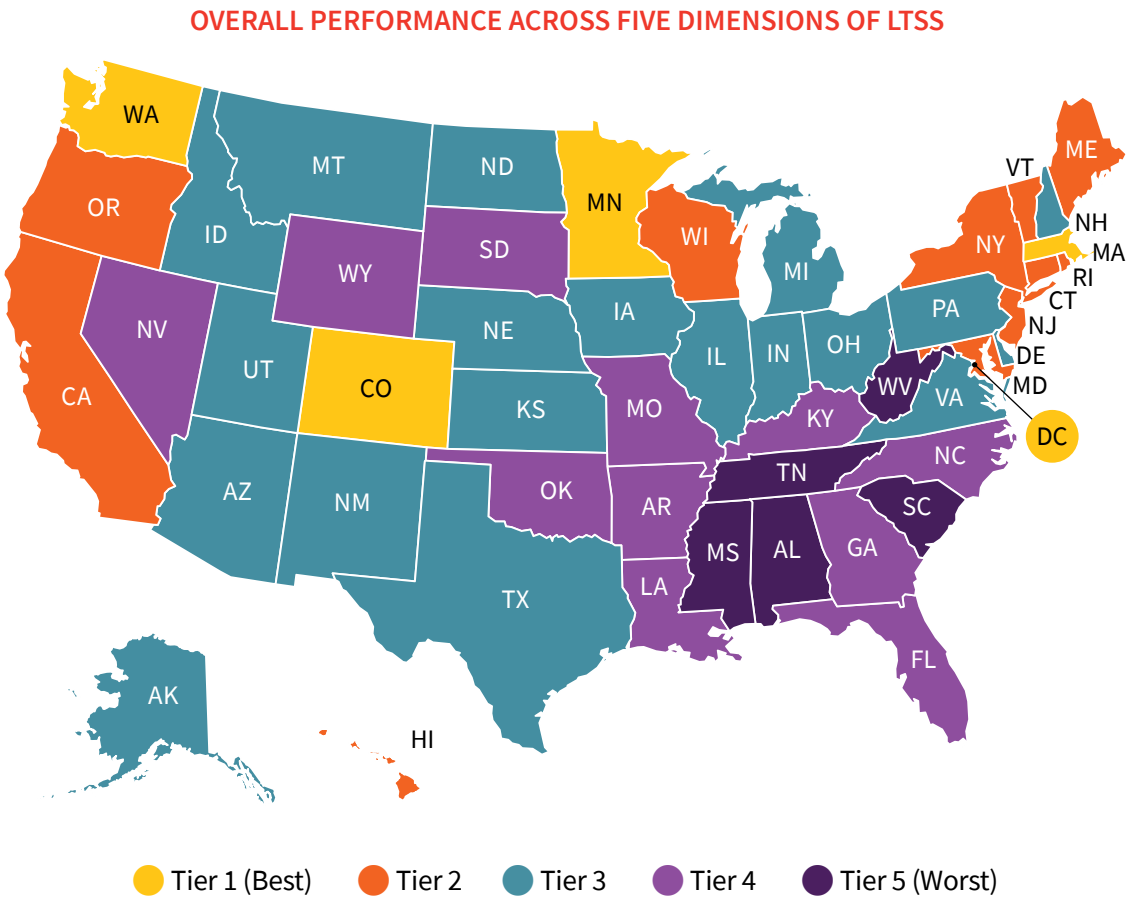
The limited availability of demographic data for LTSS recipients is a significant barrier to this effort. Our ultimate goal is to provide a comprehensive look at how different groups experience all aspects of state LTSS systems, but that is not achievable at this time. There are too many gaps in data collection, data reporting and data quality. However, considering this goal to be an imperative, we saw an opportunity with this *Scorecard* to take the first step, with race/ethnicity data only.

High-Level Findings

OVERALL PERFORMANCE AND STATE RANKINGS

As with previous *Scorecards*, states are ranked 1-51 relative to one another for each indicator, each dimension, and overall. While previous editions of the *Scorecard* have grouped states into equally sized quartiles, this edition groups states into performance tiers, to better reflect the natural distribution of state performance, where historically, most states fall closely together in the middle and very few states perform significantly above or below the national average. Only five states (Colorado, District of Columbia, Minnesota, Washington, Massachusetts) consistently scored high enough across all 50 indicators to reach the top tier of performance. See Exhibits A1 and A2.

EXHIBIT A1 | States are grouped into five performance tiers



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

Source: Long-Term Services and Supports State Scorecard, 2023.

EXHIBIT A2 | States are ranked 1-51 in overall performance, from top to bottom performance

TIER 1	
State	Rank
Minnesota	1
Washington	2
District of Columbia	3
Massachusetts	4
Colorado	5

TIER 2	
State	Rank
New York	6
Oregon	7
Hawaii	8
Vermont	9
New Jersey	10
California	11
Rhode Island	12
Connecticut	13
Maryland	14
Wisconsin	15
Maine	16

TIER 3	
State	Rank
Delaware	17
Nebraska	18
North Dakota	19
New Mexico	20
Pennsylvania	21
Arizona	22
Iowa	23
New Hampshire	24
Illinois	25
Alaska	26
Indiana	27
Virginia	28
Utah	29
Kansas	30
Michigan	31
Ohio	32
Montana	33
Texas	34
Idaho	35

TIER 4	
State	Rank
South Dakota	36
Arkansas	37
Missouri	38
Georgia	39
Wyoming	40
North Carolina	41
Kentucky	42
Florida	43
Nevada	44
Louisiana	45
Oklahoma	46

TIER 5	
State	Rank
Tennessee	47
Mississippi	48
South Carolina	49
Alabama	50
West Virginia	51

Source: Long-Term Services and Supports State Scorecard, 2023.

ACCELERATING PROGRESS

For the indicators in which we can track change over time, more states made significant progress in the last three years (2020–2023) than the previous three years (2017–2020). For the first time, the *Scorecard* finds more than half of Medicaid LTSS spending for older people and adults with physical disabilities went to HCBS, at a rate of 53 percent in FY 2020 (from which the 2023 *Scorecard* scores and ranks states). In addition, 12 states spend the majority of Medicaid LTSS funding for older people and adults with physical disabilities on HCBS (up from seven states in 2009).

The indicator showing the most improvement nationally is Self-Direction Enrollment, which increased by 10 percent or more in 35 states. Some states recording massive increases in enrollment across their self-directed programs of 500-1000 percent. Since the first *Scorecard* edition, the total number of people who self-direct services more than doubled from just under 740,000 in 2009 to more than 1.5 million in 2021.

SUPPORT FOR FAMILY CAREGIVERS

Among the five dimensions, the *Support for Family Caregivers* dimension shows the most consistency from the previous 2020 *Scorecard*. This in part reflects significant progress documented in previous editions of the *Scorecard*. States that already have policies that support family caregivers in place do not need to change but rather maintain their policy framework and ensure effective implementation of laws passed. The pace of change between the 2020 and 2023 *Scorecards* was relatively slow and states have many opportunities for further action. States that do well supporting family caregivers tend to have stronger overall LTSS systems; the scores and ranks of the *Support for Family Caregivers* dimension showed the highest correlation out of all five dimensions to overall scores and ranks.

COVID-19, NEW INDICATORS, AND STATE POLICY CHOICES

For this *Scorecard*, we used only data from 2020 and later to capture how the LTSS system faired during the pandemic. From the *Scorecard* data alone, we cannot determine whether observed changes are because of COVID-19, associated with the response to COVID-19, reflective of existing trends that were magnified by the pandemic, or entirely unrelated. However, we know from a wide body of other recent research how COVID-19 impacted people in LTSS systems, including high rates of cases and deaths, social isolation, and more. With this context in mind, for indicators we could track over time, there were significant changes to indicators of supply, safety, and cost that are likely related to the pandemic and how states and the federal government responded.

High Level Findings At-a-Glance

FINDING 1: Progress accelerated overall, particularly in *Choice of Setting and Provider* and *Affordability and Access* dimensions.

FINDING 2: Long-term progress maintained in *Support for Family Caregivers*.

FINDING 3: The impact of COVID-19 appears to have been significant in several areas.

FINDING 4: New and revised indicators contributed significantly to overall state performance, especially in the *Safety and Quality* and *Community Integration* dimensions.

FINDING 5: State policy choices that are highly aligned with state performance overall include those related to family caregivers, Medicaid, access to and enrollment in public programs, and focus on people with disabilities.

FINDING 6: States are laboratories for innovation.

FINDING 7: All top-performing states showed better-than-average performance on workforce indicators.

FINDING 8: Nursing home residents' experience varies widely across race/ethnicity groups.

Altogether, there are 20 new indicators that show how states compare in key areas related to LTSS workforce, nursing home safety and quality, programs targeted to people with disabilities (exclusively or in addition to older adults), housing, transportation, and performance across different racial and ethnic groups. Across all the indicators, those that pertain to access and enrollment in public programs and state Medicaid policy decisions are highly aligned with how states perform overall. Because Medicaid pays for the majority of LTSS, the choices that states make setting Medicaid policy have broad impacts on the entire LTSS system.

INNOVATION POINTS

There are six new "innovation point" indicators to recognize states for taking groundbreaking steps to improve their systems. In LTSS, cities, counties and states can serve as laboratories of innovation. However, for innovations to scale to the statewide level, they must be well-understood by state leaders and policymakers and supported by broad coalitions of people across sectors.[2]

We found that states are innovating across all regions and in a wide range of overall system performance, with 28 states credited for at least one of the innovations. Four states stand out for getting full or partial credit for three or more innovations (Colorado, California, Missouri, and New York). It is notable that all four include Multisector Plans for Aging as one of the innovations.

2023 Innovation Points Awarded

AFFORDABILITY AND ACCESS

Presumptive eligibility for HCBS

CHOICE OF SETTING AND PROVIDER

CAPABLE (Community Aging in Place—Advancing Better Living for Elders) Program

and Green House Nursing Homes

SAFETY AND QUALITY

Enhanced State Hazard Mitigation Plans

SUPPORT FOR FAMILY CAREGIVERS

Caregiver Tax Credit

COMMUNITY INTEGRATION

Multisector Plan for Aging

2 Susan Reinhard, Jane Tilly and Brendan Flinn, "From Ideation to Standard Practice: Scaling Innovations in Long-Term Services and Supports," November 2022: https://www.aarp.org/content/dam/aarp/ppi/2022/11/from-ideation-to-standard-practice-scaling-innovations-long-term-services-supports.doi.10.26419-2fppi.%2000176.001.pdf.coredownload.pdf

LTSS WORKFORCE

A strong direct care workforce is foundational to overall LTSS system performance. This workforce includes home health and personal care aides working in HCBS and certified nursing assistants working in nursing homes, among many other job titles. Direct care workers provide hands-on support to people with LTSS needs. Worker shortages and workforce instability have been major challenges for many years and were exacerbated by the COVID-19 pandemic. New indicators related to wages, turnover, and staffing levels shed light on what states are doing to recruit and retain workers. All states in the top two performance tiers demonstrate better-than-average performance specific to the workforce indicators.

EQUITY IN LTSS

Seven of the nine indicators for which we were able to analyze race/ethnicity data pertain to residents in nursing homes because of the federal requirements for nursing home reporting. No analog data resources exist for HCBS, but future editions of the *Scorecard* may provide more information to the extent that government agencies begin to collect and make public more HCBS data.

The *Scorecard* spotlights key areas for improvement with respect to equity for nursing home residents. These include hours of care per patient per day, residents with low care needs, top-rated facilities, and rates of pressure sores. Using the AARP Livability Index, the *Scorecard* also found differences across neighborhoods with different racial/ethnic make-ups in the assessment of housing and transportation systems.

Insights and Opportunities

In reflecting on 2023 *Scorecard* findings overall, the following insights arose—each coming with opportunities to take action.

- **Movement to shift balance to HCBS for older adults and people with physical disabilities is reaching a tipping point.**
- **Coalitions are more important than ever.**
- **Opportunities abound to scale innovations, especially to support family caregivers.**
- **Glaring gaps in data persist and more is needed to better understand equity in LTSS.**
- **A strong direct care workforce is essential.**

CHAPTER 1

Introduction and Purpose

The *2023 LTSS State Scorecard* (the *Scorecard*) is a compilation of state data and analysis based on a new vision of a high-performing state long-term services and supports (LTSS) system.[1] Released every three years, the *Scorecard* uses data from a wide range of sources to describe how state LTSS systems are performing. Our intention is to identify strengths and weaknesses in state systems to spark and inform the development of actionable solutions at the local, state, and national levels—solutions that respond in meaningful ways to individual preferences and family choices and care needs as well as to new pressures and challenges. We hope that it will help everyone who is part of these state systems to take action that will transform and modernize them.

LTSS systems affect everyone. As the country ages and adults with physical disabilities seek more options to remain independent, the need for LTSS will continue to grow. States have the opportunity to act now in strengthening LTSS systems and identifying new ways to maximize the use of limited resources to account for these demographic shifts. LTSS includes a continuum of services provided in the home and community or an institutional setting. These supports help older people and adults with physical disabilities manage tasks that would be difficult or impossible to perform on their own, such as personal care (e.g., bathing, dressing, and toileting); medical care (e.g., medication administration, wound care); home care (e.g., help with housekeeping and meal preparation), and transportation. Although older people are more likely to need LTSS, people of all ages rely on the LTSS system. In 2018, more than half (56 percent) of American adults who needed LTSS were ages 65 or older, while 44 percent were ages 18 to 64.[2] The formal structure of paid LTSS can also be a source of support for approximately 48 million family caregivers who help family and close friends with daily tasks.[3] Across all payer sources, the United States spent more than $400 billion on LTSS in 2020.[4]

See these sections for more about what's new in 2023…

New Dimensions and Indicators, p. 20

Innovation Points, p. 25

Indicators with Race/Ethnicity Breakdowns, p. 22

Performance Tiers, p. 26

1 Brendan Flinn, "High-Performance Revisited: Examining Long-Term Services and Supports System Performance," Long-Term Services & Supports State Scorecard, November 10, 2022, https://www.longtermscorecard.org/publications/promising-practices/high-performance-revisited.

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

3 AARP and National Alliance for Caregiving, "Caregiving in the U.S.: 2020 Report," May 2020, http://www.aarp.org/uscaregiving.

4 Priya Chidambaram and Alice Burns, "10 Things About Long-Term Services and Supports (LTSS)," KFF, September 15, 2022, https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/.

This 5th edition of the *Scorecard* relies on indicators that have been tracked since the first *Scorecard* in 2011 to show trends over time. It also includes new indicators and new ways of analyzing and displaying data to provide a more comprehensive picture of state performance. The COVID-19 pandemic put unprecedented pressure on all health and human service systems. In LTSS, it intensified longstanding problems, exposed gaps in the system, and had a catastrophic impact on the lives of people receiving services and working in LTSS systems. The data in this *Scorecard* come from the year 2020 and later, so it gives us a view into the immediate impact of COVID-19 and how state systems fared in the crisis. We have added race and ethnicity data for many of the indicators to measure equity in performance across all populations.

As we reflect on the impact of the pandemic, many of the original measures in the *Scorecard* have gained relevance and significance. For example, it is clearer now more than ever before that LTSS workers must have paid sick leave and time off that allows for family caregiving. Individuals should be able to tend to their own health and prevent spread of the disease without risk of losing their income. In addition, reflecting another previous indicator, policies that promote direct patient access to nurse practitioners, working to the full extent of their education and training, expands the health care workforce capacity to manage a future health crisis.

Many of the new and revised measures this year also directly address issues amplified by COVID-19. For example, states and employers that offer direct care workers more competitive wages are better able to recruit and retain workers, improving service stability and reducing unmet need. Nursing homes that facilitate COVID-19 vaccinations for both staff and residents have lower case rates and fewer deaths.

The *Scorecard* is a tool that states can use to identify needed improvements. It can be a catalyst for dialogue as well as action. While state government agencies play a large role in LTSS systems, making change happen requires more than action at the state level. It is an effort that must be informed and steered by the older adults and people with physical disabilities who rely on LTSS, as well the family caregivers and direct care workers who support them on a day-to-day basis. It requires collaboration across public and private sectors, the federal government the provider industry, insurers, philanthropic organizations, and community-based organizations. Along with health and human service systems, the ability of older adults and people with physical disabilities to live to their greatest potential in their communities depends on housing and transportation systems, employment systems, and disaster response systems. The experiences of individuals and families must drive decision-making. We must work together, and everyone has a part to play.

The *2023 LTSS State Scorecard* aims to empower all of these collaborators to do the following:

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

About the *Scorecard*

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

With support from The SCAN Foundation and The Commonwealth Fund, the AARP Public Policy Institute (PPI) published the first *Scorecard* in 2011. This first-of-its-kind project measured state LTSS system performance and ranked states in comparison to one another, based on several years of planning with a national advisory panel and funders). Building on the work of previous *Scorecard* projects focused on health care (e.g., The Commonwealth Fund's State Scorecard on Health System Performance) this *Scorecard* sought to raise the profile of LTSS and drive action both federally and within states. Since then, the *Scorecard* has helped both drive and spotlight change in state LTSS systems as well as improve services and supports that older adults and people with physical disabilities receive. For more discussion about the background and history of the *Scorecard*, see Appendix A.

What is New in 2023

NEW VISION OF A HIGH-PERFORMING SYSTEM

LTSS may involve, but are distinct from, short-term and/or medical care for older people and adults with disabilities. Definitions of the term vary; in this *Scorecard* we have revised the definition using some of the original research that led up to the *2011 Scorecard*, which included an extensive literature review and key expert interviews, as well as discussion with our National Advisory Panel (NAP) and other stakeholders. We define LTSS as follows:

> *Assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and complex care tasks provided to older people and other adults with disabilities who cannot perform these activities on their own due to a physical, cognitive, or chronic health condition that is expected to continue for an extended period of time, typically 90 days or more.*
>
> *LTSS include human assistance, supervision, cueing and standby assistance, assistive technologies/ devices and environmental modifications, health maintenance tasks (e.g., medication management), information, and care and service coordination for people who live in their own home, a residential setting, or a nursing facility. LTSS also include supports provided to family members and other unpaid caregivers.*

A high-performing LTSS system provides services and supports in a manner that is equitable across groups, particularly by race and ethnicity. It must also be coordinated with housing, transportation, and health care services, especially during periods of transition among acute, post-acute, and other settings. A system that delivers "good" care for some and "lesser" care for others does not serve all and cannot be considered high-performing while leaving individuals, families and communities behind.

For this *Scorecard*, we do not include services for people whose need for LTSS arises from intellectual disabilities, developmental disabilities, or behavioral health diagnoses. Further, the *Scorecard* does not include LTSS for children.

Summary of What's New

- **New Vision of High-Performing System** | SEE PAGE 17
- **Changes to Dimensions** | SEE PAGE 19
- **Changes to Indicators** | SEE PAGE 20
- **Innovation Points** | SEE PAGE 25
- **Performance Tiers** | SEE PAGE 26
- **New *LTSS Choices* Website** | SEE PAGE 26

NEW FRAMEWORK AND DIMENSION

Since the *Scorecard* was first published in 2011, five key dimensions have framed it: *: Affordability and Access, Choice of Setting and Provider, Quality of Life and Quality of Care, Effective Transitions,* and *Support for Family Caregivers*. These dimensions not only have framed the *Scorecard* since its inception but also collectively measure state system performance. While the *Scorecard* framework remained constant through the fourth edition in 2020, every edition has included some indicators that were revised from the prior version as well as new indicators. This year, we made two changes to the five dimensions: changing the title of *'Quality of Life and Quality of Care'* to *'Safety and Quality'* and replacing *'Effective Transitions'* with '*Community Integration*.' The COVID-19 pandemic along with a slate of natural disasters affecting LTSS have made clear that both safety and quality are essential to a strong LTSS system. Some of the indicators that had previously been organized under *Quality of Life* and *Quality of Care* and *Effective Transitions* are now part of *Community Integration*, along with several new indicators.

This *Scorecard* is based on an updated vision of a high-performing LTSS system…

1. **Affordability and Access**
   Consumers can easily find and afford services, with meaningfully available safety net for those who cannot afford services. Safety net LTSS do not create disparities by income, race/ethnicity, or geography.

2. **Choice of Setting and Provider**
   A person- and family-centered approach allows for consumer choice and control of services (including self-directed models). A well-trained and adequately paid workforce is available to provide LTSS. Home and community-based services (HCBS) are widely available. Provider choice fosters equity, and consumers across communities have access to a range of culturally competent services and supports.

3. **Safety and Quality**
   Consumers are treated with respect and preferences are honored whenever possible, with services maximizing positive outcomes- including during and after care transitions. Residential facilities and HCBS settings are adequately staffed and prepared for emergencies. Policy-, system-, and practice-level efforts reduce and/or prevent disparities in quality and outcomes.

4. **Support for Family Caregivers**
   Family caregivers are recognized and their needs are assessed and addressed, so they can receive the support they need to continue their essential roles. A robust LTSS workforce limits over-reliance on family caregivers. Family caregiver supports are culturally appropriate and accessible to all communities.

5. **Community Integration**
   Consumers have access to a range of services and supports that facilitate LTSS, including safe and affordable housing. Communities are age-friendly, supported by state Multisector Plans for Aging. Policy and programming that facilitates livable communities also drive equitable communities.

EXHIBIT 1 | *2023 LTSS Scorecard* Framework

FIVE DIMENSIONS OF LTSS PERFORMANCE, CONSTRUCTED FROM 50 INDIVIDUAL INDICATORS

AFFORDABILITY AND ACCESS

1. Home Care Cost
2. Nursing Home Cost
3. Long-Term Care Insurance
4. ADRC/NWD (Aging and Disability Resource Center/ No Wrong Door) Functions
5. ***Medicaid for Low-Income People with Disabilities^***
6. Medicaid Buy-In
7. Medicaid HCBS Presumptive Eligibility

CHOICE OF SETTING & PROVIDER

1. Medicaid LTSS Balance: Spending on HCBS
2. Self-Directed Program Enrollment
3. Assisted Living Supply
4. Adult Day Services Supply
5. Home Health Aide Supply
6. ***Nursing Home Residents with Low Care Needs^^***
7. LTSS Worker Wage Competitiveness
8. PACE (Program of All-Inclusive Care for the Elderly) Enrollment
9. LTSS Worker Wage Pass-Through
10. Green House® Policies and Availability
11. Point: CAPABLE (Community Aging in Place—Advancing Better Living for Elders) Availability

SAFETY AND QUALITY

1. HCBS Quality Benchmarking: NCI-AD™
2. HCBS Quality Benchmarking: HCBS CAHPS®
3. HCBS Quality Benchmarking: NCQA
4. Home Health Hospital Admissions
5. ***NH Hospital Admissions^^***
6. ***NH Residents with Pressure Sores^^***
7. ***NH Inappropriate Antipsychotic Use^^***
8. NH Staff Turnover
9. NH COVID-19 Vaccinations: Residents
10. NH COVID-19 Vaccinations: Staff
11. ***Nursing Home with Top Quality Ratings^^***
12. ***Nursing Home Staffing Levels^^***
13. State Emergency Management Plans

SUPPORT FOR FAMILY CAREGIVERS

1. Nurse Delegation
2. Nurse Scope of Practice
3. Family Responsibility Protected Classification
4. State Exceeds Federal FMLA (Family Medical Leave Act)
5. Paid Family Leave
6. Mandatory Paid Sick Days
7. Flexible Sick Days
8. Unemployment Insurance for Family Caregivers
9. Spousal Impoverishment Protections
10. CARE (Caregiver, Advise, Inform and Enable) Act Legislation
11. Respite Care through Medicaid Waivers
12. State Caregiver Tax Credits

COMMUNITY INTEGRATION

1. Employment Rate for People with Disabilities
2. ***Successful Discharge from NH to Community^^***
3. ***Livability Index: Transportation^^***
4. ***Livability Index: Housing^^***
5. ***Access to Housing Assistance for People with Disabilities^***
6. Age-Friendly Health Systems
7. Multisector Plans for Aging

ADRC/NWD = Aging Disability Resource Center/No Wrong Door
CAHPS = Consumer Assessment of Healthcare Providers and Systems
HCBS = Home- and Community-Based Services
LTSS = Long-Term Services and Supports
NCI-AD = National Core Indicators - Aging Disability
NCQA = National Committee for Quality Assurance
NH = Nursing Home(s)

Source: Long-Term Services and Supports State Scorecard, 2023.

TABLE LEGEND

^ Race/Ethnicity data displayed
^^ Race/Ethnicity data used to calculate score
- Existing 2020 Indicator
- New 2023 Indicator
- New 2023 Innovation Point

NEW INDICATORS

Our team and advisors along with the wide range of stakeholders we consulted suggested many new indicators to add to the *Scorecard*. Many of these address priority topics of equity and workforce. Others relate to the work states are doing to better address needs of people with disabilities specifically, promoting employment (Medicaid Buy-in Programs), planning for disasters and emergencies, and providing more livable age-friendly communities. Many of the new indicators speak to aspects of the LTSS system that do not fall under the singular purview of any one state agency. They underscore the interdependence and interconnectedness of state systems, the importance of cross-sector collaboration, and the role of many different entities in improving outcomes.

Most indicators are based on quantitative metrics with continuous variables. Others are scored on a yes/no basis to reflect policies and practices that may or may not be present. Several composite indicators are constructed from a range of data in a related area (e.g., indicators for Aging and Disability Resource Center/No Wrong Door systems, Housing and Transportation), enabling us to rank states in areas of performance that would otherwise be difficult to assess.

This *Scorecard* includes two new indicators that measure state performance in areas specific to people with physical disabilities, including access to affordable housing for low-income people with disabilities and Medicaid buy-in eligibility policies for working people with disabilities. These two join longstanding *Scorecard* indicators related to people with disabilities, such as self-direction, employment, and Medicaid enrollment. These additions were intentional and meant to drive the *Scorecard* toward more fully representing how LTSS systems serve people with physical disabilities.

As with prior *Scorecards*, depending on data availability and level of relevance, some indicators over time have been removed from the framework or replaced by other indicators. Appendix B presents the framework for the 2011, 2014 and 2017 *Scorecards*.

For inclusion in the *Scorecard*, indicators must be:

- Important
- Meaningful
- Understandable
- Clear in directionality
- Based on comparable state level data
- Based on data that will likely be updated regularly so that change can be observed over time

DEFINING EQUITY IN LTSS SYSTEMS

The new vision of a high-performing LTSS system that centers on equity will serve as a basis for the *Scorecard* now and going forward. With significant input from our advisors, we developed the following definition:

> *Equity in a high-performing LTSS system means that high performance is shared across all groups, defined by race/ethnicity, gender identity, sexual orientation, age, disability status, and income, among others.*
>
> *States where every measured group does well will score highly, and states in which some groups perform poorly will score lower.*

We recognize that even a strong "average" or "median" LTSS experience may not be available to all communities—and that no LTSS system can really deliver strong results unless it can do so for people across populations.

We encountered major challenges to considering equity in this *Scorecard*. The limited supply of demographic data for LTSS recipients is a significant barrier to this effort. Our goal is to provide a comprehensive look at how different groups experience all aspects of state LTSS systems, but that is not achievable at this time. There are too many gaps in data collection, data reporting and data quality. However, considering this goal to be an imperative, we saw an opportunity with this *Scorecard* to take the first step.

Even without data available for most indicators or for all the groups we want to consider, we decided to move forward by considering the demographic data we could access as best we could for as many indicators as we could. We found that demographic data are available at the individual, nursing facility or community levels for 11 indicators in four dimensions only *(Affordability and Access, Choice of Setting and Provider, Safety* and *Quality, and Community Integration*). For 9 of these 11, we were able to use these data to derive state scores and ranks.

MEASURING AND SCORING EQUITY

We developed our scoring approach to align with the vision statement that equity in a high-performing LTSS system means that all groups perform well. Strong performance in one or more large groups and for the overall population, with much weaker performance in other groups, is not equity. Poor performance across all groups is also not equity; it is just poor performance.

To inform our approach to scoring the data, we consulted with NAP advisors and other researchers in the field as well as reviewed the literature about measuring racial and ethnic disparities in LTSS. There is not one widely accepted way of factoring equity into performance measurement and ranking, and we did not find an example in the literature comparable to what we wanted to do. We needed to develop something that would work across the three types of indicators for which we had race/ethnicity data: nursing home level, community level, and individual level. We ultimately considered and devised several approaches, identifying and discussing the strengths and limitations of each with advisors. The importance of producing something as transparent, simple, and intuitively meaningful as possible helped us settle on the approach we selected. Even with its

limitations, the tradeoffs of advantages and disadvantages were acceptable to our team and our advisors—for now. We are optimistic that as more data about different groups are collected and become available and as this field advances, we will be able to improve our approach. To that end, the following describes our approach to indicators that help measure equity in LTSS.

1. **Divide the total population into groups and calculate the values for all groups.**
   - For facility and neighborhood level indicators, divide total population into groups for the following races and ethnicities with data available: American Indian/Alaska Native, Asian, Black, Hispanic, Native Hawaiian/Pacific Islander, White, Multiracial
   - For individual level indicators, where sample sizes are too small to analyze for some groups in some states, divide total population into two groups: 1) white group and 2) group combining American Indian/Alaska Native, Asian, Black, Hispanic, Native Hawaiian/Pacific Islander, and Multiracial
2. **Identify the lowest group value**
3. **Compare that value with the national average for all populations**
4. **Rank states in order of how much higher or lower their lowest group value is compared to the national average.**

The strengths and weaknesses we identified for this approach are detailed as follows.

For all three types of indicators, this approach compares the group in each state experiencing the lower performance on an indicator with a national benchmark for all populations, not a state-specific benchmark for one race or ethnic group. By using this benchmark, we are not comparing states with their own highest performance (which may still be low compared to that of other states) or with unusually high performance in unusually high-performing states. Rather, states' lowest performance is being compared with the average performance across all states for all populations. This tactic illuminates what level of performance on these indicators should be achievable in all states and how much needs to be done to improve access and quality for those experiencing the poorest outcomes.

Another important strength of this approach is that for indicators based on individual level data, it does away with the statistical problem of small sample sizes for some racial and ethnic groups in states where the resident population is very small. By dividing the total population into two groups for individual level indicators, we have two groups that cover the entire population in the state and this ensures that both groups are large enough to analyze in all states. This approach recognizes the biggest concern in equity research—that people who are American Indian/Alaska Native, Asian, Black, Hispanic and Native Hawaiian/Pacific Islander have less access to needed services, experience lower quality services and poorer outcomes than the general population. A large body of research focused on health systems has confirmed that people of color often experience lower quality services and poorer outcomes than white people being served in those same systems.

The limitations to this approach for individual level indicators are that combining so many races and ethnicities into one group and using that average value can mask what could be widely different

outcomes across several smaller diverse populations. By definition, the average value of that group will be higher than that of the lowest subgroup, so will not illuminate the full extent of the difference between people experiencing better and worse outcomes. Some of those groups may experience as high or higher performance than the white population while others may experience extremely low performance relative to that of others. However, combining avoids the problem of having too small a sample size for various subgroups, and combining this with our method of displaying data for every group allows us to be transparent about state performance across all measurable groups.

Another issue to note is that for the many multiracial people living in the United States—and even among people who identify as being part of one race or ethnicity—the differences are vast. Every state is diverse to some extent and each group has a unique history, set of challenges, and experiences. To make meaningful policy changes, it is important to look as closely as possible at the experiences of individual groups of people, yet the data being collected and reported do not capture these differences consistently. This problem is widely recognized and we anticipate that the many efforts underway at the federal, state and provider levels will improve data quality and comprehensiveness going forward.

LTSS WORKFORCE CHALLENGES

Virtually every stakeholder with whom we have engaged in recent years has pointed to direct care workforce challenges as a critical issue affecting all populations and services. We conducted a scan of the data and potential indicators available and identified new measures we could add regarding the topic—specifically, on state efforts to recruit enough workers to meet people's needs (added to *Choice of Setting and Provider*) and efforts to improve service quality and workforce stability (added under *Safety and Quality*).

The major challenge to adding more about LTSS workforce to the *Scorecard* is the lack of consistent data at the state level on the topic, particularly in home and community-based settings. People with many different job titles and job descriptions working in different settings constitute the direct care workforce. States face major challenges collecting data and tracking indicators across the multiple providers that employ these workers about the volume of the workforce, the compensation and benefits they receive, and stability measures of turnover and retention. We made use of the work PHI (phinational.org) does in compiling and analyzing information about worker wages,[5] including its Direct Care Workforce State Index. We also relied on data from the Care Compare tool about nursing home staffing levels and turnover. We were not able to include indicators about what training workers are required or supported to receive, what states require in terms of supervisory support, or what kinds of employee benefits workers get. Because few states have requirements for these types of workforce policies (especially in HCBS) and providers' policies vary widely, tracking this at the state level is not possible. The Centers for Medicare & Medicaid Services (CMS) published a set of HCBS Quality Measures in 2022[6] and as of June 2023 is working on policies about requiring states to collect and report on some, which may improve the availability of workforce data in the future.[7]

5 PHI, "The Direct Care Workforce State Index," last modified January 10, 2023, https://www.phinational.org/state-index-tool/.

6 Centers for Medicare & Medicaid Services, "CMS Releases First-Ever Home- and Community-Based Services Quality Measure Set," July 21, 2022, https://www.cms.gov/newsroom/press-releases/cms-releases-first-ever-home-and-community-based-services-quality-measure-set.

7 Centers for Medicare & Medicaid Services, "Ensuring Access to Medicaid Services (CMS 2442-P) Notice of Proposed Rulemaking," April 27, 2023, https://www.cms.gov/newsroom/fact-sheets/ensuring-access-medicaid-services-cms-2442-p-notice-proposed-rulemaking.

INNOVATION POINTS

In this *Scorecard*, we have added six new indicators that award "innovation points" to acknowledge and give states credit for taking innovative steps to improve their systems. With the additional federal funds allocated through the American Rescue Plan Act of 2021 (ARPA), states are busy trying new improvement strategies and adopting new policies. In LTSS, cities, counties and states can serve as laboratories of innovation. However, for innovations to scale to the statewide level, they must be well-understood by state leaders and policymakers and supported by broad coalitions of people across sectors.[8] As more states adopt these policies and implement these programs, we anticipate making them core indicators and identifying new innovations to highlight in future editions. With this current *Scorecard*, through these points we sought to call attention to programs or policies that meet the following criteria:

- Programs or policies that only a few states have adopted statewide but that have notable potential for scaling
- Programs or policies that are promising or evidence-based
- Programs or policies that are within the control of state government leaders to implement or adopt
- Programs or policies with explicit goals of improving state performance in at least one of the dimensions of the *Scorecard*

2023 Innovation Points Awarded

AFFORDABILITY AND ACCESS

Presumptive eligibility for HCBS

CHOICE OF SETTING AND PROVIDER

CAPABLE (Community Aging in Place—Advancing Better Living for Elders) Program

and Green House Nursing Homes

SAFETY AND QUALITY

Enhanced State Hazard Mitigation Plans

SUPPORT FOR FAMILY CAREGIVERS

Caregiver Tax Credit

COMMUNITY INTEGRATION

Multisector Plan for Aging

8 Susan Reinhard, Jane Tilly and Brendan Flinn, "From Ideation to Standard Practice: Scaling Innovations in Long-Term Services and Supports," November 2022: https://www.aarp.org/content/dam/aarp/ppi/2022/11/from-ideation-to-standard-practice-scaling-innovations-long-term-services-supports.doi.10.26419-2fppi.%2000176.001.pdf.coredownload.pdf

States that earn these points have this "extra credit" added to their overall dimension score. For example, states that have a Multisector Plan for Aging will receive extra credit in the *Community Integration* dimension. This credit reflects the value of each innovation in strengthening a state's overall LTSS system. In some cases, credit earned through an innovation point may improve a state's ranking within a given dimension and/or to their overall rank.

PERFORMANCE TIERS

In this *Scorecard*, we introduce a performance tier system. States are categorized into a performance tier from Tier 1 to Tier 5, from best to worst performance respectively—for each dimension and overall performance. These are not the quartiles that previous editions of the *Scorecard* used, with states evenly distributed into four groups. Instead, tiers provide more contextual information about which states are close together in terms of performance and where there are significant gaps in between groups of states even if they are ranked closely. Tiers show, for example, if there is a large drop between the performance of states ranked 1 through 5 and those ranked 6 through 10. For some dimensions, most states are clustered in the middle with very little difference in how they performed across indicators with a few states performing notably better or notably worse than the rest.

Introducing the LTSS Choices Website and *Scorecard* Tools and Resources

The work in driving towards a high-performing system with actionable solutions, as showcased through the *Scorecard*, continues through the LTSS Choices website: www.ltsschoices.aarp.org. Here, users will find a digital version of the new *Scorecard*, along with previous versions for review. Users can explore topics of interest more deeply, engage in content with peers, and learn what other states and organizations are doing to improve performance in current and emerging areas of interest. For example, the site features interactive maps and visuals for users to see and compare state data, findings, performance, and rankings. Fact sheets for each state are available for easy download.

In addition to hosting the digital *Scorecard* and its derivative products, the LTSS Choices website features information and tools on transformations in workforce, housing choices, services and supports, and community integration. Fresh content includes a mix of articles, blogs, catalogs to links with other resources, podcasts, videos, and other media. LTSS Choices publications, providing concrete examples of programs and states that have performed well in specific areas, are available to download, read and share.

To learn more access more information regarding the *Scorecard,* please visit our website at ltsschoices.aarp.org

Users will want to bookmark the site to stay updated on the changing landscape of LTSS and to see how colleagues and peers are seizing opportunities and overcoming challenges as we work toward a better LTSS system.

How Different Stakeholders Can Use the *Scorecard* and the LTSS Website

First and foremost, the *Scorecard* provides data to inform a wide range of stakeholders. It can serve as a road map to improve the lives of individuals who use LTSS and increase efficiencies in state LTSS systems. We all have a role to play in advancing a high-performing, equitable LTSS system, and the *Scorecard* can provide data insights to drive strategic action. While policymakers and advocates remain dominant forces in LTSS reform, the private sector is uniquely positioned, given its strengths in innovation, resource management, and operations, to take a more prominent position in addressing persistent gaps in the system. Following are some ways that different audiences can use the *Scorecard* to advance action.

POLICY MAKERS AT FEDERAL, STATE, AND COMMUNITY LEVELS

With the *Scorecard*, this group of stakeholders can do the following:

- **Use data to identify priorities and ensure resources are being allocated equitably.** To the degree possible, direct more investment toward areas of greatest need considering the disparate needs of urban and rural communities and different groups of residents.

- **Identify and remove policy barriers.** Review existing laws and regulations to determine what could be impeding progress.

- **Ensure effective implementation.** State agencies play a critical role in executing policy decisions in their state while federal agencies often focus on quality monitoring. Areas of weakness identified by the *Scorecard* may signal the need for additional resources or technical assistance that state or federal agencies could provide. In the absence of sufficient data to guide decisions, policymakers should seek more data as part of any plan of action.

- **Engage the public and private sectors.** Consider sharing the information about state rankings with community partners, advocates, the private sector, and other stakeholders to assess what is or is not working. The *Scorecard* measurements can help guide those conversations and drive consensus on action steps.

- **Discover promising practices.** The *Scorecard* highlights a handful of states that stand out in performance. Examples of innovative solutions are documented in Promising Practices and Emerging Innovations reports. Policymakers may choose to adopt successful strategies from other states to improve their LTSS system.

ADVOCATES AND ADVOCACY ORGANIZATIONS

With the *Scorecard*, this group of stakeholders can do the following:

- **Seek robust quality data and public reporting.** To be well-informed and prepared to advocate for themselves and their family members, consumers must have access to reliable and current LTSS data for both institutional and community settings. Where public reporting and data collection are inconsistent, advocates should seek more data and transparency.

- **Identify opportunities.** Advocates can consider how recent initiatives and strategies have affected state performance across various indicators over time. If there are links between recent policy implementation or budget decisions and improvements in performance, advocates may choose to celebrate and publicize that progress. Advocates can apply the information available in the *Scorecard* to tackle needs and leverage opportunities locally.

- **Evaluate legislative and budget proposals against *Scorecard* measurements.** *Scorecard* data, charts, state fact sheets, and state comparisons can provide advocates with an evidence-based rationale to support policy changes and enactment of model legislation. Advocates may wish to refer to *Scorecard* findings when delivering public testimony before legislative committees or making presentations to relevant stakeholders.

- **Draw comparisons and inspiration from other states.** Advocates may wish to adopt successful strategies from high-performing states and seed those ideas with key policymakers and legislators. When looking for other state examples, it may be useful to start with neighboring states or those with similar population size or demographics.

- **Spark conversation.** The *Scorecard* can be a useful resource to build bridges with other organizations and spark conversation with the public so that those and other stakeholders can understand state results, assess common priorities, and identify opportunities for action.

- **Capture the attention of key influencers.** Advocates may wish to leverage the *Scorecard* to draw attention to the findings and implications for local residents. Advocates can help identify points of intersection between state policy priorities and the *Scorecard* findings. Additionally, advocates can help contextualize the data by sharing personal stories and experiences with policy makers.

- **Influence policy debates.** Agency officials and program managers can look within their own state data to understand what the *Scorecard* is measuring and how those measurements reflect performance against other states. State agency officials can refer to *Scorecard* findings to inform policy decisions, evaluate funding proposals, and shape public debate.

INDUSTRY/PRIVATE SECTOR/EMPLOYERS

With the *Scorecard*, this group of stakeholders can do the following:

- **Promote innovation.** Private sector entities can utilize *Scorecard* data to drive innovation and target resources to improve outcomes and enhance the overall quality of long-term care. This can include assistive technologies to promote safety at home, data-level interoperability to improve service coordination and consumer experience, and telehealth platforms to expand the availability of care options.

- **Spur healthy competition.** Fostering healthy competition in the LTSS system has the potential to incentivize providers to strive for higher quality of care to meet the unique needs and preferences of older adults. Healthy competition could also result in improved affordability, access, and choice for older adults and people with physical disabilities, as well as support for family caregivers and paid workers.

- **Bolster existing policies implementation and outcomes.** By implementing their own internal policies and practices, private sector employers can enhance existing federal, state, and local regulations to support older adults and family caregivers. For example, employers can use *Scorecard* caregiving data to make a business case for an employee benefit offering flexible work arrangements for caregivers or an employee assistance program to help manage stress and navigate the challenges of caregiving.

- **Form partnerships.** Building a high-performing LTSS system will require strong public-private partnerships and collaboration to address systemic challenges. Private sector entities can use the *Scorecard* to form alliances and work collectively with policymakers, advocates, and other stakeholders to advance evidence-based and equitable solutions in long-term care.

INDIVIDUALS WHO USE LTSS AND FAMILY CAREGIVERS

With the *Scorecard*, this group of stakeholders can do the following:

- **Learn more about the types of programs and resources that might be available in which states.** The *Scorecard* may alert family caregivers about a new resource or an underutilized benefit in their own state. For example, a family caregiver may learn that their state or locality guarantees family caregivers workplace protections against discrimination or flexible leave to help balance work and family responsibilities.

- **Become more empowered to act.** Take full advantage of what employers offer, inspire culture change, demand tools to help families.

- **Get involved with the policy development process.** Bring information and experience to public hearings, and community meetings to help policy makers better understand challenges and prioritize potential changes.

CHAPTER 2

State Rankings

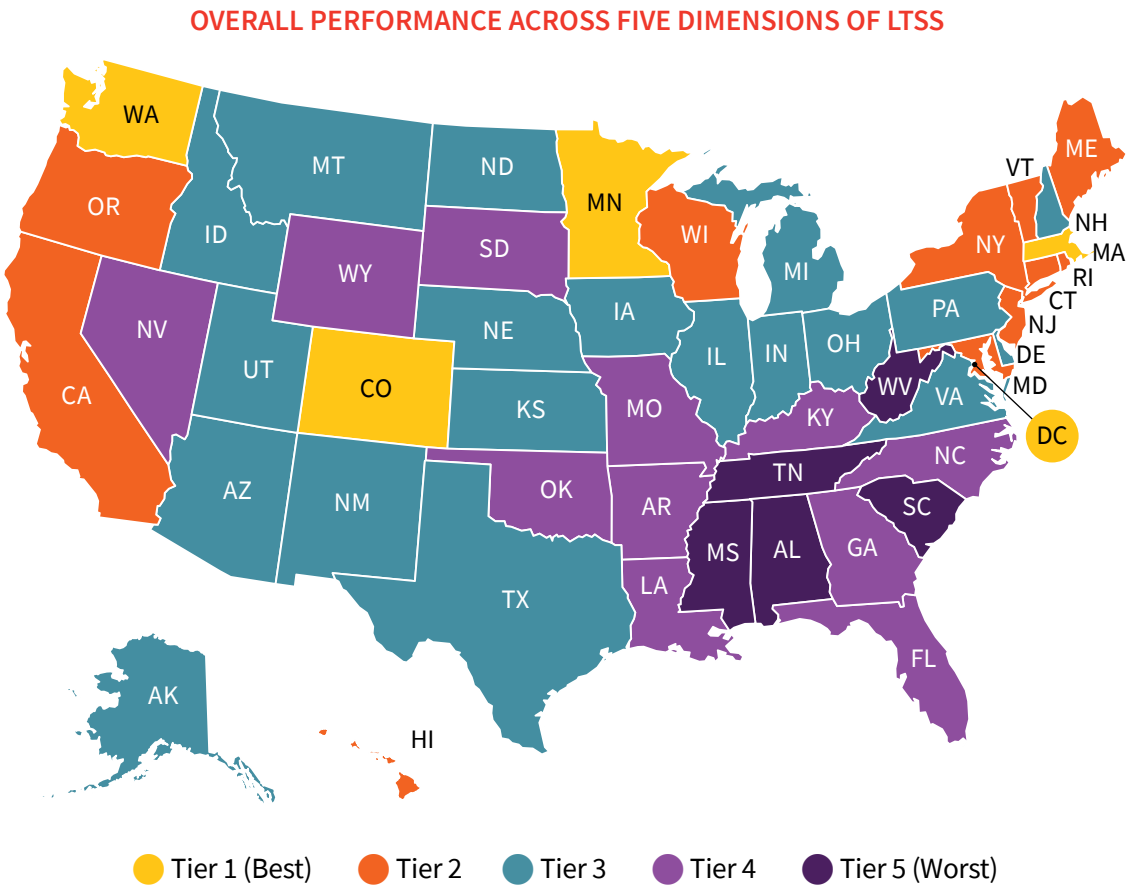
For the first time, the *LTSS Scorecard* includes performance tiers for all 51 states alongside their rankings. In lieu of grouping states into quartiles, the *2023 Scorecard* sorts states into five performance tiers for overall performance and within each of the five dimensions of LTSS system performance. Previous *Scorecard* editions used quartiles that did not reflect clusters of states and gaps between them. Now, performance tiers reflect the natural distribution of state performance, where historically, most states fall closely together in the middle; very few states perform significantly above or below the national average. As a result, only five states consistently scored high enough across all 50 indicators to reach the Top Tier of performance. Similarly, only five states fell to the Bottom Tier. In comparison, the *2020 Scorecard* grouped 13 states in the top quartile and 12 states in the bottom quartile. In Exhibit 3 and for additional tables in the appendices, visual representations using shaded circles depict performance improvement.

As with previous *Scorecards*, states are ranked 1-51 relative to one another for each indicator, each dimension and overall. Overall state rankings have shifted quite a bit compared with the *2020 Scorecard*, likely due to both real changes on the ground as well as changes and additions

Many things factor into this assessment of states' overall performance:

- **State policy changes**
- **Continuing trends**
- **Impacts of COVID-19** | SEE PAGE 41
- **The new Community Integration dimension with five new or revised indicators** | SEE PAGE 45 AND PAGE 80
- **Addition of six Innovation Point indicators** | SEE PAGE 48
- **Addition of four new Workforce indicators** | SEE PAGE 50
- **New consideration of race/ethnicity on nine indicators, some old and some new** | SEE PAGE 56
- **Family caregiver indicators were disaggregated so some policies have more weight than in 2020** | SEE PAGE 39
- **With 50 indicators instead of 26, each indicator has less weight individually than in 2020**

EXHIBIT 2 | States are grouped into five performance tiers.



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

Source: Long-Term Services and Supports State Scorecard, 2023.

in dimensions, indicators, and our methodology. While it's tempting to compare rankings in this *Scorecard* to previous editions, we caution against reading too much into changes in dimension and overall rank. We *do* track change over time for individual indicators for which there are comparable data in previous editions of the *Scorecard* to track state progress in specific areas (e.g., assisted living supply, nursing home hospital admissions). See Appendix F for more information about how we measure change over time.

New states appear among the top and bottom rankings since the last *Scorecard*. Colorado, the District of Columbia, and Massachusetts all joined Minnesota and Washington in the top five. Florida and Kentucky moved out of the bottom five to join 11 other states in Tier 4 of performance. Indiana, the District of Columbia, New Hampshire, and Rhode Island showed the most movement in rank while 19 other states have improved. Only seven states rank the same as reported in 2020. And with many new indicators and one new dimension of performance, even states with no change in rank will find new information in this *Scorecard*. With that said, all states show room to improve. See Appendix G for overall and dimension tiers and rankings by state.

EXHIBIT 3 | States are ranked 1-51 in overall performance, from top to bottom performance.

TIER 1	
State	Rank
Minnesota	1
Washington	2
District of Columbia	3
Massachusetts	4
Colorado	5

TIER 2	
State	Rank
New York	6
Oregon	7
Hawaii	8
Vermont	9
New Jersey	10
California	11
Rhode Island	12
Connecticut	13
Maryland	14
Wisconsin	15
Maine	16

TIER 3	
State	Rank
Delaware	17
Nebraska	18
North Dakota	19
New Mexico	20
Pennsylvania	21
Arizona	22
Iowa	23
New Hampshire	24
Illinois	25
Alaska	26
Indiana	27
Virginia	28
Utah	29
Kansas	30
Michigan	31
Ohio	32
Montana	33
Texas	34
Idaho	35

TIER 4	
State	Rank
South Dakota	36
Arkansas	37
Missouri	38
Georgia	39
Wyoming	40
North Carolina	41
Kentucky	42
Florida	43
Nevada	44
Louisiana	45
Oklahoma	46

TIER 5	
State	Rank
Tennessee	47
Mississippi	48
South Carolina	49
Alabama	50
West Virginia	51

Source: Long-Term Services and Supports State Scorecard, 2023.

> “Comparing the rankings in this *Scorecard* to previous editions is tempting, but we caution against reading too much into rank changes, especially at the dimension and overall levels.”

EXHIBIT 4 | States are organized into performance tiers for each dimension and overall.

2023 Rank	State	Affordability & Access	Choices of Settings & Provider	Safety & Quality	Support for Family Caregivers	Community & Integration	Overall
1	Minnesota	2nd	2nd	2nd	1st	1st	1st
2	Washington	1st	2nd	1st	1st	3rd	1st
3	District of Columbia	1st	3rd	2nd	1st	1st	1st
4	Massachusetts	2nd	1st	2nd	2nd	2nd	1st
5	Colorado	2nd	1st	1st	1st	3rd	1st
6	New York	2nd	2nd	3rd	2nd	2nd	2nd
7	Oregon	3rd	2nd	2nd	1st	2nd	2nd
8	Hawaii	2nd	3rd	1st	2nd	2nd	2nd
9	Vermont	3rd	2nd	2nd	2nd	2nd	2nd
10	New Jersey	2nd	3rd	2nd	1st	3rd	2nd
11	California	3rd	1st	1st	2nd	3rd	2nd
12	Rhode Island	3rd	2nd	3rd	3rd	2nd	2nd
13	Connecticut	2nd	3rd	3rd	2nd	3rd	2nd
14	Maryland	2nd	3rd	3rd	2nd	3rd	2nd
15	Wisconsin	3rd	1st	3rd	2nd	3rd	2nd
16	Maine	4th	3rd	3rd	2nd	2nd	2nd
17	Delaware	3rd	3rd	1st	3rd	3rd	3rd
18	Nebraska	3rd	3rd	3rd	3rd	2nd	3rd
19	North Dakota	4th	3rd	2nd	3rd	1st	3rd
20	New Mexico	3rd	3rd	3rd	2nd	3rd	3rd
21	Pennsylvania	3rd	1st	3rd	4th	2nd	3rd
22	Arizona	3rd	4th	3rd	2nd	3rd	3rd
23	Iowa	3rd	3rd	2nd	3rd	3rd	3rd
24	New Hampshire	3rd	3rd	3rd	3rd	2nd	3rd
25	Illinois	2nd	3rd	4th	4th	4th	3rd
26	Alaska	4th	3rd	2nd	2nd	5th	3rd
27	Indiana	3rd	3rd	3rd	4th	2nd	3rd
28	Virginia	2nd	3rd	4th	4th	3rd	3rd
29	Utah	4th	4th	2nd	3rd	2nd	3rd
30	Kansas	2nd	3rd	3rd	4th	3rd	3rd
31	Michigan	3rd	2nd	3rd	3rd	4th	3rd
32	Ohio	2nd	3rd	4th	4th	3rd	3rd
33	Montana	3rd	4th	4th	3rd	2nd	3rd
34	Texas	3rd	3rd	4th	4th	3rd	3rd
35	Idaho	4th	3rd	2nd	4th	4th	3rd
36	South Dakota	3rd	4th	3rd	4th	3rd	4th
37	Arkansas	3rd	4th	3rd	3rd	4th	4th
38	Missouri	3rd	4th	4th	3rd	3rd	4th
39	Georgia	3rd	4th	4th	3rd	4th	4th
40	Wyoming	4th	4th	3rd	3rd	4th	4th
41	North Carolina	4th	3rd	4th	5th	3rd	4th
42	Kentucky	4th	3rd	4th	4th	4th	4th
43	Florida	4th	3rd	3rd	5th	3rd	4th
44	Nevada	5th	4th	4th	3rd	3rd	4th
45	Louisiana	3rd	5th	4th	4th	4th	4th
46	Oaklahoma	5th	4th	4th	3rd	4th	4th
47	Tennessee	4th	3rd	4th	5th	4th	5th
48	Mississippi	3rd	4th	5th	4th	5th	5th
49	South Carolina	5th	3rd	4th	4th	4th	5th
50	Alabama	4th	5th	4th	4th	5th	5th
51	West Virgina	4th	5th	4th	4th	5th	5th

1st Tier (Best) 2nd Tier 3rd Tier 4th Tier 5th Tier (Worst)

Source: Long-Term Services and Supports State Scorecard, 2023.

"Notably, this *Scorecard* for the first time finds that more than half of Medicaid LTSS spending for older people and adults with physical disabilities went to HCBS, at a rate of 53 percent in FY 2020. In addition, 12 states spend the majority of Medicaid LTSS funding for older people and adults with physical disabilities on HCBS (up from seven states in 2009)."

EXHIBIT 5 | There are opportunities for even the top five states to improve.

Rank	State	Areas of Opportunity
1	**Minnesota**	**2nd Tier** in Affordability & Access, Choice of Setting & Provider, and Safety & Quality
2	**Washington**	**2nd Tier** in Choice of Setting & Provider **3rd Tier** in Community Integration
3	**District of Columbia**	**2nd Tier** in Safety & Quality **3rd Tier** in Choice of Setting & Provider
4	**Massachusetts**	**2nd Tier** in Affordability & Access, Safety & Quality, Support for Family Caregivers, and Community Integration
5	**Colorado**	**2nd Tier** in Affordability & Access **3rd Tier** in Community Integration

Source: Long-Term Services and Supports State Scorecard, 2023.

LOOKING BACK:

Major Themes Since the *2011 Scorecard*

The 2023 *Scorecard* is the fifth edition of the report. As we reach this milestone, we reflect back to our first edition published in 2011, which reported data from as early as 2008, and consider the progress made since its publication. Key areas we continue to monitor include the following:

HOME AND COMMUNITY-BASED SERVICES (HCBS) SPENDING BALANCE: 2009 was the first year we collected data on the LTSS spending balance for older adults and people with physical disabilities and, at that point, just 37 percent of these dollars went to HCBS. In this *Scorecard*, we find for the first time that more than half of LTSS dollars for this population go to HCBS, at a rate of 53 percent. See more information on page 69.

SELF-DIRECTION: Across all *Scorecards*, the rate of people with disabilities who self-direct services has grown more than 60 percent, from 22.3 people per 1,000 people in 2009 to 35.8 in 2021. During the same period, the *total* number of people who self-direct services more than doubled from just under 740,000 to more than 1.5 million in 2021. Since 2010, eleven states increased more than fivefold the number of people who self-directed services. See more information on page 69.

EMPLOYMENT OF PEOPLE WITH DISABILITIES: The *Scorecard* tracked the employment rate of people with disabilities relative to that of people without disabilities across several editions. From 2009 to 2021, the relative rate declined by about 2 percentage points, from 23.9 percent to 21.6 percent. Over the last several years, just 16 states improved their performance in this indicator. As society moves beyond COVID-19 and the labor market continues to tighten, stakeholders at all levels must do more to ensure people with disabilities have full opportunity for employment. See more information on page 81.

NURSE DELEGATION: The ability for a registered nurse to delegate certain medical/nursing tasks to nurse aides is a critical support for family caregivers and one that for which the *Scorecard* has documented improvement over more than a decade as more states allow such delegation across more tasks. From 2009 to 2022, 16 additional states allowed registered nurses to assign the administration of oral medication; 20 additional states allowed delegation for intramuscular medication administration; another 15 states allow delegation for eye/ear drops; and 11 additional states allow delegation for ostomy care. This increase marks real progress, allowing more paid workers to perform these tasks for consumers and potentially lessen what family caregivers must perform independently in the absence of a registered nurse. See more information on page 77.

MEDICAID ENROLLMENT FOR LOW-INCOME PEOPLE WITH DISABILITIES: Enrollment of low-income people with disabilities into Medicaid programs has increased steadily since the first *Scorecard*, from about 52 percent in the 2011 Scorecard (2008-2009 data) to 59 percent in 2021. Progress in this indicator exists across states. In 2008-2009, just 25 states had more than half of low-income people with disabilities enrolled in Medicaid. By 2021, almost all states (46) reached this threshold. See more information on page 67.

High Level Findings

Although we do not compare *state ranks* in this edition of the *Scorecard* to ranks in previous editions, we are able to track the absolute values of several individual indicators over time to monitor progress in specific areas. Of note, we are able to track 26 indicators over time, predominately those that fall in the dimensions of *Affordability and Access*, *Choice of Setting and Provider*, and *Supporting Family Caregivers* (21 of 26).

FINDING 1: Progress accelerated overall, particularly in the *Choice of Setting and Provider* and *Affordability and Access* dimensions.

Of the 26 indicators for which we can track change over time, more states made significant progress in the last three years (2020–2023) than the previous three years (2017–2020). State performance between 2017 and 2020 remained largely flat across most of the 21 indicators for which performance could be measured over time for the *2020 Scorecard*. In that edition, at least 60 percent of states showed little or no change for at least 70 percent of the indicators (15 of 21) indicators. In 2023 43 percent of states show little or no change for at least 70 percent of these trackable indicators.

Notably, more than half of Medicaid LTSS spending for older people and adults with physical disabilities went to HCBS, at a rate of 53 percent in FY 2020 (the year of data available for the *2023 Scorecard*). In addition, 12 states spend the majority of Medicaid LTSS funding for older people and adults with physical disabilities on HCBS (up from seven states in 2009).

High Level Findings At-a-Glance

FINDING 1: Progress accelerated overall, particularly in *Choice of Setting and Provider* and *Affordability and Access* dimensions.

FINDING 2: Long-term progress maintained in *Support for Family Caregivers*.

FINDING 3: The impact of COVID-19 appears to have been significant in several areas.

FINDING 4: New and revised indicators contributed significantly to overall state performance, especially in the *Safety and Quality* and *Community Integration* dimensions.

FINDING 5: State policy choices that are highly aligned with state performance overall include those related to family caregivers, Medicaid, access to and enrollment in public programs, and focus on people with disabilities.

FINDING 6: States are laboratories for innovation.

FINDING 7: All top-performing states showed better-than-average performance on workforce indicators.

FINDING 8: Nursing home residents' experience varies widely across race/ethnicity groups.

Other findings:

- Twenty-one states improved their Medicaid spending balance by 10 percent or more between 2018 and 2020.
- Six other states declined by at least 10 percent between 2018 and 2020.
- New Mexico saw the most decline but still has 57 percent of LTSS spending going to HCBS, an amount greater than the national average.
- California leads the national balancing percentage with 83.2 percent of its LTSS spending for older people and adults with disabilities goes to HCBS.

Continued LTSS balancing and investment in HCBS will provide a better foundation to expand elsewhere and strengthen system performance.

In addition, 33 states improved on five or more indicators. Only two states declined on five indicators.

The greatest improvement across states occurred across indicators in *Choice of Setting and Provider*, with 40 states improving on two or more indicators and 21 improving on three or four. In *Affordability and Access*, 18 states improved on two or more indicators with three as the maximum. Six states improved on two or more indicators in the *Support for Family Caregivers* dimension.

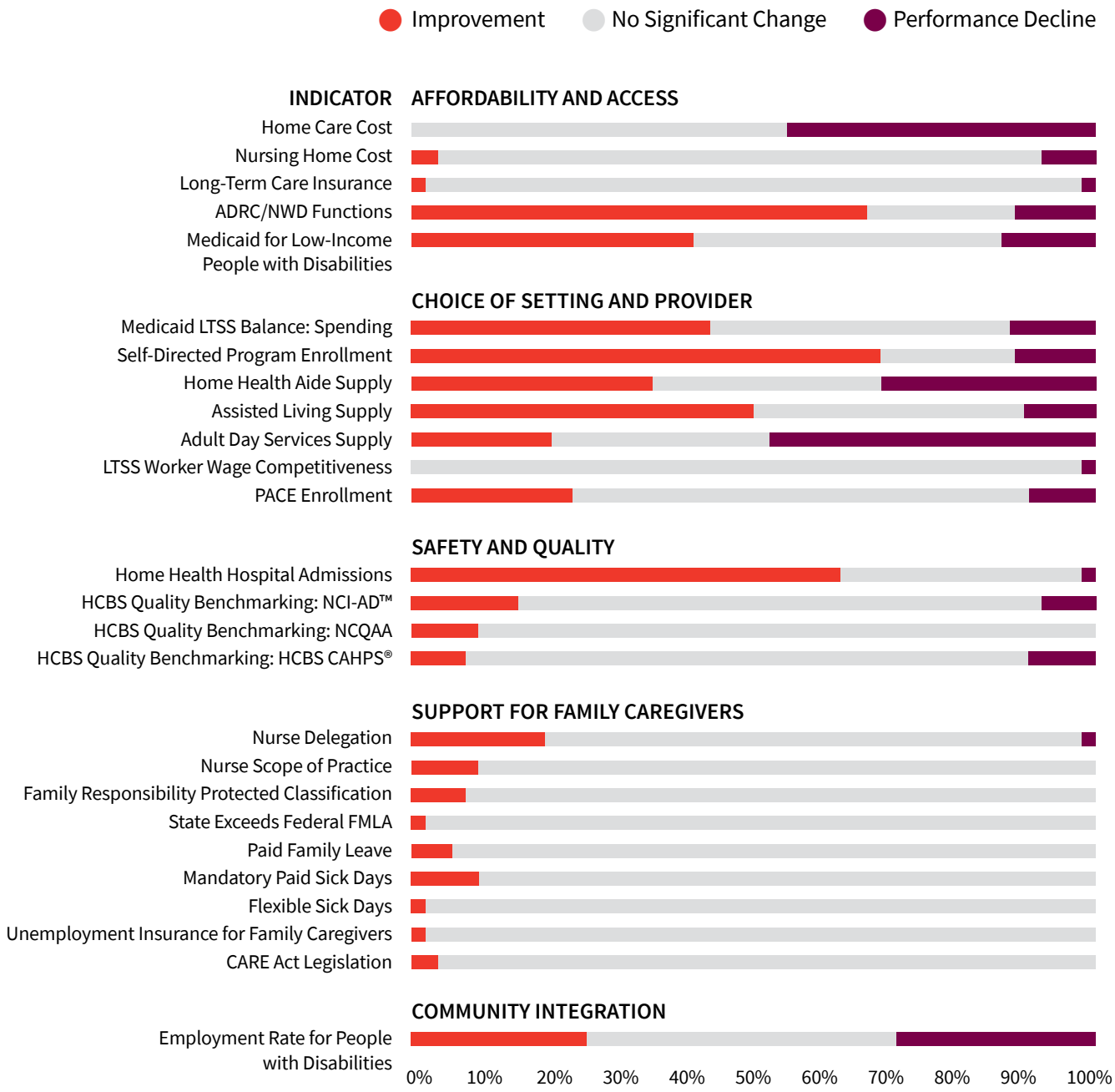
EXHIBIT 6 | The greatest number of states showed significant improvement in Self-Direction Enrollment, Aging and Disability Resource Centers/ No Wrong Door systems, and Home Health Hospitalizations.

Indicators With Most States Showing **Improvement**	Indicators With Most States Showing **Decline**
• Self-Direction Enrollment (35 states)	• Home Care Cost (23 states)
• Aging and Disability Resource Center/No Wrong Door (34 states)	• Adult Day Services Supply (21 states)
• Home Health Hospitalizations (32 states)	• Home Health Aide Supply (16 states)

Source: Long-Term Services and Supports State Scorecard, 2023.

EXHIBIT 7 | Across 26 indicators, there was more overall improvement than decline across states.

CHANGE IN STATE PERFORMANCE ON 26 INDICATORS FROM 2020 TO 2023 SCORECARDS



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

Source: Long-Term Services and Supports State Scorecard, 2023.

FINDING 2: Long-term progress maintained in *Support for Family Caregivers*

Among the five dimensions, *Support for Family Caregivers* shows the most consistency from the previous *2020 Scorecard*. In some cases, no change here is good news and reflects significant progress documented in previous editions of the *Scorecard*. States that already have laws that support family caregivers in place, such as the CARE Act, cannot necessarily improve in those same areas but they could work on monitoring and enforcement of laws passed. However, the pace of change between the *2020 Scorecard* and *2023 Scorecard* is slower compared to previous editions; most states still have many policy changes they could make that would better support family caregivers moving forward.

> "Most states still have many policy changes they could make that would better support family caregivers moving forward."

One indicator, nurse delegation, saw moderate improvement with 10 states reporting expansions in the number of tasks registered nurses can delegate to aides. Three states—Colorado, New York and Maine—improved the most within the last three years with three indicators of change each. For some indicators, such as paid sick leave, some cities and localities are still recording progress (as detailed in Appendix R). Most states have opportunitiy for improvement for the majority of indicators.

States that do well supporting family caregivers tend to have stronger overall LTSS systems. In fact, the scores and ranks of the *Support for Family Caregivers* dimension showed the highest correlation among all five dimensions with overall state scores and ranks.

The *Support for Family Caregivers* dimension was designed to emphasize the importance of family caregivers to high system performance in LTSS. It is meant to put family caregivers on the same footing as other key dimensions. It varies from other dimensions in that it's almost entirely comprised of policy indicators. Credit goes to states that have a policy in place; those without receive no credit. Family caregiver supports included in this dimension require states to adopt public policies that can be difficult to enact. They often require large coalitions of advocates and stakeholders to work together and get support from elected leaders. With the worsening worker shortage, much more rapid change is needed in this area. At the federal level, the Administration for Community Living published the National Strategy to Support Family Caregivers; this resource acts as a roadmap and contains more than 500 actions available at all levels of government for improving family caregiver supports.[1]

1 Administration for Community Living, "2022 National Strategy to Support Family Caregivers," last modified May 1, 2023, https://acl.gov/CaregiverStrategy.

> "The scores and ranks of the *Support for Family Caregivers* dimension showed the highest correlation among all five dimensions with overall state scores and ranks."

The indicators in this dimension do not exist in a vacuum and are far from the only indicators in the *Scorecard* that support family caregivers. For indicators across the other dimensions, strong state performance is good for family caregivers. States with greater access to self-directed services, stronger ADRC/NWD networks, or with more robust supply of services—from home health to assisted living—make it easier for both consumers and families and reduce what a family caregiver might need to do.

THE LTSS WORKFORCE AND FAMILY CAREGIVING

State performance as it relates to the LTSS workforce has crucial implications for family caregivers. Although paid care is not a substitute for family caregiving, it can help family caregivers balance caregiving with other responsibilities, such as work and family. A more robust supply of workers makes paid care (including what Medicaid covers) more available to consumers and families. Similarly, nursing homes with adequate, stable staffing can provide family members peace of mind knowing their relative is in a safe place. The absence of a robust, high-quality LTSS workforce is burdensome to family caregivers and leaves them without the supports needed to balance out care responsibilities.

In addition to the five workforce indicators, the *Scorecard* has long included two indicators focused on nursing that pertain to family caregiver supports: nurse practitioner scope of practice and nurse task delegation. In states where nurse practitioners are able to practice to the fullest extent of their education and training, and where nurses are legally able to delegate tasks to aides, the work of caregiving can be better distributed between paid workers and family caregivers. States can use workforce policy levers to alleviate how much family caregivers may need to do for those people in their care.

Exhibit 8 shows the nine indicators in this dimension tracked in the *Scorecard* over multiple editions and where states have the most room to improve in the coming years.

EXHIBIT 8 | Even with changes in individual indicator performance between 2020 and 2023, there is a lot of opportunity for states to improve.

Indicator	Number of States with Less than Full Credit in 2020	Number of States Showing Improvement in 2023	Percentage of States with Potential but No Improvement in 2023
Nurse Delegation	40	10	75% (30/40)
Nurse Scope of Practice	28	5	82% (23/28)
Family Responsibility Protected Classification	48	4	92% (44/48)
State Exceeds Federal FMLA	41	1	98% (40/41)
Paid Family Leave	42	3	93% (39/42)
Mandatory Paid Sick Days	38	5	87% (33/38)
Flexible Sick Days	34	1	97% (33/34)
Unemployment Insurance for Family Caregivers	25	1	96% (24/25)
CARE Act Legislation	10	2	80% (8/10)

Source: Long-Term Services and Supports State Scorecard, 2023.

FINDING 3: The impact of COVID-19 appears to have been significant in several areas.

The *2020 Scorecard*, released in September 2020 using data from 2019 and earlier, could not describe what if any impact the pandemic had on LTSS systems. For this *Scorecard*, we used only data from 2020 and later to paint a picture of LTSS system performance during the pandemic. For indicators that track change over time, reference data are from 2019 or earlier, before COVID. From the *Scorecard* data alone, we cannot determine whether observed changes are because of COVID-19, associated with the response to COVID-19, reflective of existing trends that were magnified by the pandemic, or entirely unrelated. However, we know from a wide body of other recent research that COVID-19 impacted people in LTSS systems, including high rates of cases and deaths[2], social isolation[3], and more.[4] With this context in mind and for indicators we could track over time, there were significant changes likely related to the pandemic and how states and the federal government responded.

2 AARP Public Policy Institute, "AARP Nursing Home COVID-19 Dashboard," last modified May 18, 2023, https://www.aarp.org/ppi/issues/caregiving/info-2020/nursing-home-covid-dashboard.html.

3 Jennifer Abbasi, "Social Isolation—the Other COVID-19 Threat in Nursing Homes," JAMA 324, no. 7 (July 2020): 619–20, https://doi.org/10.1001/jama.2020.13484.

4 Susan C. Reinhard, Brendan Flinn, and Carrie Blakeway Amero, "COVID-19's Impact on Community-based Long-Term Services and Supports," Generations: American Society on Aging, April 27, 2022, https://generations.asaging.org/covid-19s-impact-community-based-ltss.

> “The absence of a robust, high-quality LTSS workforce is burdensome to family caregivers and leaves them without the supports needed to balance out care responsibilities.”

SELF-DIRECTION ENROLLMENT: From the 26 indicators for which the *Scorecard* measures change over time, states collectively showed more improvement in self-direction enrollment than any other indicator. Thirty-five states increased their enrollment in self-directed programs by 10 percent or more, with some states recording massive increases and more than doubling enrollment in these programs. Six states showed greater than a 100 percent increase and 12 showed more than a 50 percent increase in enrollment. In 2023, 33 states had 10 or more out of 1,000 people with disabilities participate in self-directing services, and nationally more than 1.5 million people with disabilities participate in self-direction. State performance at enrolling people into self-directed programs improved more than any other indicator from the 2020 edition to the 2023 edition of the *Scorecard*. As worker shortages widened during the pandemic, many states shifted LTSS participants into self-directed programs and introduced and/or expanded the ability of consumers to hire and pay family caregivers to provide care. These policy changes, often authorized by the Centers for Medicare & Medicaid Services (CMS) through Appendix K and other similar authorities for HCBS programs[5], allowed more family members who may have already been part of a consumer’s household or “COVID pod” to serve as paid caregivers. By making these changes, states helped to better meet consumer needs while easing the demand for agency-employed workers.

HOME CARE COST: Twenty-three states saw a 10 percent or more increase in cost and the rest remained essentially the same. We can attribute the increase to a confluence of factors, including overall inflation, steadily growing demand as the population ages, and long-standing consumer preference for home care over nursing home care. At the same time, COVID-19 led many families to seek home care instead of nursing home services while the supply of workers did not increase to meet additional demand.

5 Centers for Medicare & Medicaid Services, “Emergency Preparedness and Response for Home and Community Based (HCBS) 1915(c) Waivers,” Medicaid.gov, last accessed August 10, 2023, https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/home-community-based-services-public-health-emergencies/emergency-preparedness-and-response-for-home-and-community-based-hcbs-1915c-waivers/index.html.

ADULT DAY SERVICES SUPPLY: Twenty-one states saw a 10 percent or more decline in supply for the *2023 Scorecard* based on data collected in the second half of 2020 and 2021, after the initial months of the pandemic led to extensive temporary or permanent closures of adult day services centers. Most HCBS services provided outside the home shut down. Many adult day providers closed their doors temporarily at first and then permanently, jeopardizing the field at large and reducing options for consumers.[6] Adult day services are a critical resource for family caregivers while they work or attend other matters. In addition, more than half of adult day services participants are Black, Hispanic, Asian and/or Native American.[7]

HOME HEALTH AIDE SUPPLY: Sixteen states saw a 10 percent or more decrease in supply while 18 states recorded a 10 percent or more increase. At a time when demand is surging for direct care, especially in HCBS, we would hope to see consistent increases in the size of this workforce but the story is mixed across states. Turnover has historically been high in this workforce, but for a variety of reasons including COVID-19, we know the churn in this workforce in the last three years was unprecedented. Employers and consumers lost direct care workers in droves during the pandemic due to worker or consumer illness, lack of paid sick leave, lack of health insurance, or lack of childcare.[8]

HOME HEALTH HOSPITALIZATIONS: The rate of hospitalizations among home health recipients declined in 32 states. The Kaiser Family Foundation observed a similar trend[9], finding the rate of hospitalizations was 105 out of 1,000 before the pandemic and then 95/1,000 in 2020. At least one contributing factor could be that people were choosing to avoid going to the hospital in situations in which they might have gone before, to avoid catching COVID.

In addition to these indicators, the *Scorecard* also measures statewide performance specific to COVID-19 vaccinations in nursing homes among staff and residents as of February 2023. These indicators focus on initial vaccination as well as being up to date with boosters.

> “35 states increased their enrollment in self-directed programs by 10 percent or more, with some states recording massive increases.”

6 Reinhard, Flinn, and Amero, “COVID-19’s Impact.”

7 National Center for Health Statistics, National Post-acute and Long-term Care Study, 2020, https://www.cdc.gov/nchs/npals/index.htm

8 Verena Cimarolli and Natasha Bryant, “COVID-19: Experiences of Direct Care Workers in Aging Services,” LTSS Center, February 2021, https://www.ltsscenter.org/wp-content/uploads/2021/02/COVID-Brief-LTSS-Feb-2021_FINAL.pdf.

9 KFF, Hospital Admissions per 1,000 Population by Ownership Type, https://www.kff.org/other/state-indicator/admissions-by-ownership/

Supply of LTSS is Critical to Strong System Performance, but Challenges Remain

The presence and availability of multiple types of LTSS providers are essential to a strong LTSS system. From the *Scorecard*, we know there are not enough providers to go around.

Adult day services immediately experienced an impact from COVID-19, from which the industry has not fully recovered. At the pandemic's outset, most providers suspended in-person services and although many eventually reopened, some closed permanently. The absence of adult day services had stark implications for both consumers and family caregivers, who often rely on adult day services to provide LTSS, as well as socialization and monitoring for their loved ones while they work.

In recent years, the supply of assisted living beds has increased, but challenges remain in accessing them. Assisted living is expensive, and there is limited Medicaid coverage that pays only for the service component of assisted living. Some assisted living communities are part of continuing care retirement communities, which are prohibitively expensive for most people and serve a predominantly white clientele. In other words, these services are not meaningfully available to most people or available in an equitable manner.

Direct care workers underwrite all paid LTSS. Although the supply of home health and personal care aides has ticked up in recent years, shortfalls remain in the number of workers available relative to how many people need care. Turnover in the field is high, as evidenced by the nursing home staff turnover indicator. The wage competitiveness indicator underscores just how poorly paid direct care workers are relative to other fields that current and prospective workers may consider.

These factors not only exacerbate long-existing problems in the field, but they also drive up LTSS costs and increase pressure on family caregivers. Across service lines, paid LTSS is unaffordable for most families, and rising costs resulting from long-term impacts of the pandemic and workforce shortages only serve to make these critical supports out of reach for too many people.

> "Thirty-two states recorded 10 percent or more fewer hospitalizations among home health recipients."

COVID-19 STAFF VACCINATIONS: Nationally 22 percent of nursing home staff were up to date with their COVID-19 vaccinations as of March 2023. In no state were more than half of staff up to date with their vaccine series and in just California and the District of Columbia did up-to-date rates exceed 40 percent. Fully half of states (25), on the other hand, saw up-to-date rates below 20 percent, including three below 12 percent: Alabama, Tennessee, and Mississippi. This is in marked contrast to the initial vaccination roll-out in 2020. Approximately 88 percent of staff were vaccinated with a primary series, but only one quarter of these were up to date with more current boosters.

COVID-19 RESIDENTS VACCINATIONS: Although higher than staff, at 53 percent nationally, the percentage of nursing home residents up to date with COVID-19 vaccinations fell short of previous vaccination efforts. South Dakota, had the highest rate at 77 percent, while Arizona lagged at 34 percent.

FINDING 4: New and revised indicators contributed significantly to the overall picture of state performance, especially in the *Safety and Quality* and the *Community Integration* dimensions.

All five dimensions contain new indicators, with the most falling into the revised dimension of *Safety and Quality* and the new dimension of *Community Integration*. The new indicators show how states compare in key areas related to LTSS workforce, nursing home safety and quality, programs targeted to people with disabilities (exclusively or in addition to older adults), community integration, and performance across racial and ethnic groups.

In *Safety and Quality*, there are both new and revised indicators that consider differences in state performance across race and ethnicity. This dimension contains data focused mostly on nursing home settings for two reasons: 1) lack of comparable quality data available for HCBS, and 2) growing nursing home quality concerns during the pandemic. *Community Integration* includes two new indicators from the AARP Livability Index that address many different aspects of states' transportation and housing systems.[10]

10 AARP, "Livability Index," last accessed August 10, 2023, https://livabilityindex.aarp.org/.

FINDING 5: State policy choices that are highly aligned with state performance overall include those related to family caregivers, Medicaid, access to and enrollment in public programs, and focus on people with disabilities.

The *Scorecard's* design is such that every metric contributes equally to dimension performance, every policy indicator contributes equally to dimension performance, and each dimension contributes equally to overall performance. With equal weighting, certain indicators and dimensions are more closely aligned, or correlated, with overall state performance than others.

Across the five dimensions, state performance on *Support for Family Caregivers* is more closely aligned with overall state performance than any other, followed closely by *Safety and Quality*. In other words, states that rank the best with respect to their policies to support family caregivers tend to rank higher overall across the dimensions.

EXHIBIT 9 | At the dimension level, state performance in *Support for Family Caregiver* and *Safety and Quality* aligns most with overall state performance.

Dimension	Correlation Between Dimension Performance and Overall Performance
Support for Family Caregivers	0.84
Safety and Quality	0.80
Choice of Setting and Provider	0.77
Community Integration	0.70
Affordability and Access	0.65

Source: Long-Term Services and Supports State Scorecard, 2023.

Among the 50 indicators, there are eight indicators for which state rankings showed little variance from state ranks overall. Though no single indicator can predict overall state performance, these indicators show the highest degree of overlap between high performance at the individual indicator level and state performance overall. Notably, six of these indicators relate to access and/or enrollment in different types of programs. Four indicators relate to programs primarily designed for or used by people with physical disabilities (not for or not limited to older adults) and three relate to Medicaid policies specifically. Of the five that could be tracked over time, all saw significant change in the last three years.

The *Scorecard* observed this pattern in previous editions. Because Medicaid pays for the majority of LTSS, the choices that states make setting states' choices about Medicaid policy have broad impacts on the entire LTSS system.

EXHIBIT 10 | At the indicator level, indicators related to access/enrollment in public programs including Medicaid and programs that are targeted towards people with disabilities (in addition to older adults) align most with overall state performance.

Indicator	Metric Correlation	Change *Scorecard* ≥ 10% since 2020 *Scorecard*	Access/ Enrollment to Public Programs	Medicaid	Focus on People with Disabilities
Community Integration: Access to Housing Assistance for People with Disabilities	**0.72**	New/ not trackable	●		●
Safety and Quality: COVID-19 Vaccinations for NH Staff	**0.72**	New/ not trackable			
Choice of Setting and Provider: Medicaid HCBS Spending	**0.70**	21 states improved	●	●	●
Choice of Setting and Provider: Home Health Aide Supply	0.62	18 states improved; 16 declined			●
Affordability and Access: Medicaid Enrollment for Low Income People with Disabilities	0.58	21 states improved	●	●	●
Affordability and Access: Long-Term Care Insurance Policies	0.57	1 state improved; 1 declined			
Community Integration: Transportation	0.56	New/ not trackable			
Safety and Quality: NH with Top Quality Ratings	0.54	New/ not trackable			
Affordability and Access: Medicaid Buy-In	0.53	New/ not trackable	●	●	●
Choice of Setting and Provider: Self-Direction Enrollment	0.52	35 states improved	●	●	●

Source: Long-Term Services and Supports State Scorecard, 2023.

FINDING 6: States are laboratories for innovation.

States are innovating across all regions and in a wide range of overall system performance, with 28 states credited with implementing at least one of the six innovations. Four states stand out at the top for getting full or partial credit for three or more innovations (Colorado, California, Missouri, and New York). It is notable that all four include Multisector Plans for Aging as one of the innovations. This suggests it is possible that the focus on systemic improvement and the type of coalitions required to develop a Multisector Plan for Aging are also associated with the commitment and capacity to innovate overall.

Although more than half of states receive credit for at least one of these innovations, most states do not yet have most of these innovations in practice. We consider each innovation to be a "next step" policy or programmatic area for states and hope to see each more broadly scaled in future editions of the *Scorecard*.

> "Four states stand out at the top for getting full or partial credit for three or more innovations (California, Colorado, Missouri and New York). It is notable that all four of these include Multisector Plans for Aging as one of the innovations."

EXHIBIT 11 | At least one Innovation Point is included in every dimension.

Innovation Point	Inclusion Criteria	Importance	States
Affordability & Access: Medicaid HCBS Presumptive Eligibility	States with permanent or public health emergency-based policies providing for Medicaid HCBS presumptive eligibility.	People entering Medicaid LTSS often cannot wait weeks or months for a waiver application to be processed. HCBS PE allows expedited enrollment and helps keep people in their homes and communities while a full eligibility determination takes place.	11 (CA, CO, IL, IN, MI, MN, NJ, OH, OR, RI, WA)
Choice of Setting & Provider: Green House Availability	State funding and/or policy support for Green House facilities; more than 200 Green house beds.	Green House and similar facilities have proven to have better outcomes than those of traditional nursing homes and serve residents in a more home-like setting with empowered staff.	10 (AR, CO, CT, IN, KS, MS, MI, NY, OH, RI)
Choice of Setting & Provider: CAPABLE Availability	State funding for the CAPABLE model.	CAPABLE is the primary model of restorative care in the United States and could help older adults delay or avoid entirely costly LTSS and alleviate pressure on family caregivers.	7 (CO, CT, IL, MA, NY, OK, VT)
Safety & Quality: State Emergency Management Plans	States with enhanced state hazard mitigation plans approved by the Federal Emergency Management Agency that include statewide analysis of vulnerable populations such as seniors and people with disabilities using a social vulnerability index.	States need to have effective plans in place for disaster preparedness and response that includes specific plans to meet the needs of older adults and people with disabilities.	9 (CA, CO, GA, MO, NC, ND PA, SD, WA)
Support for Family Caregivers: State Family Caregiver Tax Credits	States with tax credits that cover out-of-pocket expenses of taxpayers caring for family members aged 18 or over experiencing difficulty with at least one activity of daily living.	Family caregiver tax credits provide much-needed financial support for family caregivers. Almost 80 percent of caregivers shoulder out-of-pocket care expenses. Existing policy provides little to no support for these financial pressures.	6 (GA, MO, MT, ND, NJ, SC)
Community Integration: Multisector Plans for Aging (MPA)	States with a developed/ implemented MPA or legislation/executive order on a MPA.	An MPA establishes a 10-year blueprint that guides the restructuring of state and local policy and programs while connecting the public, private, and independent sectors to better serve older adults and those who support them.	8 (CA, CO, MA, MO, NC, NY, UT, VT)

Source: Long-Term Services and Supports State Scorecard, 2023.

FINDING 7: All top-performing states showed better-than-average performance on workforce indicators.

A strong LTSS workforce is foundational to overall LTSS system performance. The LTSS field relies on the labor of both paid workers and family caregivers to meet the needs of consumers. Most of the care that LTSS provides must be performed by a person, in-person, and cannot be automated or done remotely. Thus, policy and practice that affects the ability of LTSS workers to do their jobs and remain in the field must be considered when assessing system performance. To that end, this *Scorecard* prioritizes workforce considerations and includes longstanding and new indicators that measure state performance as it relates to these critical workers.

Since its inception, the *Scorecard* has measured each state's supply of home health and personal care aides. Quantifying the number of workers available to carry out LTSS delivery is important, and we continue to measure each state's supply. This *Scorecard* builds upon previous editions and includes new indicators that measure LTSS worker wage competitiveness, state LTSS worker payment policies in Medicaid, and nursing home staffing levels and turnover.

EXHIBIT 12 | Five workforce indicators are included in 2023.

Indicator Name	Indicator Data Source	Indicator Data Year(s)
Home Health/Personal Care Aide Supply	American Community Survey Data	2020-2021
New: Direct Care Worker Wage Competitiveness	PHI State Workforce Data Index	2021
New: Direct Care Worker Wage Pass Through Policy	PHI State Workforce Data Index	2022
New: Nursing Home Staffing Levels	Centers for Medicare & Medicaid Services	2021
New: Nursing Home Staff Turnover	Centers for Medicare & Medicaid Services	2022

Source: Long-Term Services and Supports State Scorecard, 2023.

With the addition of four new, workforce-centric indicators, this *Scorecard* considers the role of the LTSS workforce—and relevant policy and practice—to a state's overall system performance.

All states in the top two performance tiers demonstrate better-than-average performance specific to the five workforce indicators. As seen in Exhibit 13, the top performing states share strong performance in some or all of the workforce indicators.

Performing well on workforce indicators does not guarantee a state's overall strong performance; however, multiple states with strong workforce performance place overall in the lower tiers of state performance. Pennsylvania and Alaska, for example, are second and sixth, respectively, in best performance specific to workforce indicators, but ultimately both states performed in Tier 3 and ranked 22nd and 23rd, respectively.

From these data, the *Scorecard* finds that a strong LTSS workforce is necessary to high-performing overall system performance but is not enough in and of itself. In addition, while these states may be performing better than others, workforce performance continues to be a major concern, even in these states.

EXHIBIT 13 | All states in Top Tiers overall perform well in workforce indicators.

State	Overall Rank	Performance Tier	Workforce Aggregate Rank[11]
Minnesota	1	1	10
Washington	2	1	7
District of Columbia	3	1	12
Massachusetts	4	1	1
Colorado	5	1	18
New York	6	2	5
Oregon	7	2	19
Hawaii	8	2	21
Vermont	9	2	24
New Jersey	10	2	16
California	11	2	3
Rhode Island	12	2	17
Connecticut	13	2	4
Maryland	14	2	20
Wisconsin	15	2	14

Source: Long-Term Services and Supports State Scorecard, 2023.

Stark Inequities Exist in Nursing Home Staffing and Most States Don't Meet Consumer Needs Across All Groups

A 2001 CMS study of staffing levels in nursing homes found that, in general, residents of these facilities need about 4.1 hours per day of nursing care, including from registered nurses, licensed practical nurses, and certified nursing assistants. The 4.1 hours per day threshold has become a common reference point in the LTSS field, although it is not a threshold set in policy or something that CMS enforces as part of nursing home oversight. In 2022, CMS began a new study to determine potential nursing home staffing standards and as of August 2023, that work continues.

The *Scorecard* includes nursing home staffing levels as a new indicator for this 2023 edition. In addition, this indicator is one that we can assess through the lens of LTSS equity. Across all residents and across all specific racial/ethnic groups, nursing facilities do not meet the recommendation of 4.1 hours per day. Among the group of facilities in each state with the fewest average number of nursing care hours per day, just three states (Alaska, the District of Columbia, and California) meet the threshold.

11 The workforce aggregate rank was calculated to illustrate state performance across the five workforce indicators. It is not part of overall or dimension state scores or ranks.

> “Residents of nursing homes with the most admissions of Black residents receive almost 200 hours per year less of nursing care compared with residents of nursing homes with the most admissions of white residents.”

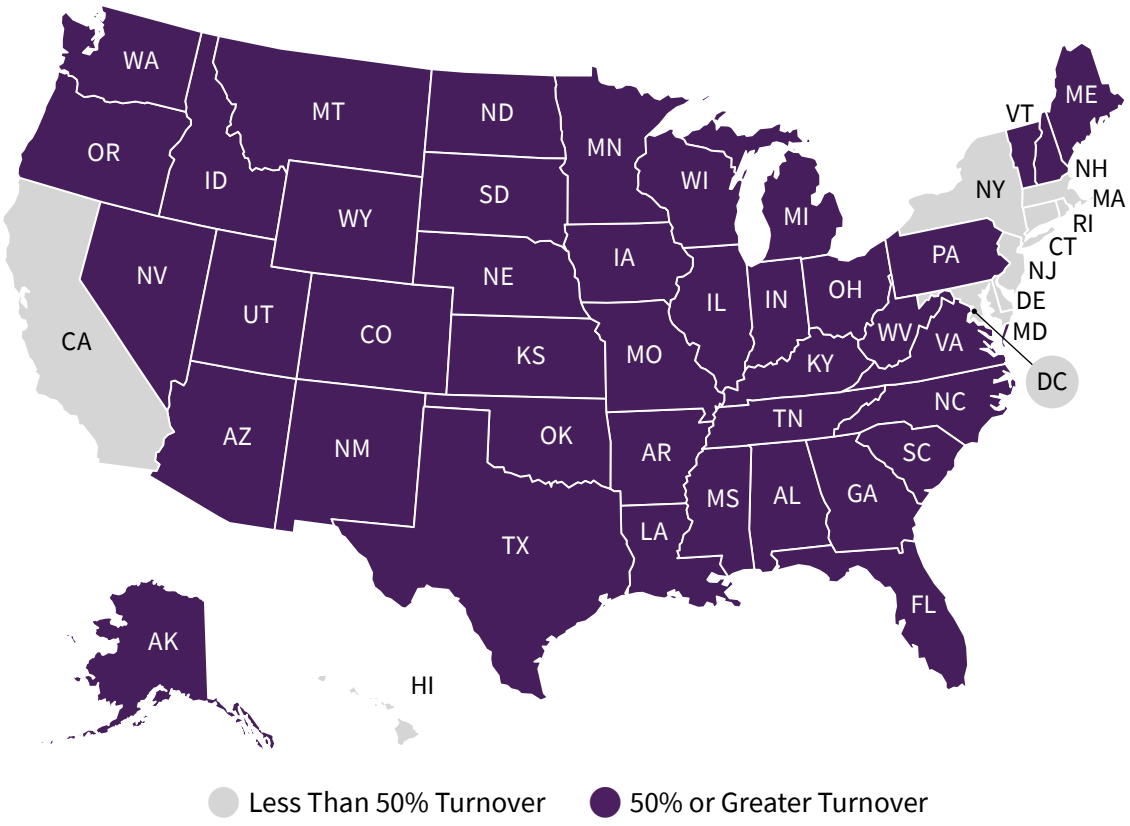
EXHIBIT 14 | There are differences by race/ethnicity in how many staff hours per day are provided to residents across nursing homes, ranging from an average of 3.85 at the top to 3.31 at the bottom.

Group		Nursing care hours per resident per day (highest to lowest)	Fewer **minutes** of care per **day** compared to group with most hours of care	Fewer **hours** of care per **year** compared to group with most hours of care
All facilities		**3.53**		
Facilities with the top 10% of admissions by race/ethnicity	White residents	3.85	N/A	N/A
	Multiracial residents	3.56	17	106
	Asian residents	3.54	19	113
	Native Hawaiian and Pacific Islander residents	3.50	21	128
	American Indian/Alaska Native residents	3.49	22	131
	Hispanic residents	3.42	26	157
	Black residents	3.31	32	197

Source: Long-Term Services and Supports State Scorecard, 2023.

There is more than a half-hour (32 minutes) gap in nursing care hours per resident per day between the group with the highest level of staffing (facilities with the most admissions of white residents) and the group with the lowest levels (those with the most admissions of Black residents). This factors out to a difference of almost 200 hours of care per year per resident between these two

EXHIBIT 15 | High staff turnover in nursing homes is pervasive across states.



Source: Long-Term Services and Supports State Scorecard, 2023.

groups, a gap of about 16 percent. This gap can compound other care-related challenges that residents face due to their race or ethnicity.

Notably, none of the racial/ethnic subgroups here receive adequate nursing care hours per day, as none meet the threshold of 4.1 hours per day. Nursing home residents across all groups need better staffing in their facilities, but it is worth noting that residents in their facilities with the highest percentages of every group of nonwhite residents receive at least 100 fewer care hours per year than the facilities with the most white resident admissions.

In addition to nursing home staffing levels, the *Scorecard* considers turnover among nursing staff in these facilities. Evidence consistently demonstrates that high turnover contributes to poorer outcomes for consumers. For this indicator, states with lower rates of turnover among this cohort of workers receive more credit than states with higher turnover rates. Nationally, the turnover rate of nursing staff in nursing homes is 53.9 percent, and all but 10 states have turnover rates that exceed 50 percent . In other words, across the country and in most states, at least *half* of the in nursing homes working in January 2022 had left their facilities by January 2023. This has serious implications for resident safety and quality of care that could be examined further through continuing research and analysis.

> “Nationally, the turnover rate of nursing home nursing staff is 53.9 percent, and all but 10 states have turnover rates that exceed 50 percent.”

Direct Care Worker Median Wages Lag Behind Other Occupations with Comparable or Lesser Entry Requirements Nationally

In every state, the median wage for direct care workers is lower than that for occupations with similar or lesser entry requirements. Across states, wage shortfalls range from $1.56 to $5.03 per hour. In all likelihood, shortfalls of this nature contribute (but may not fully account for) difficulties in recruiting and retaining an adequate workforce.

These wage shortfalls matter. Annualized based on a full-time schedule, the wage shortfall in even the best performing state (New Hampshire) represents more than $3,000 in lower pay compared to similarly situated occupations. In most states, the annualized shortfall exceeds $5,000. The median pay for direct care workers[12] was around $30,000 in 2021, the year from which the *2023 Scorecard* scores states.

Measuring the shortfall of these wages is important to understanding the workforce because in practice, job seekers who may be considering the direct care field are not looking at potential opportunities to work in direct care across several states. Instead, they are often looking at opportunities to work in direct care and opportunities in other fields, all within the same state (and often the same market). Measuring the competitiveness of LTSS worker wages within specific states helps us better understand how well (or poorly) the field is positioned to attract new workers and retain talented ones.

Looking at nominal wages alone, for instance, omits potential confounding factors like cost of living. States with a higher cost of living generally have higher wages, but what matters most is how wages for LTSS workers compare with those other jobs that potential new workers may consider in their states.

It is also helpful from a retention standpoint. Someone currently employed as an LTSS worker is less likely to stay in the field if another opportunity exists that pays several dollars more per hour. Ensuring that LTSS worker wages are competitive within specific state markets is critical to building and keeping LTSS workforces in place to meet the needs of consumers and family caregivers.

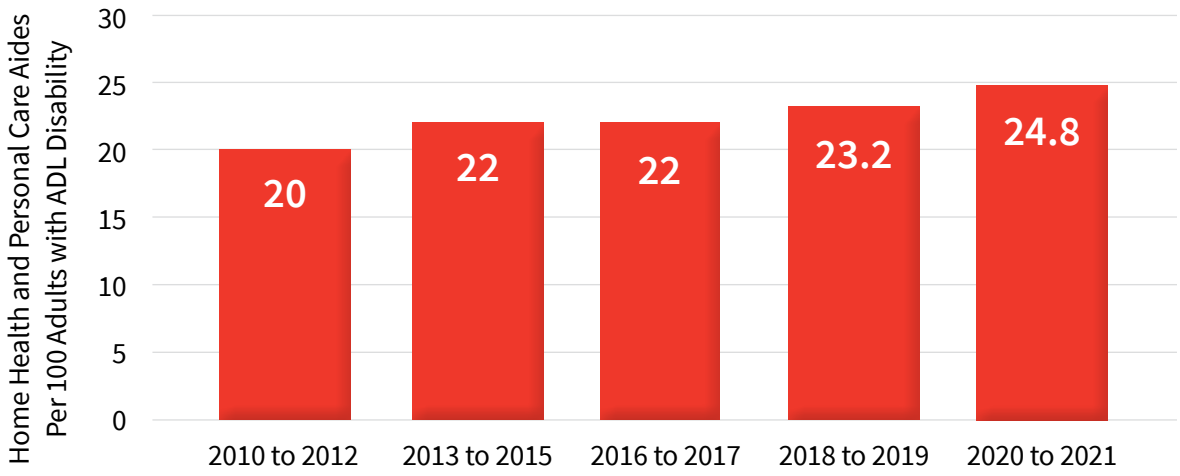
12 US Bureau of Labor Statistics, “Home Health and Personal Care Aides," last modified September 8, 2022, https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm.

Home Health Aide Supply Ticks Up Nationally but Varies Considerably by State

For 2020 and 2021, the data years from which the *2023 Scorecard* scores and ranks states, there were about 24.8 home health/personal care aides available per 100 adults with disabilities in the United States. This represents a small increase (6.9 percent) from two years prior, 2018 and 2019, the data years used in the *2020 Scorecard*, during which there were about 23.2 aides available. In previous editions of the *Scorecard*, there were about 21 aides available to the same population. The number of home health and personal care aides continues to grow but is likely insufficient to meet the needs of all consumers and families.

State performance on this indicator varies from 9 to 56 aides per 100 adults with disabilities, and individual state change over time ranges from a more than 20 percent increase to a more than 20 percent decrease of the supply of workers.

EXHIBIT 16 | The supply of home health/personal care aide has grown slowly from 2010 to 2021.



Source: Long-Term Services and Supports State Scorecards, 2017, 2020, 2023.

State Policy Choices May Drive Worker Access to Better Pay

The *Scorecard* includes an indicator that gives credit to states with policies under which states require providers receiving Medicaid reimbursement to pass through either a certain dollar amount or percentage of reimbursements to direct care workers. Through the PHI State Workforce Index data, we found that policies exist in 20 states. This policy may help workers access better pay by setting a floor in terms of how much Medicaid reimbursements must reach direct care workers. Further study would uncover the strength of these pass-through policies and their impact on overall worker pay. By crediting states with policies in place, the *Scorecard* takes the first step in recognizing the importance of these policies by crediting states with policies in place.

Potential Limitations

Although the *Scorecard* includes important information about the LTSS workforce, there are limitations to what we can explore:

Lack of HCBS Data Stymies Full Understanding of the Issues: The *Scorecard* provides more in-depth information about nursing home staffing relative to that in HCBS settings because of the gaps in available data. CMS has publicly available staffing data for nursing homes, for example, but no such data exist for home care, adult day services, or other HCBS service lines. This limitation is reflected throughout the *Scorecard*: more and better data are available for nursing homes, so we are able to study nursing homes more fully than HCBS.

Limited Data Available on LTSS Worker Benefits: There are not widely available, state-level data that quantify direct care worker-specific access to and utilization of employment benefits, such as paid leave, retirement savings, and employer-sponsored insurance. Without a full understanding of benefits (or lack thereof), the relationship between benefits and outcomes cannot be fully examined.

Cause and Effect of LTSS Worker Wage Shortfalls Unclear: More study is needed about what drives LTSS worker wage shortfalls, and what impact those shortfalls have on state LTSS systems. There is no clear association, for example, between worker wage shortfalls and the indicators for supply of home health and personal care aides, and worker wage pass through policies. New York has one of the largest hourly wage shortfalls, yet also has the largest supply of home health and personal care aides indexed to its population of adults with disabilities and the state ranks third in nursing home staff turnover. Statistical analyses show only weak correlation between state wage shortfalls and these other two indicators. Multiple factors could be at play, including market conditions outside of LTSS, Medicaid rates for services relevant to direct care, benefits, and other policies and practices.

FINDING 8: Nursing home residents' experience varies widely across race/ethnicity groups.

Overview and Cross-Indicator Performance

For the first time, the *Scorecard* considers equity in the assessment of LTSS system performance. Adhering to the *Scorecard* definition that LTSS equity means that high-performance is shared among all groups, we focus on race/ethnicity for this edition and hope to include other groups in future editions as more data become available.

There are nine indicators for which data are available by race/ethnicity at the state level. Most of these focus on aspects of nursing home care, with additional indicators focused on broader aspects of community living (housing and transportation). Although these indicators are an important first step in describing performance by race/ethnicity, the field needs more and better state data to fully understand where disparities exist and how each state serves its diverse populations. Exhibit 17 shows the national values by race/ethnicity for each of the nursing home indicators.

As seen in Exhibit 17, when compared with all other groups, Black residents received the lowest quality care in four of seven nursing home indicators. Performance varied across groups for other indicators, with Native Hawaiian/Pacific Islander residents having the highest performance in three of seven indicators, when compared with all other groups.

EXHIBIT 17 | Nursing home residents of different race/ethnic groups experience different outcomes.

		Rates by Race/Ethnicity with the worst performance rates underlined in red						
Indicator	**Rate for All Nursing Home Residents Nationally**	**American Indian/ Alaska Native**	**Asian**	**Black/ African American**	**Hispanic/ Latino**	**Native Hawaiian/ Pacific Islander**	**White**	**Multi-Racial/ Some Other Race**
Nursing Home Long-Stay Resident Hospitalizations	**18%**	15%	16%	19%	17%	12%	17%	23%
% of Nursing Home Residents with Low Care Needs	**9%**	15%	9%	8%	9%	7%	9%	8%
% of High-Risk Nursing Home Residents with Pressure Sores	**10%**	12%	9%	13%	11%	8%	9%	9%
% of Nursing Home Residents Inappropriately Prescribed Antipsychotics	**10%**	10%	6%	7%	8%	7%	10%	7%
% of Nursing Home Residents Living in a 5-Star Facility	**22%**	19%	29%	13%	19%	29%	24%	25%
Nursing Home Nurse Staffing Per Resident Per Day*	**3.54**	3.49	3.54	3.31	3.43	3.50	3.86	3.56
% of Short-Stay Nursing Home Residents with a Successful Discharge to the Community*	**52%**	51%	50%	45%	47%	54%	51%	55%

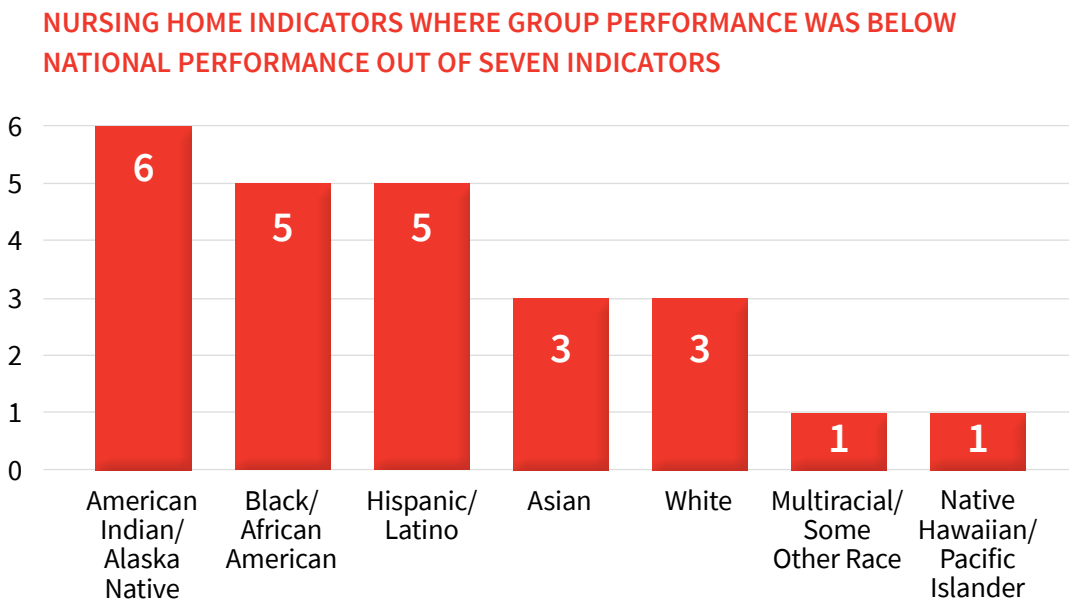
Note: Figures in table are based on nursing home resident data from CMS that represents nearly a complete census of nursing home residents at the time data were collected.
*Indicators measure performance at the facility level *(see methodology for further detail)*

Source: Long-Term Services and Supports State Scorecard, 2023.

In Exhibit 18, we provide a count of the number of indicators where individual racial/ethnic group performance is below national performance across all groups. For each group, we compare their scores to the national average for all groups.

We found that American Indian/Alaska Native residents receive poorer care compared to the national rate in six of seven nursing home indicators. The same is true for five of seven indicators for Black and Hispanic residents. Native Hawaiian/Pacific Islander and multiracial residents experienced lower quality of care than the national average for only one indicator each. The following sections provide additional review of individual indicators and their implications for our understanding of LTSS equity.

EXHIBIT 18 | When indicators where race/ethnicity could be considered, nursing home performance in serving American Indian/Alaska Natives, Black/ African Americans, and Hispanic/Latinos was worse than overall performance.



Source: Long-Term Services and Supports State Scorecard, 2023.

Black and Multiracial Long-Stay Nursing Home Residents Were Most Likely to Be Hospitalized

Close to one in five (18 percent) of long-stay nursing home residents are hospitalized. Relative to the national average, Native Hawaiian/Pacific Islander residents are the least likely to be hospitalized at 12 percent, followed by American Indian/Alaska Native group residents at 15 percent.

Notably, just two groups of long-stay residents are hospitalized at a rate higher than the national average—Black residents (19 percent) and multiracial residents (23 percent). Multiracial residents had the highest rate of hospitalization and further study is needed to better understand their care patterns and ways to reduce hospitalizations.

Most Racial/Ethnic Groups Have a Similar Share of Nursing Home Residents with Low-Care Needs—Except American Indian/Alaska Native

Nationally, fewer than ten percent of nursing home residents have low-care needs. Because these residents are not rehab patients, do not have dementia, and need less help with activities of daily living (ADLs) compared with other residents a nursing home is not an appropriate setting. Their presence in nursing homes may indicate a lack of available options to receive care in a more appropriate setting. By race/ethnicity, most groups have similar rates of residents with this level of need (7 to 9 percent), but among American Indian/Alaska Native residents, 15 percent of residents have low care needs. The five states with the highest percentages of American Indian/Alaska Native residents also have some of the highest rates of American Indian/Alaska Native people with low care needs living in nursing homes, shown in Exhibit 19.

EXHIBIT 19 | Some of the largest percentages of people with low care needs living in nursing homes are found among American Indian/Alaska Native nursing home residents in states where the percent of American Indian/Alaska Native living in the state are the highest.*

State	Percent of state residents who are American Indian/Alaska Native (Top 5 states from high to low)	Percent of American Indian/Alaska Native residents with low care needs	Low Care Needs Indicator Ranking
Alaska	20%	16%	32
Oklahoma	13%	24%	50
New Mexico	11%	12%	43
South Dakota	10%	23%	49
Montana	8%	22%	47

*The national average is 9%

Source: Long-Term Services and Supports State Scorecard, 2023.

Black Nursing Home Residents Have Less Access to Top-Quality Facilities

Nationally, about one in five (22 percent) nursing home residents live in a facility with a 5-star quality rating, the highest rating possible in the CMS Star Ratings for these facilities. Disparities exist, however, in who has access to these facilities. Close to three in ten (29 percent) of Asian and Native Hawaiian/Pacific Islander residents live 5-star facilities, more than double the rate of Black residents who live in these nursing homes (13 percent). Residents of 5-star facilities constitute a similar share of Hispanic and American Indian/Alaska Native residents, about 19 percent each. Black, Hispanic, and American Indian/Alaska Native residents have less access to top nursing homes relative to the national rate.

At the state level, this issue becomes even more acute. In one state, for example, about 33 percent of all nursing home residents live in a 5-star facility, far above the national rate. At the same time, only 3 percent of Black residents and 12 percent of Hispanic residents live in these facilities.

Nursing Home 5-Star Ratings System

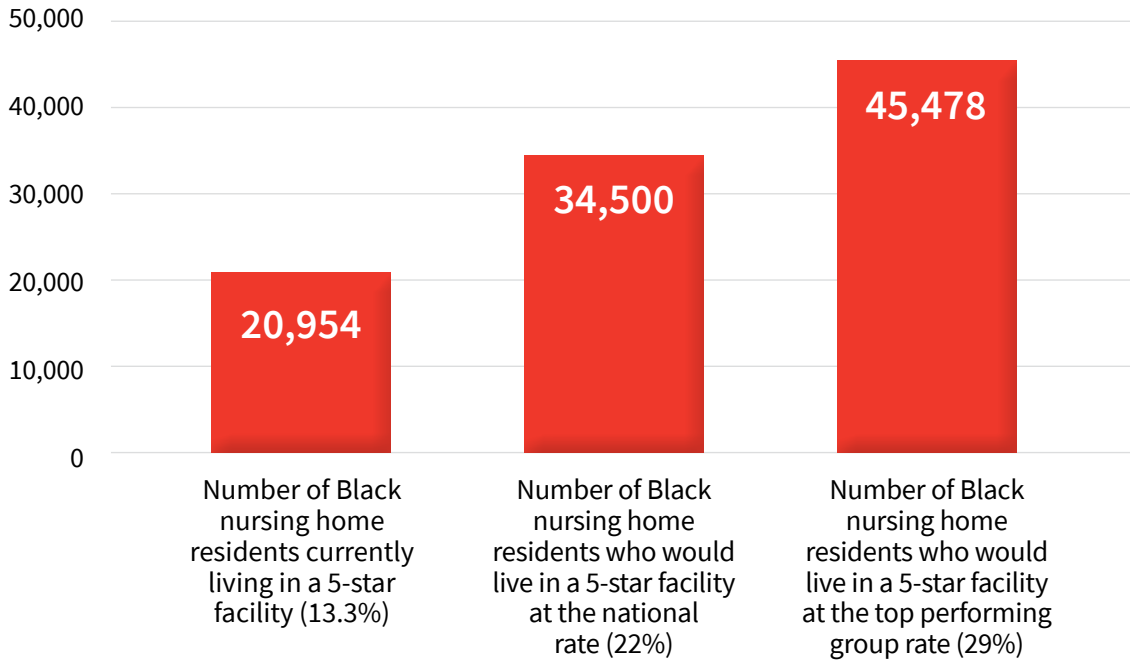
CMS rates each Medicare- and Medicaid-certified nursing home on a 1 to 5 Star basis, with 5-Star ratings going to facilities with the best quality according to the Star Rating system. Star ratings derive from three subcomponents: health inspection ratings, quality measurement ratings, and staffing ratings. Facilities receive an overall star rating and a star rating for each subcomponent.

Evidence shows a strong correlation between residing in a 5-star facility and receiving higher quality patient care and improved outcomes. This finding highlights the importance of driving equity in access to these facilities. Of course, more people across all groups should live in top-quality facilities, and nursing homes nationally must improve their collective performance and quality. The present disparities in who lives in these facilities now, however, underscore the need for action to improve facility performance for those groups with less access. By increasing access for Black residents to top-performing nursing homes, we would significantly improve care to thousands of people. As an example, see Exhibit 20 which illustrates the disparity between the current number of Black residents receiving care in 5-star facilities and the potential number if estimates were based on the national rate or the rate of the top-performing group. Implementing either estimate would effectively double the number of Black individuals receiving care in these highly rated facilities.

Rate of Pressure Sores in Nursing Home Residents Increased Nationally, Relatively Consistently Across Groups

Nationally, 10 percent of nursing home residents experienced a pressure sore compared to the *2020 Scorecard*, when the national rate of pressure sores was seven percent. As with inappropriate administration of antipsychotics, the rate of pressure sores in nursing home residents is fairly

EXHIBIT 20 | Thousands more Black nursing home residents would be living in 5-Star facilities if their rates matched the national rate or highest rates.



Source: Long-Term Services and Supports State Scorecard, 2023.

consistent across groups; no group strayed more than 3 percentage points away from the national average. At the same time though, a key concept of the *Scorecard's* equity approach comes to light: poor performance across groups is unacceptable. Although the COVID-19 pandemic saw increased isolation and sedentariness among nursing home residents, all efforts must be made to bring the rate of pressure sores down in future years.

Inappropriate Administration of Antipsychotics Similar Across Groups but Questions Remain

There is little difference by race/ethnicity in the inappropriate administration of antipsychotics among nursing home residents. Nationally, about 10 percent of residents received these drugs inappropriately, a decrease from the 14 percent in the *2020 Scorecard*. Across groups by race/ethnicity, the rate of inappropriate administration is very close, ranging from 6 to 10 percent of residents. The core issue with this indicator, however, isn't administration of antipsychotics alone. Other considerations that happen before an antipsychotic administration takes place, such as diagnosis, inform the issue more broadly.

This indicator's data measure whether the administration of an antipsychotic was appropriate; however, the data do not capture whether the underlying diagnosis was appropriate or accurate. Research has found, for example, that Black nursing home residents may be more likely than others to be diagnosed with schizophrenia. What is considered inappropriate is not the administration

of these drugs but rather the diagnosis, but a lack of data make this hard to determine. We need better data in this area to fully understand and address the entire pattern of care that leads to antipsychotic administration and ensure that inappropriateness at any stage is addressed and done so equitably.

Black and Hispanic Nursing Home Residents Have Slightly Less Likelihood of Successful Discharge to Community

This indicator measures the percentage of residents in Medicare skilled nursing homes who were successfully discharged back to the community at the end of their stay. Medicare nursing home stays are designed to be short-term and help prepare residents to return home to their community without hospitalization or nursing home readmission. Lower levels of successful community discharge indicate problems with a state's availability of community resources, consumer access to them, and supports available after the Medicare stay. Across all residents in Medicare nursing homes, about 52 percent successfully return to the community. There is a lower rate of successful discharge, however, among Black (45 percent) and Hispanic (47 percent) residents. Other groups come within 1 to 2 percentage points below the national rate or exceed it.

Data Infrastructure Limitations Prevent Full Understanding of LTSS Equity

The majority of indicators for which the *Scorecard* could assess for equity relate to nursing homes. In no small part, this is because robust data exist for nursing homes, and have for several years. Using the Minimum Data Set and other federally maintained data assets, researchers and the public better understand nursing home performance by state, and by race/ethnicity, than other service lines of the LTSS continuum. No analog data resources exist for HCBS, which would provide insights on provider performance at the individual provider, local, or state levels.

The federal government collects Medicaid data through the CMS T-MSIS platform, which in large part relies on state agencies to report complete, timely, and accurate data. In practice, this often does not happen and as a result, federal Medicaid data often lag several years behind occurrence and has incomplete fields that limit understanding of Medicaid services. Several reports in recent years have underscored data quality issues in the Medicaid data infrastructure, including and with respect to state collection and reporting of beneficiary race/ethnicity data.

Meanwhile, nursing home data are largely publicly available or otherwise easy to obtain, while most Medicaid-specific data require an extensive application and licensing process as well as financial resources to pay for fees that make them inaccessible to most people.

Lack of access to data has real world implications. Throughout the COVID-19 pandemic, policymakers and the public at large knew in real-time what was going on in nursing homes related to cases, deaths, and vaccinations. That no similar data have ever been made available for HCBS, indicates further need for change.

As a result, data are less available and reliable to address HCBS by race/ethnicity and by state. Future editions of the *Scorecard* will provide more insights on HCBS equity (or lack thereof) to the extent that government agencies are better able to make the data publicly available.

Strong LTSS Systems Across Communities Require Better Access to Housing and Transportation

AARP created the AARP Livability Index (www.aarp.org/livabilityindex) to measure every neighborhood and community in the country across seven categories, including 40 metrics and 21 policies. This edition of the *Scorecard* adopts the AARP Livability Index's methodology and findings to comprehensively describe and score states based on performance in housing and transportation. The goal of the index is to provide residents and community leaders with an interactive, online tool that enables them to visualize their performance against key indicators of livability.

Two of the AARP Livability Index's categories are particularly relevant to the LTSS population and their ability to become or remain integrated in communities of their choice: Transportation options that allow them, their caregivers, and the LTSS workforce to get around communities as needed; and Housing options they can afford and that meet their needs in their communities of choice. The *Scorecard* uses statewide AARP Livability Index scores to compare the options in communities within each state.

Both the AARP Livability Index transportation and housing components measure metrics and policies related to both areas. Metrics refer to how livable communities are in the present, and policies account for actions that communities can take to improve livability over time.

For more information on the Index and how scores are generated, visit livabilityindex.aarp.org

EXHIBIT 21 | The Transportation and Housing indicators from the AARP Livability Index consider several Livability Index metrics and policies.

Transportation Metrics	Transportation Policies
• Frequency of local transit service	• State and local Complete Streets policies
• ADA-accessible stations and vehicles	• State human services transportation coordination
• Walk trips	• State volunteer driver policies
• Congestion	
• Household transportation costs	
• Speed limits	
• Crash rates	
Housing Metrics	**Housing Policies**
• Zero-step entrances	• State and local inclusive design laws
• Availability of multi-family housing	• State and local housing trust funds
• Housing costs	• State manufactured housing protections
• Housing cost burden	• State foreclosure prevention and protection
• Availability of subsidized housing	• State support for accessory dwelling units

Source: Long-Term Services and Supports State Scorecard, 2023.

THE AARP LIVABILITY INDEX AND TRANSPORTATION

State and Group Performance

The AARP Livability Index transportation category score is an equity indicator, using the worst transportation score among the ten percent of state neighborhoods with the highest percentage of the population that is Asian, Black, Hispanic, or White. AARP Livability Index category scores range from 0 to 100, with a mean of approximately 50. National performance for the neighborhoods with the highest percentage of Asian, Black, and Hispanic residents exceeded the national average across all neighborhoods, while the performance in the most heavily white neighborhoods was worse than the national average at 47 points. The 10 percent subgroup with the highest white population was the lowest performing group in 46 states and was not the highest performing group in any state. The most heavily Black neighborhoods had the best transportation scores in 23 states, compared with 19 states for neighborhoods with the most Hispanic residents and nine states for neighborhoods with the most Asian residents.

The District of Columbia, Rhode Island, and Montana had the best statewide transportation scores, while 5 of the 6 lowest scoring states were in the Southeast: Kentucky, Tennessee, Georgia, Alabama, and Mississippi.

Performance in Context

Higher scoring places often provide different transportation options that are convenient and affordable. People most likely live in safe travel environments that are good for pedestrians, cyclists and drivers, and people with varying levels of mobility. State and local governments try to ensure that people of all ages and abilities can find transportation to get people where they want to go.

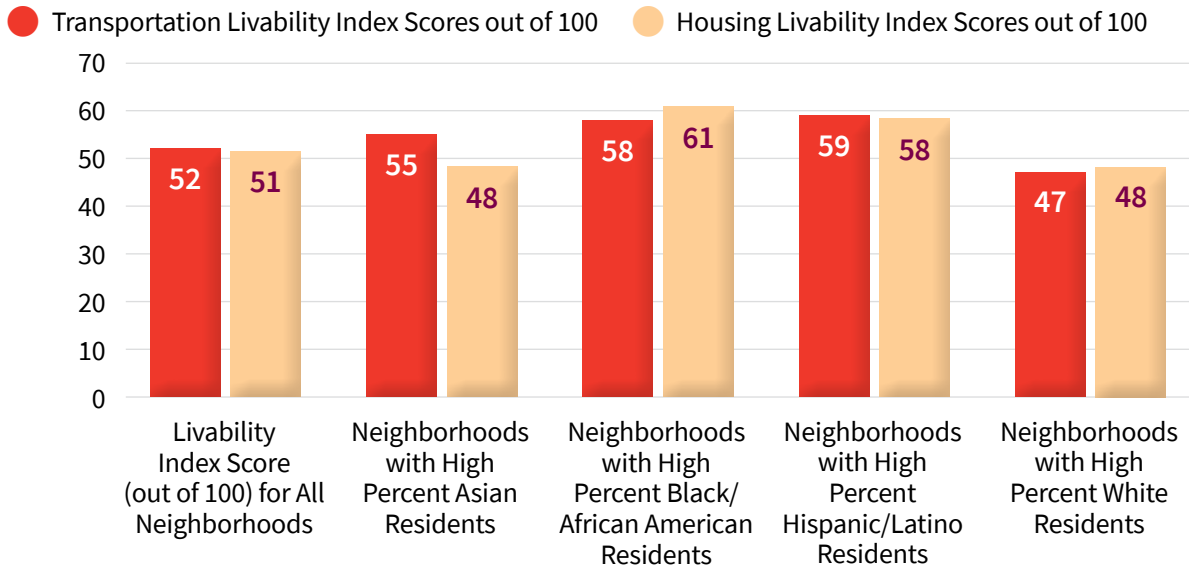
Lower scoring places tend to lack transportation options, including for those who do not drive, get a ride from family or friends, take public transportation, or deal with long commutes due to traffic congestion. Pedestrians, cyclists, and drivers may find it difficult to get around if road conditions are dangerous due to high traffic speeds, and state and local governments are likely not passing and implementing policies to support transportation needs of residents especially as they age.

THE AARP LIVABILITY INDEX AND HOUSING

State and Group Performance

For the AARP Livability Index Housing category scores, the 10 percent of neighborhoods in each state with the highest percentage of Black and Hispanic residents significantly outperformed the national average by 10 and 7 points respectively, which the neighborhoods with the highest percentage of Asian and White residents was worse than the national average. In 32 states, the most heavily white neighborhoods scored lowest of the four groups for housing. The same was true for Asian neighborhoods in 17 states, and for Black and Hispanic neighborhoods in 1 state each. The 10 percent neighborhoods with the most Black residents had the best scores for housing in 33 states, compared with 16 states for neighborhoods with the most Hispanic residents and 2 states for neighborhoods with the most Asian residents.

EXHIBIT 22 | Neighborhood AARP Livability Index scores for Transportation and Housing vary by racial/ethnic make-up of residents.



Source: Long-Term Services and Supports State Scorecard, 2023.

Performance in Context

States performing higher in housing may have more housing options including affordable, subsidized and accessible housing options. States and local governments use a variety of policies and programs to expand housing options and create ways for people to find housing in their preferred communities.

In states performing lower in housing, people are more likely housing cost burdened, meaning they spend more than 30 percent of household income on housing costs and lack of housing options to meet the needs of different households/families. People in these areas may have to move out of their preferred communities if they can't find suitable housing within their budgets or if housing options are inadequate for their current and future circumstances.

Tradeoffs exist in every neighborhood and community. When neighborhoods in one state score higher in a given category, they often face challenges in at least one other category. For people who need LTSS, neighborhoods that are often seen as "desirable" pose challenges. For example, expensive suburbs may be isolated, have expensive housing without zero step entrances and other features for home access, and lack transportation options for those who do not drive. Rural states score often score higher in the housing component due to lower housing costs.

According to a recent analysis from the AARP Livability Index, "Vulnerable older adults, including those with lower incomes and people of color, do have access to high-livability neighborhoods that have higher scores on housing, transportation, and neighborhood—yet lower scores on health, environment, opportunity, and engagement."[13] Stakeholders at the local, state, and federal levels must take steps to ensure that neighborhoods and communities facilitate rather than inhibit the receipt of LTSS regardless of where a person lives.

13 Rodney Harrell et al., "Which Older Adults Have Access to America's Most Livable Neighborhoods? An Analysis of AARP's Livability Index," AARP Public Policy Institute, October 2020, https://www.aarp.org/pri/topics/livable-communities/which-older-adults-have-access-to-americas-most-livable-neighborhoods.html

CHAPTER 3

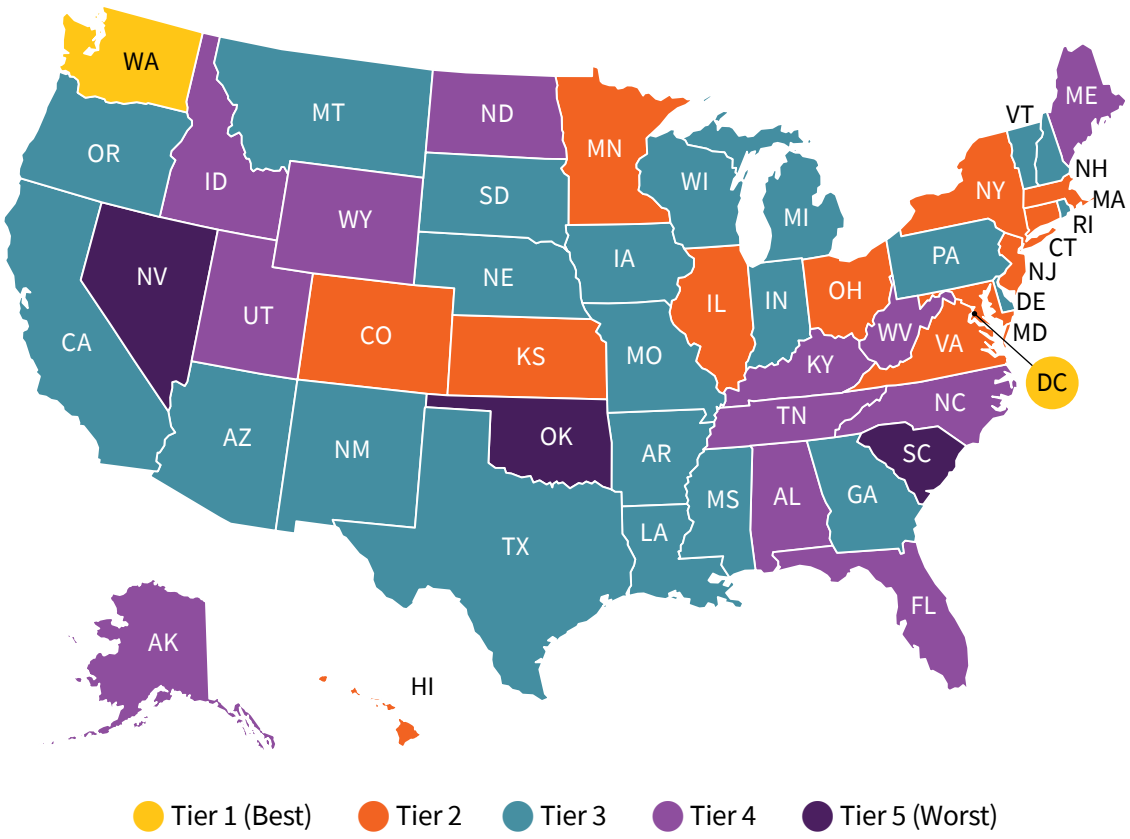
Key Findings by Dimension

KEY FINDINGS FOR AFFORDABILITY AND ACCESS

Vision for *Affordability and Access*

Consumers can easily find and afford services, with meaningfully available safety net for those who cannot afford services. Safety net LTSS do not create disparities by income, race/ethnicity, or geography.

EXHIBIT 23 | This map shows states in each performance tier in *Affordability and Access.*



Source: Long-Term Services and Supports State Scorecard, 2023.

Home Care Cost: Home care cost increased in 47 states between 2019 and 2021, with 23 states showing more than a 10 percent increase in cost relative to income. On average, the annual per person cost of home care in 2021 was roughly $42,000 a year (for 30 hours of weekly care at $27 per hour)—more than 20 percent higher than in 2019. Home care is more affordable than nursing homes, which have an annual average cost of $108,000 for a private room, but it still exceeds what many older households can afford to pay with their income. Nationally, home care costs account for 83 percent of the entire income of the typical, older middle-income family. It ranges from 63 percent of a typical annual income in Hawaii and Maryland to 106 percent of a typical annual income in Minnesota.

Nursing Home Cost: Nursing home care remains unaffordable for middle-income Americans in every state. The average annual cost of nursing home care is more than $108,000 in a private room, more than twice the typical annual income for people age 65+. The cost relative to income went up in 38 states between 2019 and 2021. With the cost of care that high, many people with LTSS needs quickly exhaust their savings and must enroll in Medicaid for assistance. The cost of nursing home care ranges from just under 170 percent in Missouri and Illinois to more than 300 percent in New York, Connecticut, North Dakota, West Virginia, and Alaska.

Long-Term Care Insurance (LTCI): Despite the high cost and growing demand for LTSS, relatively few adults age 40 and older purchase LTCI and that number continues to decline. This downward trend is consistent across nearly all states. Between 2018 and 2021, there were slight decreases in the number of people covered in all states except two, West Virginia (increase of 4 percent) and Washington (increase of 55 percent). The dramatic increase in the number of policy holders in Washington can be attributed at least in part to the new public LTCI program the state is rolling out now.[1] Starting in July 2023, workers who do not have private policies will be automatically enrolled in the public program. In anticipation of this, many residents have started to purchase private policies.

Medicaid for Low-Income People with Disabilities: Enrollment of low-income people with disabilities into Medicaid programs has increased steadily since the first *Scorecard*, from about 52 percent in 2011 to 59 percent in 2021, the data year scored in this edition of the *Scorecard*. Driving this increase at the national level have been Medicaid expansion and policies implemented in response to COVID. Since the *2020 Scorecard*, 21 states increased enrollment by 10 percent or more; only seven states decreased by 10 percent or more.

Aging and Disability Resource Centers/No Wrong Door (ADRC/NWD) Functions: Two-thirds of states made progress toward fully functional status with their ADRC/NWD systems—networks of organizations at the state and community levels that help consumers and family caregivers learn about, consider and navigate LTSS options, both public and private. High-performing states must have strong collaborative partnerships between state aging, disability, and Medicaid agencies. The greatest improvements were recorded in delivering person-centered counseling and streamlining eligibility for public programs.

1 WA Cares, "WA Cares Pays for Long-Term Care at Home," accessed August 11, 2023, https://wecareforwacares.org/.

NEW INDICATOR—Medicaid Buy-In Policies and Availability: Since its enactment in 1999, the Ticket to Work and Work Incentives Improvement Act has allowed states to expand Medicaid coverage to people with disabilities through the Medicaid Buy-In program. The program provides people with disabilities an opportunity to work and earn wages while simultaneously maintaining their Medicaid eligibility and coverage. By giving people the opportunity to become or remain employed while keeping their Medicaid coverage, the Medicaid Buy-In program contributes to a more inclusive workforce and better fiscal outcomes within states (Administration for Community Living, 2019). The Medicaid Buy-In program also limits the "churn" of people with disabilities cycling in and out of Medicaid due to being over the income limit. Of note, the Medicaid Buy-In program does not exist in all states; where it's available, eligibility criteria vary.

To measure state performance in availability of Medicaid-Buy-in programs, we look at policies states can choose from with respect to setting income and asset limits for individuals and couples and when monthly premium rates are charged. Higher scoring states are those with policies that maximize enrollment and affordability to allow more working people with disabilities to get and keep their Medicaid benefits. Three states stand out for making Medicaid Buy-In available in the most expansive ways (Arkansas, District of Columbia, and Colorado) and six others are near the top (Illinois, Massachusetts, Minnesota, New Jersey, New York, and Washington). Alabama, South Carolina, and Tennessee do not have a Medicaid Buy-In for this population.

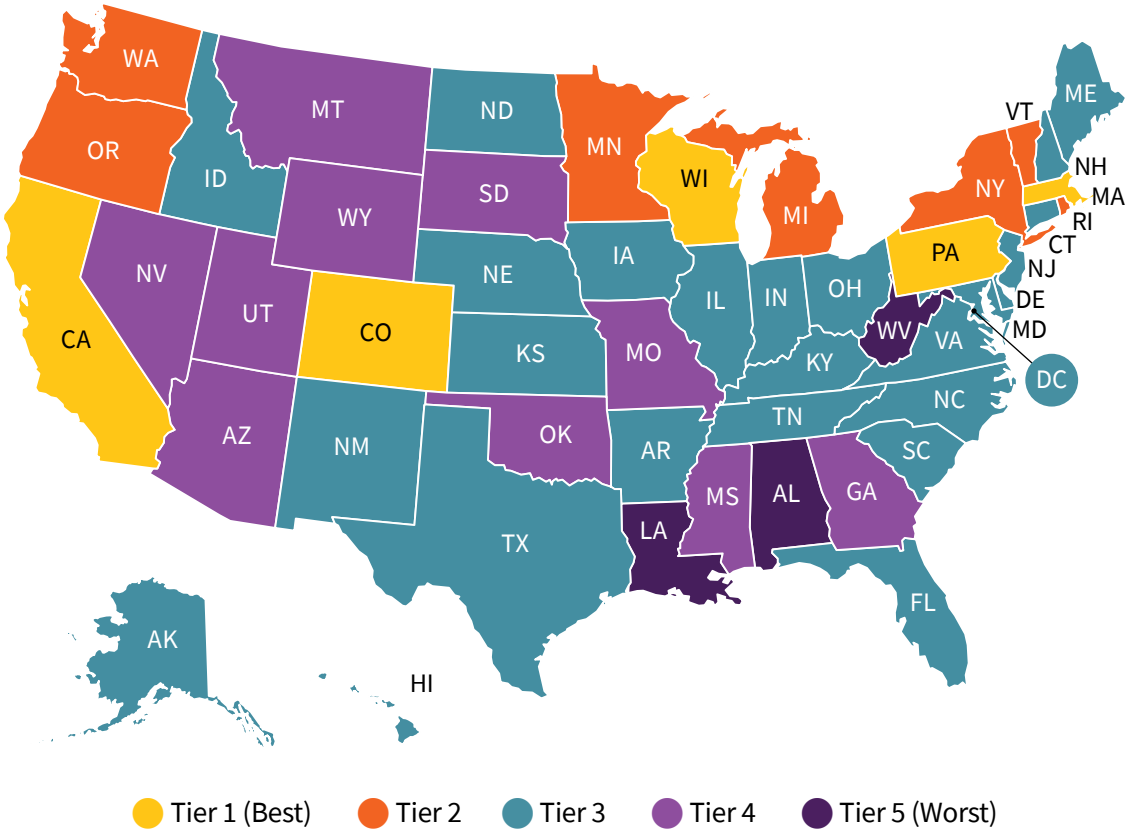
NEW INNOVATION POINT—Medicaid Home and Community-Based Services Presumptive Eligibility: Federal regulations require that Medicaid LTSS applications be processed by state offices within 45 days. For people who need LTSS right away, this wait is often too long. Nursing homes are usually willing to begin services while someone's application for Medicaid is still pending, while HCBS providers typically cannot afford to do this. Presumptive eligibility allows for HCBS services to start and for providers to be paid while the individual's full application is still being processed. Then Medicaid will cover those costs back to the date of the application. In states with HCBS presumptive eligibility, applicants assessed and presumptively determined to be eligible are rarely found to be ineligible once their full applications are processed. These policies can help people access HCBS almost as quickly as they can access nursing home services, thus helping people to avoid short-term nursing home stays that can turn into much more expensive long-term stays.

KEY FINDINGS FOR CHOICE OF SETTING AND PROVIDER

Vision for *Choice of Setting and Provider*

A person- and family-centered approach allows for consumer choice and control of services (including self-directed models). A well-trained and adequately paid workforce is available to provide LTSS. Home and community-based services are widely available. Provider choice fosters equity, and consumers across communities have access to a range of culturally competent services and supports.

EXHIBIT 24 | This map shows states in each performance tier in *Choice of Setting and Provider.*



Source: Long-Term Services and Supports State Scorecard, 2023.

Medicaid LTSS Balance—Spending: This *Scorecard* for the first time finds that more than half of Medicaid LTSS spending nationally for older people and adults with physical disabilities went to HCBS, at a rate of 53 percent in FY 2020 (the year this *Scorecard* uses to score and rank states). Eleven states exceed this national average. In addition, 12 states spend the majority of Medicaid LTSS funding for older people and adults with physical disabilities on HCBS (up from seven states in 2009). In 18 states, however, significant opportunity to improve exists as these states spend less than $1 in $3 Medicaid LTSS dollars on HCBS for older adults and people with physical disabilities.

Self-Directed Program Enrollment: More than 1.5 million, including veterans and Medicaid participants, self-directed the LTSS they receive, in 2022 and 2023. This represents an 18 percent increase from 2019, or almost 300,000 more people. Since the *2020 Scorecard*, 35 states saw an increase of self-directing participants per 1,000 adults with disabilities by 10 percent or more, while just six states saw a decrease of the same magnitude. South Dakota saw the largest increase—more than tenfold—from 1.6 to 17.1 percent of self-directing participants per 1,000 adults with disabilities.

Assisted Living Supply: Since the *2020 Scorecard*, the supply of assisted living increased by 15 percent to 55 beds per 1,000 adults age 75+. This indicator shows widespread improvement with almost half (24) of states increasing performance by 10 percent or more. Hawaii saw the largest increase of 54 percent relative to the last *Scorecard*. Minnesota has the largest supply ratio at 138, while New York has the smallest at just 20 per 1,000.

Adult Day Services Supply: Adult day services supply nationally fell by 11.5 percent to 54 slots per 10,000 people age 65+ in 2020–2021, which the *2023 Scorecard* applies to state scores and ranks. The COVID-19 pandemic likely played a role in this decrease as adult day centers nationally suspended in-person services; many never reopened, which diminished the available supply. At the state level, just nine states saw an increase in supply by 10 percent or more, while 21 saw supply decrease by 10 percent or more. California led the nation with 154 adult day slots available per 10,000 adults age 65+ while Arizona and Oregon trailed at just 5 slots per 10,000.

Home Health Aide Supply: National performance in this indicator increased slightly from the previous *Scorecard* and from prior editions. In the *2023 Scorecard*, there were 24.8 aides per 100 adults with a self-care disability, compared to 23.2 in the *2020 Scorecard* and 20 in 2010–2012. The slow historic trend of home health and personal care aide supply has not—and will not—meet the needs of older adults and people with physical disabilities requiring care. A lack of workers adds pressure to the LTSS system as a whole and to family caregivers who must step in the absence of an available paid worker.

Nursing Home Residents with Low Care Needs: Where there are large numbers of people living in nursing homes who have low care needs, this can indicate a lack of HCBS access and/or service capacity in that area. People who require fairly low levels of support can almost always be served more appropriately in the community. While this indicator uses nursing home data, we consider it primarily an indicator of how much choice people have with regard to setting and provider. At the national level, nine percent of nursing home residents have low care needs. At the state level, this rate ranges from under five percent in seven states (District of Columbia, Hawaii, Indiana, Maine, Maryland, North Carolina, Utah) to more than 20 percent in five states (Montana, Kansas, South Dakota, Oklahoma and Missouri).

NEW INDICATOR—LTSS Worker Wage Competitiveness: Across states, workforce shortages persist in the LTSS field and low pay is one reason why insufficient numbers of direct care workers are joining and staying in the field. A new indicator that measures the gap between the median hourly wage of direct care workers and other occupations with comparable or lesser entry requirements helps detect where direct care jobs are competitive within each state's job market. Measuring the shortfall of these wages is important to understand the workforce because in practice, job seekers who may be considering the direct care field are not looking at potential opportunities to work in direct care across several states. Across all states, the median wage for workers fell short of that of other occupations, although some states had much closer gaps than others. See Appendix K (Indicators in Choice of Setting and Provider) for states with the most and least competitive direct care worker wages.

EXHIBIT 25 | Direct care worker wages are lower than those of entry-level jobs in other industries across all states—with the shortfall ranging from $1.56 less per hour in New Hampshire to $5.03 less per hour in the District of Columbia.

States with the most competitive direct care worker wages		States with the least competitive direct care worker wages	
State	**Average hourly wage shortfall**	**State**	**Average hourly wage shortfall**
New Hampshire	($1.56)	New York	($4.12)
Alaska	($1.58)	California	($4.19)
South Dakota	($1.65)	Texas	($4.33)
Kentucky	($1.75)	Louisiana	($4.88)
Rhode Island	($1.79)	District of Columbia	($5.03)

Source: Long-Term Services and Supports State Scorecard, 2023.

NEW INDICATOR—PACE Enrollment: The Programs of All-Inclusive Care for the Elderly (PACE) is a capitated model for delivering acute care and LTSS to people age 55+ who are eligible for both Medicare and Medicaid and live in community settings. States can choose to offer PACE to Medicaid beneficiaries on an optional basis. PACE then becomes the sole provider of Medicare and Medicaid to those participants. In addition, individuals who are not enrolled in Medicaid can pay privately for PACE. A wide body of research over 30 years attests to the effectiveness of PACE programs at providing high quality care cost-effectively.[2]

This *Scorecard* measures PACE enrollment in each state, indexed to the 55+ population, to shed light on the extent to which consumers can access the service line, similar to existing indicators focused on assisted living and adult day services supply.

As of April 2023, PACE is present in 32 states. Nationally, there are about 6.5 adults age 55+ enrolled in PACE per 10,000. Colorado and Massachusetts have the highest number of PACE enrollees per 10,000 adults age 55+ at 27.5 and 24.2, respectively. Over a three-year period, five states increased their PACE enrollment figures by more than 25 percent (Arkansas, California, Kansas, Michigan, Washington). Notably, several states introduced PACE during the COVID-19 pandemic and are set to expand in the coming years. PACE organizations performed well during the pandemic, seeing national enrollment grow by 20 percent from April 2020 to April 2023. There are more than 64,000 PACE enrollees nationally in April 2023.

2 For more information about PACE, see Medicaid, "Program of All-Inclusive Care for the Elderly," accessed August 11, 2023, https://www.medicaid.gov/medicaid/long-term-services-supports/program-all-inclusive-care-elderly/index.html; National PACE Association, "An Innovative Care Program for Seniors," accessed August 11, 2023, https://www.npaonline.org/; and Brendan Flinn, Susan Reinhard, and Jane Tilly, "LTSS Choices: From Ideation to Standard Practice; Scaling Innovations in Long-Term Services and Supports," AARP PPI, November 3, 2022, https://www.aarp.org/pri/topics/ltss/home-community-services/ltss-choices-scaling-innovations-in-ltss.html.

NEW INDICATOR—LTSS Worker Pass-Through: States can enact policies with the potential to help improve pay for direct care workers and/or make sure that most Medicaid reimbursement dollars that cover direct care go to workers who provide that care. These policies are called wage pass-throughs, in which states require providers receiving Medicaid reimbursement to pass through either a certain dollar amount or percentage of reimbursements to direct care workers. Twenty-one (21) states had a policy in place as of 2022. It is not yet clear how these policies are being implemented or monitored or what impact they will have. States will need to monitor progress of implementation as well as indicators of workforce strength such as worker volume, workforce stability, and worker compensation.

NEW INNOVATION POINT—Community Aging in Place - Advancing Better Living for Elders: Known as CAPABLE, this evidence-based intervention delivers restorative care to older adults in the community through visits to the home from a nurse, an occupational therapist, and a handyperson. Several types of entities can offer the CAPABLE intervention, and some states encourage CAPABLE's growth by investing public dollars in the model.[3] The *Scorecard* awards Innovation Point credit to these states: Colorado, Connecticut, Illinois, Massachusetts, New York, Oklahoma and Vermont.

NEW INNOVATION POINT—Green House® Availability and Policies: The Green House model of care offers - in a small, home-like setting - the same services and level of care as do other nursing facilities.[4] Evidence supports the model and has found that residents of Green Houses, compared with those of larger facilities, were less likely to be bedridden or to have pressure ulcers and had better outcomes during COVID-19. States can incentivize the development of these facilities. This *Scorecard* gives Innovation Point credit to those that do. It also awards credit to those states with the highest number of Green House residents. See Appendix E (Detailed Indicator Descriptions) for Innovation Point scoring criteria; ten states met at least one criterion and thus were awarded credit.

EXHIBIT 26 | Ten states have promoted Green House development through investment or policies.

Inclusion Criteria	Number of States	States
State investment in Green Houses	2	AR, MI
State policy that supports Green Houses	5	CO, CT, IN, KS, RI
High-reach Green House states (>200 residents)	4	AR, NY, MS, OH
Total States Credited	**10**	**AR, CO, CT, IN, KS, NY, MI, MS, OH, RI**

Source: Long-Term Services and Supports State Scorecard, 2023.

3 For more information about CAPABLE and the evidence supporting the model, see Flinn, Reinhard, and Tilly, "LTSS Choices: From Ideation to Standard Practice"; Johns Hopkins School of Nursing, "Community Aging in Place—Advancing Better Living FOR Elders (CAPABLE)," accessed August 11, 2023, https://nursing.jhu.edu/faculty_research/research/projects/capable/.

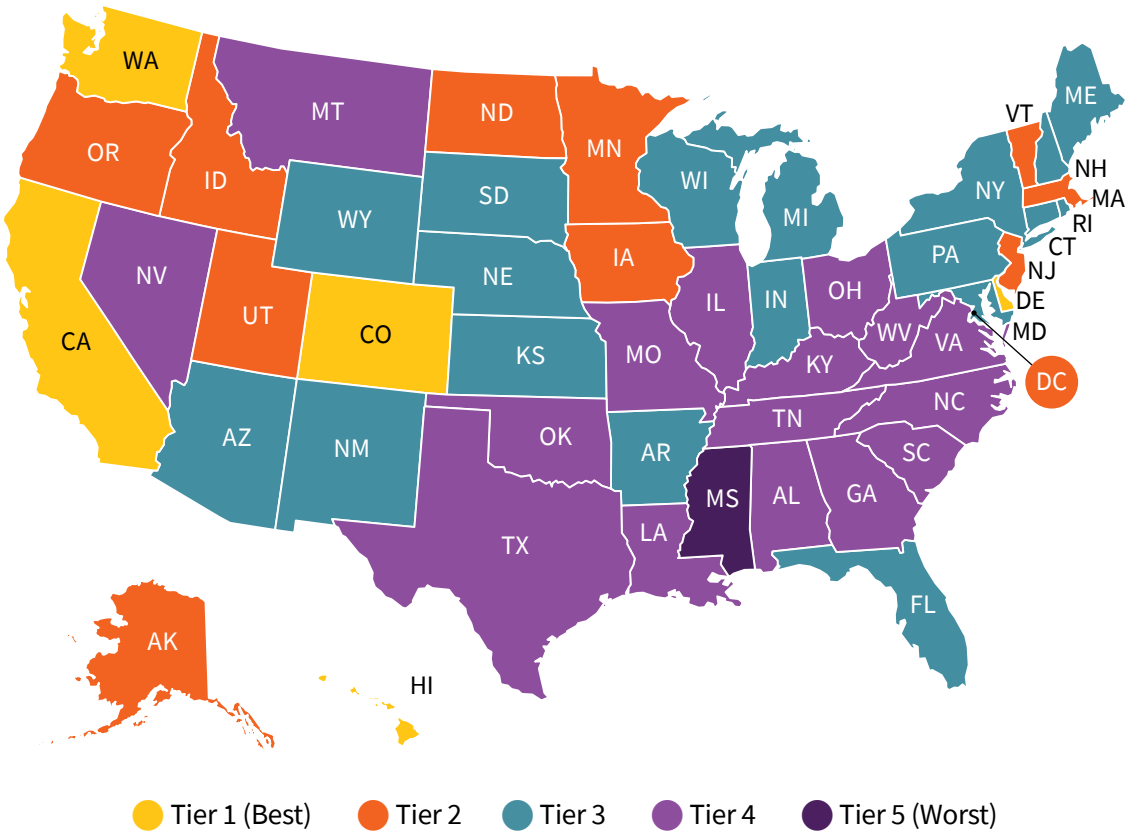
4 For more information about Green House nursing homes, see Green House Project, "Now 20 Years Strong, Green House Has Transformed Eldercare as We Know It," accessed August 11, 2023, https://thegreenhouseproject.org/our-story/who-we-are/; Susan Reinhard and Edem Hado, "LTSS Choices: Small-House Nursing Homes," AARP PPI, January 6, 2021, https://www.aarp.org/pri/topics/ltss/nursing-homes/ltss-choices-small-house-nursing-homes.html.

KEY FINDINGS FOR SAFETY AND QUALITY

Vision for *Safety and Quality*

Consumers are treated with respect and preferences are honored whenever possible, with services maximizing positive outcomes, including during and after care transitions. Residential facilities and HCBS settings are adequately staffed and prepared for emergencies. Policy-, system-, and practice-level efforts reduce and/or prevent disparities in quality and outcomes

EXHIBIT 27 | This map shows states in each performance tier in *Safety and Quality.*



Source: Long-Term Services and Supports State Scorecard, 2023.

Three HCBS Quality Benchmarking indicators:

The extent to which states measure quality in their HCBS programs and how they do it varies widely, as there are few standardized reporting requirements for Medicaid HCBS programs. Ideally, states should measure quality and consumer experience using nationally tested and validated instruments that can be benchmarked against other programs and other states. This set of three indicators are disaggregated in this edition from a single composite indicator in the 2020 edition, so use of each tool carries the same weight as other indicators. These three tools are available for states to use voluntarily, and each are characterized by the ability to be used to benchmark a participating state's performance against other participating states in the same area.

HCBS Quality Benchmarking—National Core Indicators-Aging Disability ™: The NCI-AD™ survey was developed to gather information about the experiences of participants in HCBS programs for older adults and people with physical disabilities.[5] It is part of a larger NCI program that offers standardized survey instruments for use with people with intellectual and/or developmental disabilities, people with other disabilities, and family caregivers. NCI-AD is available to states for use on a voluntary basis through a partnership between Advancing States and Human Services Research Institute. Currently, 23 states use the NCI-AD survey for one or more HCBS programs, three fewer than reported in the *2020 Scorecard*.

HCBS Quality Benchmarking—HCBS Consumer Assessment of Healthcare Providers and Services®: This indicator credits states that use the HCBS CAHPS® survey to gather information about consumer experience from participants in one or more HCBS programs.[6] Consumer experience surveys are designed to gather information from participants or patients about their interactions with service providers. HCBS CAHPS® is part of a suite of nationally validated CAHPS® instruments the U.S. Department of Health and Human Services Agency for Healthcare Quality and Research supports. HCBS CAHPS® is the only nationally validated survey designed for use across all HCBS programs that serve older adults, people with physical disabilities, people with intellectual and/or developmental disabilities, and others. Ten states were identified as having used the survey in 2021, 2022, or 2023.

HCBS Quality Benchmarking—National Committee for Quality Assurance: This policy indicator credits states that have received NCQA statewide accreditation for one or more HCBS programs—either NCQA LTSS Distinction or Case Management for LTSS. There are now 12 states accredited.

Home Health Hospital Admissions: There was widespread improvement in this indicator between 2018 and 2021. In 32 states, the percentage of home health patients with a hospital admission decreased significantly. The only state to show a significant increase between 2018 and 2021 was the District of Columbia where the percentage of home health hospital admissions rose from 14.0 percent to 15.3 percent. The U.S. average of 14.1 percent is the lowest national rate of home health hospital admissions ever reported in the *Scorecard*. This decline in hospital admission rates is likely related to the COVID-19 pandemic, which led many people to delay or forgo hospital services when possible.[7]

5 For more information about NCI-AD survey, visit https://nci-ad.org/.

6 For more information about HCBS CAHPS, see the Agency for Healthcare Research and Quality, "CAHPS Home and Community-Based Services Survey," last modified May 2023, https://www.ahrq.gov/cahps/surveys-guidance/hcbs/index.html.

7 John D. Birkmeyer et al., "The Impact of the COVID-19 Pandemic on Hospital Admissions in the United States," Health Affairs 39, no. 11 (November 2020): 2010–17, https://doi.org/10.1377/hlthaff.2020.00980.

Nursing Home Hospital Admissions: This indicator measures the percentage of nursing home residents considered long-stay residents hospitalized within a six-month period. Nationally, more than one out of every six long-stay nursing home residents (17.6 percent) were admitted to the hospital within six months of the baseline assessment. These burdensome transitions are often difficult on patients both physically and mentally, and nationally only Black and multiracial residents were hospitalized at rates higher than the national average.

Nursing Home Residents with Pressure Sores: Nationally, just over 10 percent of "high-risk" nursing home residents experienced a pressure sore—up from 7 percent in the 2020 Scorecard. These are residents who are impaired in bed mobility or transfer, comatose, or suffering malnutrition who have pressure sores (stage 2–4 or unstageable). Pressure sores can be life-threatening as they lead to bone or joint infections, cancer and sepsis. In 16 states, the lowest performing group by race/ethnicity were still under 10 percent, the national average. In two states the rate of pressure sores was above 15 percent.

Nursing Home Inappropriate Antipsychotic Use: This indicator is the percentage of long-stay nursing home residents who inappropriately receive antipsychotic medication, defined as being given an antipsychotic without a diagnosis of bipolar disorder or schizophrenia. There is a long history of inappropriate use of chemical restraints in health care. Antipsychotic medications come with various side effects that can drastically impact a patient's health and quality of life. Nationally, 1 out of 10 nursing home patients given an antipsychotic did not have a diagnosis of schizophrenia or bipolar disorder.

About one in ten nursing home residents (10 percent) received antipsychotics inappropriately in 2021. Over the last several years, literature suggests that such administrations occur disproportionately among Black residents, while more recent studies posit that decreases in recent years may stem from inappropriate diagnoses. States range in performance with this indicator, from 6.6 percent to 25 percent for each state's worst performing group, or one third lower than the national average for all groups to one and a half times higher.

NEW INDICATOR—Nursing Home Residents Living in a 5-Star Facility: Nationally, about one in five nursing home residents (22 percent) live in a facility with a 5-star rating, the highest quality rating possible as designated on CMS Care Compare star ratings.[8] Inequities exist with respect to access to these facilities (see Chapter 2). When considering each state's lowest performing group, Hawaii, Alaska, Delaware, Montana, and Maine stand out with at least 1 in 3 residents in those groups living in a 5-star facility. Across both statewide figures and figures specific to each state's lowest performing group, fewer than half of residents in every state live in a top-rated facility.

NEW INDICATOR—Nursing Home Direct Care Staff Hours Per Resident Per Day: CMS collects data at the facility-level on each nursing home's average number of nursing care hours provided per resident, per day. State scores in this indicator derive from the lowest number of nursing care hours per resident, per day by race/ethnicity, based on the nursing homes with the most admissions from each group. One state might be scored based on the nursing homes with the most Hispanic resident admissions, while another might be scored based on the nursing homes with the most Asian resident admissions, depending on which group received the lowest amount of care. Nationally, the

8 For CMS Care Compare quality ratings for nursing homes, visit https://www.medicare.gov/care-compare/?providerType=NursingHome.

lowest served groups in each state received about 3.3 hours of nursing care per resident per day. In only three states did these groups receive more than 4 hours of care per person per day, which would be in line with previous CMS recommendations.

NEW INDICATOR—Nursing Home Staff Turnover: CMS began to publicly report nursing home staff turnover data in July 2022, covering turnover among registered nurses, licensed practical nurses, and certified nursing assistants. This *Scorecard* captures data published in January 2023 which looks back at the 12-month period of 2022. Nationally, turnover for these important roles exceeds 50 percent, meaning that more than half the nursing staff in nursing homes at the beginning of 2022 were no longer at those facilities by the end of the year. Across states, turnover ranged from about 40 percent to more than 60 percent.

NEW INDICATOR—Nursing Home COVID-19 Vaccinations—Staff: This new indicator uses the same data as the AARP COVID-19 Nursing Home Dashboard to calculate the percentage of nursing home staff up to date on their COVID boosters as of February 2023. The percentage of staff up to date on their vaccinations ranged from 10.7 percent in Alabama to 44.8 percent in the District of Columbia.

NEW INDICATOR—Nursing Home COVID-19 Vaccinations—Residents: This new indicator uses the same data as the AARP COVID-19 Nursing Home Dashboard to calculate the percentage of nursing home residents up to date on their COVID boosters as of February 2023. The percentage of residents up to date on their vaccinations ranged from 34.3 percent in Arizona to 76.8 percent in South Dakota.

NEW INNOVATION POINT—State Emergency Management Plans: The COVID-19 pandemic highlighted the importance of community response and disaster preparedness to the especially vulnerable populations of seniors and people with disabilities. This new policy indicator credits nine states with enhanced state hazard mitigation plans that are approved by the Federal Emergency Management Agency (FEMA) and also include statewide analysis of vulnerable populations like seniors and people with disabilities using a social vulnerability index. States that earn FEMA approval for their enhanced plan are eligible for five percent additional federal funding to use for disaster resilience.[9]

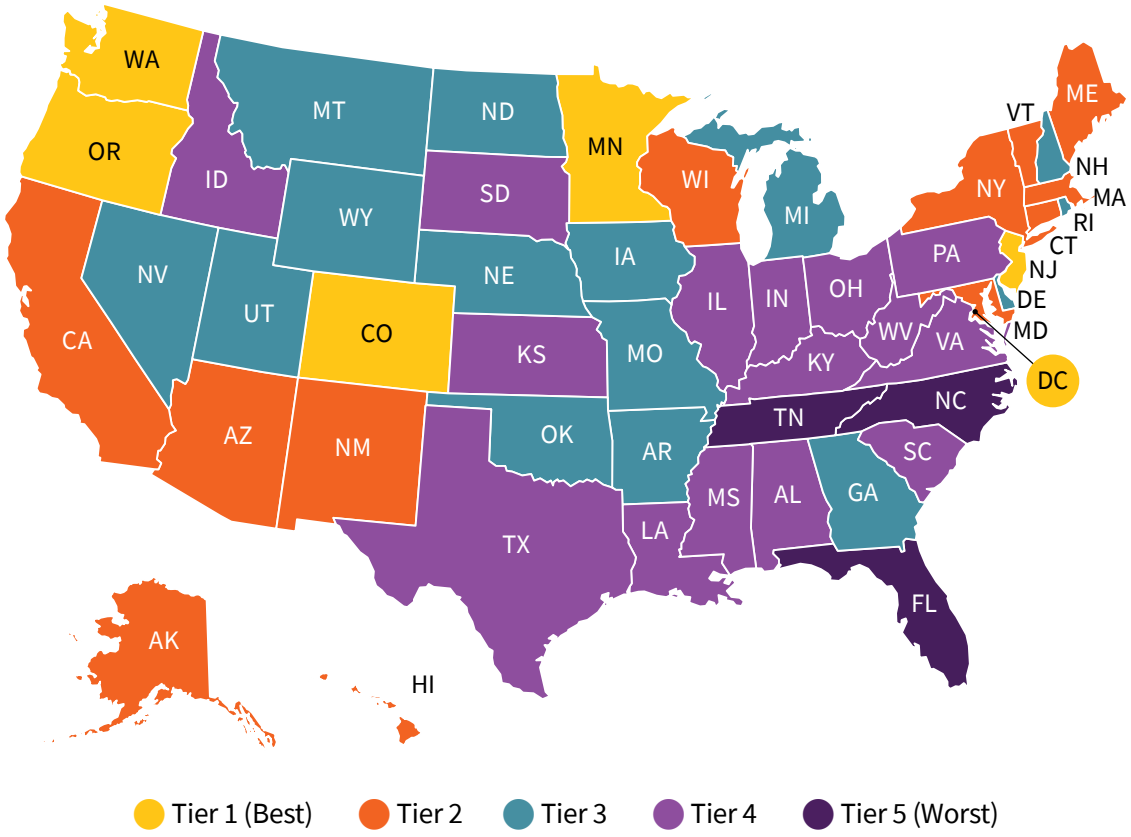
KEY FINDINGS FOR SUPPORT FOR FAMILY CAREGIVERS

Vision for *Support for Family Caregivers*

Family caregivers are recognized and their needs are assessed and addressed so they can receive the support they need to continue their essential roles. A robust LTSS workforce limits over-reliance on family caregivers. Family caregiver supports are culturally appropriate and accessible to all communities.

9 For more information about enhanced disaster mitigation plans, see FEMA, "Enhanced State Mitigation Planning: Basics for New Enhanced States," last modified September 20, 2022, https://www.fema.gov/fact-sheet/enhanced-state-mitigation-planning-basics-new-enhanced-states. For more information about social vulnerability indices, see FEMA, "Social Vulnerability," National Risk Index, accessed August 11, 2023, https://hazards.fema.gov/nri/social-vulnerability.

EXHIBIT 28 | This map shows states in each performance tier in *Support for Family Caregivers.*



Source: Long-Term Services and Supports State Scorecard, 2023.

Nurse Delegation: Family caregivers benefit from decision makers expanding the types of health maintenance tasks (e.g., giving medications, tube feedings, providing routine respiratory care) that registered nurses can delegate to home care aides. Nurse delegation helps family caregivers who may have to leave work during the day or hire a nurse to perform these routine tasks. Eleven states allow registered nurses to delegate a full range of a sample set of 22 tasks to home care aides. Some states, such as Indiana, allow registered nurses to delegate medication administration and other tasks to certified medication aides. Three states (Florida, Pennsylvania, and Rhode Island) do not permit delegation of any of the sample set of health maintenance tasks. Seven states (California, Connecticut, Delaware, Massachusetts, Mississippi, Tennessee, and South Carolina) permit nurses to delegate only five or fewer tasks.

Nurse Scope of Practice: Giving nurse practitioners authority to practice to the full extent of their education and training can ease the shortage of primary care providers. This can also help family caregivers by expanding options for care recipients to receive primary care services in the setting of their choice (e.g., medical offices, community health centers, adult day centers, at home). When the first *Scorecard* was released in 2011, just 14 states allowed patients to benefit from the full range of care nurse practitioners are educated and trained to provide. That number has now doubled to 28.

Family Responsibility Protected Classification: Family responsibility discrimination laws ensure that employed individuals are not unfairly treated or disadvantaged in the workplace due to their caregiving duties outside of work. Since the *2020 Scorecard*, four additional states (Alaska, Maine, Minnesota, and New York) have passed policies that prohibit employers from discriminating against family caregivers, bringing the total to seven. Alaska and Connecticut have statewide laws, but the provisions do not specifically define "parenthood" and "familial responsibilities," respectively; therefore it remains unclear whether the protections extend to all family relationships. Despite progress in this indicator, most states remain without state-wide laws protecting caregivers from discrimination in the workplace. See Appendix R for a list of states and localities with laws or policies that protect working family caregivers.

State Exceeds Federal Family and Medical Leave Act (FMLA): Eleven states go beyond the federal minimum FMLA by covering family members outside the scope of federal protections (e.g., grandparents, parents-in-law, and siblings), extending the length of leave or covering smaller employers. California previously had lost unpaid leave protections exceeding the federal FMLA requirements, but in September 2020, the state expanded the California Family Rights Act to offer those extended unpaid leave protections again.

Paid Family Leave: Since 2020, three additional states (Colorado, Delaware, and Maryland,) enacted paid family leave legislation, bringing the total number to 12 states. Of the three new states, paid family leave benefits will become available in 2024 in Colorado, in 2025 in Maryland, and in 2026 in Delaware. Five states (District of Columbia, New York, Oregon, Rhode Island and Washington) expanded paid leave benefits in 2022 to permit longer lengths of leave, expand the definition of covered family relationships for caregiving leave, or increase the benefit payment.

Paid Sick Days: This indicator focuses exclusively on statewide laws mandating paid sick days to employees. Since 2020, five additional states (Colorado, Maine, Minnesota, New Mexico, and New York) have enacted paid sick leave laws, bringing the total to 18 states enacting such policies in the last three years. See Appendix R for a list of states and localities that mandate paid sick days to employees.

Flexible Use of Sick Time: Like the Paid Sick Days indicator, this *Scorecard's* indicator focuses exclusively on statewide laws allowing employees to use a portion of accrued sick time for purposes beyond their own illness. Workplace benefits that allow employees to use sick time for family caregiving responsibilities help employees balance work and family responsibilities. Eighteen states have laws in place allowing flexible use of sick time. Since 2020, Colorado is the sole state enacting new legislation allowing flexible use of sick time.

Unemployment Insurance for Family Caregivers: In every state, workers can leave their jobs voluntarily and claim unemployment insurance as long as they can show "good cause." However, what qualifies as a "good cause" varies across states. Family caregivers in more than half of the states (27) can receive temporary financial assistance through state unemployment insurance programs. "Good cause" in these states might be a "family obligation" or the illness or disability of a family member. This indicator has shown no significant improvement since the *2020 Scorecard*, with only one additional state (Nebraska) enacting unemployment insurance legislation for family caregivers. The COVID-19 pandemic exacerbated paid workforce shortages, resulting in more hours of care and high-intensity care for family caregivers. Although some caregivers may be able to alter

their work schedules or take off for caregiving, others stand at risk of losing their jobs for reasons related to their family caregiver responsibilities. Access to unemployment insurance benefits is important now more than ever—for protecting the financial security of family caregivers.

Spousal Impoverishments Protections: Spousal impoverishment protection policies protect the financial interests of spouses of individuals applying for Medicaid LTSS services—by enabling them to retain a portion of the couple's assets and income. Without these policies, the spouse who is not applying for Medicaid might be forced to spend down their assets or deplete their income to cover the costs of care for their spouse. Twelve states allow the community spouse—that is, the one who is not applying for Medicaid—to retain 100 percent of a couple's assets up to the federally allowed maximum of $148,620 in 2023. Illinois allows spouses to retain 100 percent of a couple's assets up to $120,780. All other states allow spouses to retain only 50 percent of a couple's assets, or a total of $74,310, except for South Carolina which protects only $66,480 of a couple's income.

CARE (Caregiver Advise, Record, Enable) Act Legislation: The CARE Act—model legislation that supports family caregivers when family members enter a hospital and transition back home. Today, CARE's reach is nearly nationwide, as an overwhelming majority of states now have this critical support for family caregivers in place. The next step in advancing support for family caregivers and their care recipients in hospital settings is to strengthen implementation of these policies in states where the CARE Act is in place. Two more states, Arizona and Georgia, have enacted CARE Act legislations since 2020, bringing the total to 43 states with CARE Act laws as of May 31, 2023.

NEW INDICATOR—Respite Care Through Medicaid Waivers: This indicator assesses how often Medicaid HCBS waiver programs offer respite care, based on research by the National Academy for State Health Policy.[10] All but three states offer respite services for family caregivers of older adults and people with physical disabilities through Medicaid HCBS waivers. The *Scorecard* credits states having respite care as part of their applicable waiver(s), with full credit awarded to states that do not assign an arbitrary cap to the amount of respite available. In 37 states, for example, the waiver language includes a set limit above which no family caregiver can receive respite, regardless of what the participant's person-centered plan includes. Twelve states do not limit respite availability with person-centered plans determining the amount of respite available. Service caps are one way to assess a given HCBS waiver benefit. Robust data on use by state, by population, and by subgroup would provide greater insight into how respite (and other services) benefits consumers and family caregivers.

NEW INNOVATION POINT—State Caregiver Tax Credit: This new indicator measures implementation of relatively innovative state tax credit programs that offer family caregivers financial relief to offset the sizable out-of-pocket costs the overwhelming majority of family caregivers shoulder ($7,200 on average each year).[11] Six states (Georgia, Missouri, Montana, New Jersey, North Dakota, and South Carolina) have caregiver tax credits that cover out-of-pocket expenses of taxpayers caring for family members age 18 or over who experience difficulty with at least one ADL. Covered expenses may include installing home modifications to keep the care recipient mobile, safe, and able to continue living in the community; purchasing or leasing assistive devices and equipment to assist with activities of daily living; and hiring direct care workers.

10 10 Kimberly Hodges et al., " Emerging Respite Care Strategies in Medicaid Home and Community-Based Services Waivers for Older Adults, Adults with Physical Disabilities, and Their Family Caregivers," National Academy for State Health Policy, May 26, 2023, https://nashp.org/emerging-respite-care-strategies-in-medicaid-home-and-community-based-services-waivers-for-older-adults-adults-with-physical-disabilities-and-their-family-caregivers/.

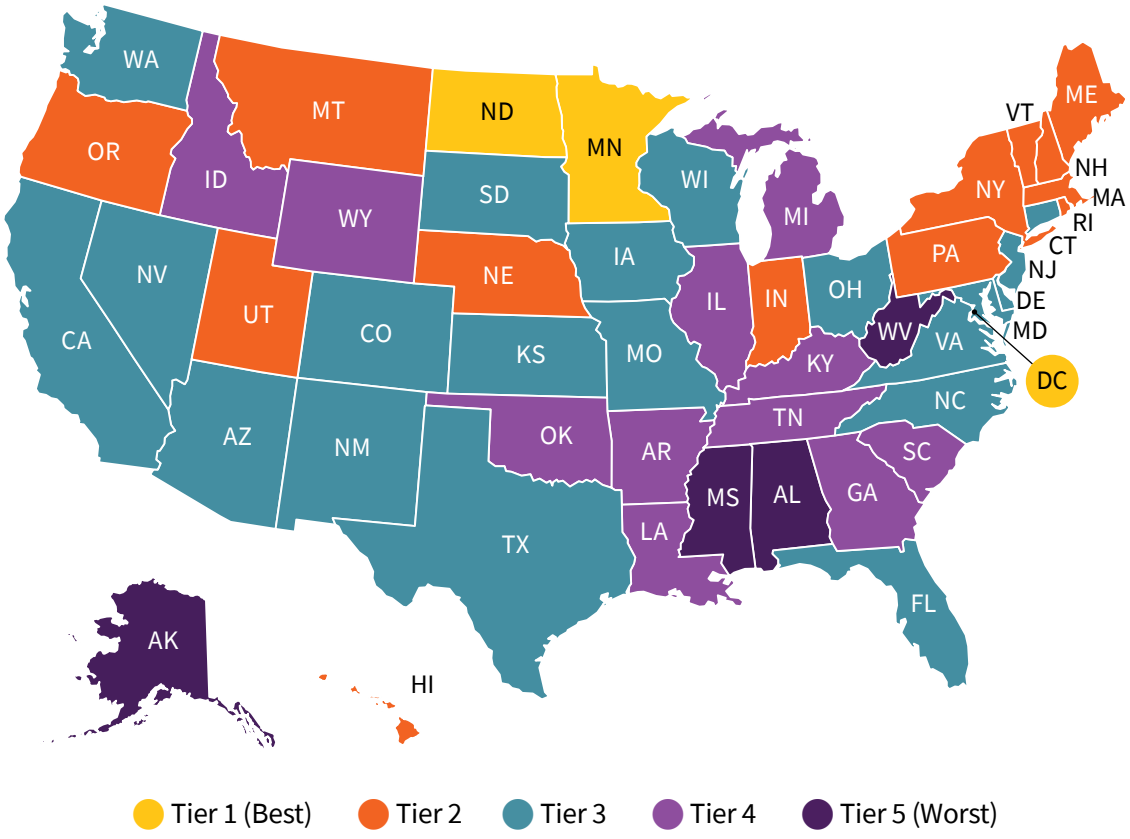
11 Laura Skufca and Chuck Rainville, Caregiving Out-of-Pocket Costs Study 2021 (Washington, DC, AARP Research, June 2021).

KEY FINDINGS FOR COMMUNITY INTEGRATION

Vision for *Community Integration*

Consumers have access to a range of services and supports that facilitate LTSS, including safe and affordable housing. Communities are age-friendly and supported by state Multisector Plans for Aging. Policy and programming that facilitates livable communities also drive equitable communities.

EXHIBIT 29 | This map shows states in each performance tier in *Community Integration.*



Source: Long-Term Services and Supports State Scorecard, 2023.

Employment Rate for People with Disabilities: Across several editions, the *Scorecard* tracked the employment rate of people with disabilities relative to that of people without disabilities. In this edition, the national rate is 21.6 percent (2021 data), which is the same as it was in the *2020 Scorecard* (2018-2019). At the state level, however, there were real fluctuations over the last few years. On one hand, performance improved by 10 percent or more in 13 states. On the other hand, 15 states saw decline in performance by the same magnitude. The District of Columbia had the greatest increase from the last *Scorecard*, improving by 11 percentage points to a rate of 29.7 percent in 2021.

Successful Discharge from Nursing Home to Community: This indicator looks at the percent of Medicare beneficiaries who are discharged from a skilled nursing facility after a short stay and are not readmitted to any facility for at least 30 days. Nationally, successful discharges occurred for more than half of short-stay Medicare nursing home residents (52 percent). Disparities exist, however, as the rate across each state's lowest served group by race/ethnicity came in at 44 percent across all states. Nationally, less than half of Black (44 percent) and Hispanic (46 percent) residents had successful discharges. In Connecticut, North Carolina, and Wisconsin, the lowest rates of successful discharge by racial/ethnic group were still close to the national average of 52 percent.

NEW INDICATOR—Livability Index—Transportation: The AARP Livability Index transportation component measures metrics and policies related to convenience, safety, and options.[12] Using our approach to measuring equity, we considered states' transportation scores in the neighborhoods with the largest percentages of most heavily Asian, Black, Hispanic and White residents and identified which had the lowest transportation scores. The District of Columbia, Rhode Island, and Montana had the best statewide transportation scores, while five of the six lowest scoring states were in the Southeast: Alabama, Georgia, Kentucky, Mississippi, and Tennessee. See pages 64-65 for additional discussion of this indicator and its implications.

NEW INDICATOR—Livability Index—Housing: The AARP Livability Index housing component measures metrics and policies that promote affordability, availability, and accessibility.[13] Using our approach to measuring equity, we considered states' housing scores in the neighborhoods with the largest percentages of most heavily Asian, Black, Hispanic and White residents and identified which had the lowest housing scores. Arizona, North Dakota, South Dakota, and West Virginia have the highest scores (over 55 out of 100 possible points). Hawaii, Massachusetts, Rhode Island have the lowest (37 out of 100 or lower). See pages 64-65 for additional discussion of this indicator and its implications.

NEW INDICATOR—Access to Housing Assistance for People with Disabilities: This new indicator measures access to this assistance specifically for low-income adults with disabilities. Nationally, just 16 percent of this group—who are likely to be eligible for housing assistance—actually receive assistance. Each state has less than half of its low-income adult population with a disability receiving housing assistance. The District of Columbia had the best performance with 43 percent of this group receiving assistance. In six states, by contrast, fewer than 10 percent of this group receives assistance: Florida, New Mexico, Oklahoma, South Carolina, Utah, and West Virginia.

12 For more information about the AARP Livability Index, see https://livabilityindex.aarp.org/.

13 For more information about the AARP Livability Index, see https://livabilityindex.aarp.org/.

NEW INDICATOR—Age-Friendly Health Systems: Age-friendly care is health care that addresses a person's unique needs and wants across the lifespan. Age-Friendly Health Systems is an initiative of The John A. Hartford Foundation and the Institute for Healthcare Improvement in partnership with the American Hospital Association and the Catholic Health Association of the United States, helps hospitals, doctor's offices, retail pharmacy clinics, nursing homes, and home-care providers deliver age-friendly care.[14] The *Scorecard* measures the presence of these facilities in each state indexed to their population of adults age 65+. Age-Friendly Health Systems exist in every state. Indiana has the largest presence indexed to its older adult population, with 306 AFHS sites per million older adults. The District of Columbia (233), Nebraska (221), Hawaii (128), and Maine (125) round out the top five states in this indicator. States with the lowest presence of AFHS sites include Alaska (10), Alabama (10), Wyoming (10), South Dakota (8), West Virginia (8) and Mississippi (6). Notably, this indicator counts the number of Age-Friendly Health System sites, each of which have different capacity in terms of how many patients they can serve.

NEW INNOVATION POINT—Multisector Plans for Aging (MPA): Developing and following a strong, strategic and comprehensive plan is crucial to secure lasting success in state LTSS systems. Multisector Plans for Aging (previously called Master Plans for Aging) fulfill this need. The SCAN Foundation describes MPAs as having the following elements:[15] a) covers 10 or more years; b) led by a governor with other executive and legislative leaders; and c) developed to guide the restructuring of state and local policy, programs, and funding toward aging well in the community. The *Scorecard* gave full credit to three states (California, Colorado, Massachusetts) for having developed/implemented a Multisector Plan for Aging and partial credit to five states (Missouri, New York, North Carolina, Utah, and Vermont) that have legislation or an executive order calling for a Multisector Plan for Aging.

Insights and Opportunities

In reflecting on the *2023 Scorecard* findings overall, we came to the following insights—each with opportunities to take action.

INSIGHT: Movement to shift balance to HCBS for older adults and people with physical disabilities is reaching a tipping point.

It has long been the fundamental goal across the LTSS field for every individual who needs LTSS to have the option to get services at home within their communities. For the first time, counting only programs primarily serving older populations and people with physical disabilities, spending on HCBS as a portion of national spending on LTSS overall has crossed over the 50 percent mark. Many states saw significant increases in the last few years. This continues a long-term trend, but it appears the pandemic had a noticeable effect, putting pressure on states to serve people in community

14 For more information about Age-Friendly Health Systems, see the Institute for Healthcare Improvement, "Age-Friendly Health Systems," accessed August 11, 2023, https://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Pages/default.aspx.

15 For more information about Multisector Plans for Aging, see the SCAN Foundation, "Building a Master Plan for Aging: Key Elements from States Planning for an Aging Population," Summary, last modified October 4, 2021, https://www.thescanfoundation.org/publications/building-a-master-plan-for-aging-key-elements-from-states-planning-for-an-aging-population/; the Center for Health Care Strategies, "Developing a Multisector Plan for Aging," published June 2022, https://www.chcs.org/resource/developing-a-master-plan-for-aging/

settings while also providing more opportunities to invest in HCBS. More spending on HCBS is what made many of the other performance improvements documented in this *Scorecard* possible, particularly in *Choice of Setting and Provider*. There is still a long way to go as spending is still not commensurate with the clear preferences of individuals and their families to live in community settings. But the change since the first *Scorecard* and within the last three years is very encouraging.

OPPORTUNITIES—Continue to invest in HCBS infrastructure across the board from raising awareness about community options and providing person-centered counseling to help people make informed decisions (e.g., through ADRC/NWD systems); assisting people through the eligibility process quickly (e.g., Presumptive Eligibility); adding service options (e.g., Self-Direction, CAPABLE, PACE, Respite Care); and providing more support for family caregivers. The increase in HCBS spending is a sign that improvements are underway, but as demand for HCBS continues to grow, states must redouble their efforts to ensure that individuals who use LTSS have a wide range of meaningful choices about where they live, how they live, what kinds of support they get, and from whom.

INSIGHT: Coalitions are more important than ever.

High performance in LTSS systems depends on successful partnership and coordination across multiple independent entities. For most *Scorecard* indicators, one organization alone won't move the needle. Although one state agency may need to take the lead or play a facilitator role, to make significant progress in areas such as emergency planning for vulnerable populations, age-friendly health systems, housing, employment and transportation, states must build coalitions of change-makers across public and private sectors at state and local levels. Multisector Plans for Aging provide a solid structure and replicable process for identifying and organizing all necessary partners across the state to achieve systemwide change. They offer a roadmap for identifying the greatest areas of need, developing long-term and short-term goals, determining strategies and tactics, implementing change in a coordinated fashion, and tracking change.

OPPORTUNITIES—We encourage states to explore the multisector planning process as an organizational framework for improving performance. Keep in mind that these plans can address a wide range of things that affect the lives of older adults and people with disabilities. We recommend being as expansive in thinking and as inclusive in process as possible. Several foundations have offered support for states to carry out this work, including The SCAN Foundation, West Health, and The May and Stanley Smith Charitable Trust.[16]

OPPORTUNITIES—Build coalitions to pursue change in several related areas at once. For example, there may be a way to combine existing efforts to strengthen community supports like building more age-friendly health systems and making communities more livable, affordable, and accessible in terms of housing and transportation. The bottom line is that cross-sector coalitions of public- and private-sector organizations bring more resources, more momentum, and more expertise to the table.

16 The SCAN Foundation: https://www.thescanfoundation.org/initiatives/multisector-plan-aging/

INSIGHT: Opportunities abound to scale innovations, especially to support family caregivers.

States have been key to developing and implementing innovations in LTSS system design and service delivery for many years. This *Scorecard* illuminates the wide range of innovative policies and programs that states have tested, proven effective, primed, and readied for scaling. The six Innovation Points featured in this report represent just a few of the ways states can transform their systems. There are numerous cost effective and replicable programs and policies. Under *Support for Family Caregivers* for example, there are 12 policies states have used to support family caregivers and every state has room to further develop in these areas. We don't consider these policies to be low-hanging fruit—in fact they often require significant and sustained effort—but they are not impossible to achieve. States have seen notable successes in the last three years, even during the pandemic.

OPPORTUNITIES—Gather information and learn from the hard-earned experience of other states. Consider connecting with policymakers and implementers in other states and including individuals with experience to join your planning and improvement process. Join learning collaboratives and work groups. Several associations and organizations routinely help states to connect with and learn from one another, such as ADvancing States, USAging, Council of State Governments, National Council on Aging, and National Council for Independent Living.

INSIGHT: Glaring gaps in data persist and more is needed to better understand equity in LTSS.

Our ability to measure system performance has always been limited by a lack of data. This year, with the support of advisors and stakeholders, we widened our lens significantly to provide a more comprehensive look at state performance. We were able to find new and better data sources and add new indicators in every dimension. But these additions also make the lack of data in some key areas even more glaring. In three of the highest priority areas: equity, quality, and workforce, the data available across states are almost entirely related to nursing home settings. HCBS quality data are barely existent, much less comparable across states. The addition of race and ethnicity breakdowns for 11 of the 50 indicators is a step forward, but it leaves us to only imagine what having additional data for the other 39 indicators might show. We anticipate that some of the changes planned at the federal level in measuring quality in HCBS programs may help to fill in some of these gaps.

OPPORTUNITIES—Make the most of the data you have. Identify all data sources—both administrative and outcomes data—across agencies and organizations. Break it down using demographic and other data and look at it in different ways. This *Scorecard* provides at least one model on how to analyze race and ethnicity data for data with different units of analysis (e.g., facilities, neighborhoods, and individuals).

OPPORTUNITIES—When it comes to measuring HCBS quality, the experience of individual participants is everything. States must analyze the effectiveness and outcomes of their programs at the individual participant level. To do this, we encourage states to voluntarily adopt and routinely use at least one of the nationally validated HCBS benchmarking surveys available (e.g., NCI-AD, HCBS CAHPS).

OPPORTUNITIES—To measure workforce strength and stability, providers, employers, and health plans must be part of the effort on a voluntary basis or as a requirement in state contracts. To monitor workforce, states should be routinely collecting data that speak to volume, compensation, and retention from every employer on a routine basis. This information may not be comparable with that of other states, but you can track progress within your state over time. Finally, we encourage states to share lessons learned collecting and analyzing data with other states.

INSIGHT: A strong workforce is essential.

One of the most impactful investments states can make is improving the size, strength, and stability of the paid direct care workforce, including family caregivers paid through self-directed programs. This *Scorecard's* workforce findings offer a potential roadmap for states as they continue to work toward bolstering the workforce. Few workers in any LTSS setting are earning a living wage or basic employee benefits that provide security for their families. Most states experience high staff turnover for nursing homes and a limited supply of home health and personal care aides. These factors underscore the need for states to take continuing action to attract new workers and retain those currently in the field. At the same time, almost no state has adequately staffed nursing homes and likely have staffing shortages across service lines where the *Scorecard* may be unable to fully quantify the issue. States should review the staffing levels across their facilities and consider ways to increase staffing where it is needed.

OPPORTUNITIES—Take action to bolster the direct care workforce in real and sustainable ways. Make direct care wages for these jobs more competitive compared to other fields that current and prospective workers may likely consider. States also have a role to play in ensuring adequate staffing in nursing homes, including through setting their own staffing standards and enforcing potential future government standards. States can also choose to enact (and enforce) staffing standards across other service lines and hold providers accountable.

APPENDICES

APPENDIX A | More Background about *Scorecard*

With funding from The SCAN Foundation, The Commonwealth Fund, and now The John A. Hartford Foundation, this fifth edition of the *Scorecard* has been reimagined and vastly expanded, making use of a wider range of data sources and analytic approaches. Each edition of the *Scorecard* measures state performance against an objective, data-driven set of metrics, or indicators, that collectively tell a story of how states were doing with their LTSS systems at a given time. The *Scorecard* offers accurate, reliable, and comparable data that can serve as the basis for evidence-based solutions so that older people and adults with disabilities in all states can exercise choice and control over their lives, thereby maximizing their independence and well-being. High-performing LTSS systems also ensure that family caregivers have the support they need when caring for close relatives and friends.

Data availability shortfalls. The *Scorecard* can be only as complete and comprehensive as the data that are available to measure performance, and data availability continues to fall short of where it ought to be. In the first *Scorecard*, released in September 2011, data gaps were identified, and others have subsequently been noted. From the beginning of the *Scorecard* project, a key finding has been that better data are needed to assess state LTSS system performance, especially in home and community-based services (HCBS).

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

HOW ADVISORS AND STAKEHOLDERS INFORMED THE *2023 SCORECARD*

In 2021 The SCAN Foundation provided funding for a planning period to help the *Scorecard* team assess what impact COVID-19 had and was still having on the LTSS system. In that process, we met individually and in small groups with a mix of researchers, state policymakers, AARP staff, and other *Scorecard* users and stakeholders. See the members of the National Advisory Panel in Appendix B.

Advisors and stakeholders agreed that much of what was in the *2020 Scorecard* framework continues to be important. The most significant changes they recommended were to address new issues that emerged during COVID-19 as well as long-standing issues that are now more widely understood to have great significance. There was broad consensus that the top two priority issues we should address were LTSS workforce challenges and the effort to achieve equity across different populations in terms of service access, utilization, and quality. In addition, we heard repeatedly that the issues of safety in nursing homes, emergency responsiveness and preparedness, community integration and livability, and age-friendly communities were important to better address. Finally, we heard that recognizing states for policy innovation, trying something new and promising—especially amid the COVID-19 pandemic—would be a meaningful addition. We heard that it is important to describe not only the outcomes that can be quantifiably measured but also the efforts states make (or do not make) to respond to the needs of their residents.

The new framework is presented in Exhibit 1. With this framework and the addition of many new indicators, this *Scorecard* continues to describe how well states are responding to the needs of older adults and people with physical disabilities who receive LTSS and their family caregivers. With the addition of race and ethnicity data for several indictors, we can draw attention to those with the greatest needs and/or who are most vulnerable to the impacts of long-standing policies and practices that advantage or disadvantage different racial and ethnic groups, a dynamic sometimes referred to as structural racism. The new framework also includes innovation points that recognize states that have undertaken uncommon but promising initiatives to improve the consumer and family caregiver experience throughout the five dimensions of the *Scorecard*.

THE CHANGING LANDSCAPE OF LTSS[1]

In addition to gathering input and feedback from stakeholders, we used the planning period to conduct a scan of the LTSS landscape. In the years since the first *Scorecard* was published, there have been stark transformations both within LTSS systems and in our country more broadly that impact how people receive the services and supports they need. First, the older adult population has itself changed. In 2010, there were about 40 million Americans over the age of 65. By 2019, that number had reached more than 55 million Americans—a 35 percent increase.[2] Meanwhile, the U.S. population grew by just 6 percent over that same period. Our country will only continue aging; by 2035, the US Census Bureau forecasts that adults over age 65 will outnumber children under 18—a phenomenon that has not yet occurred in our country.[3] We must have strong LTSS systems to meet the needs of the older population over time. Moreover, we need to be adept at serving a more diverse group of people. From 2010 to 2019, older Black, Hispanic, American Indian/Alaska Native, and Asian American populations grew faster than did the older non-Hispanic white population and drove about 35 percent of the 65+ population's growth since 2010 (see Exhibit 1).[4]

Notably, Black, Hispanic, American Indian, and Asian American adults also made up a larger share of the 55- to 64-year-old population in 2019, compared with the 65+ population, which shows that over the next decade, we will see even more diversity among older adults. As the older population continues to expand and further diversify, it will be critical for LTSS systems to have equitable services and supports in place to serve all older adults. The last decade also saw a rise in the population of adults who need assistance to complete activities of daily living (ADLs). From 2010 to 2019,

For more information on the changing landscape of LTSS, please see our paper *High Performance Revisited*: https://www.longtermscorecard.org/publications/promising-practices/high-performance-revisited

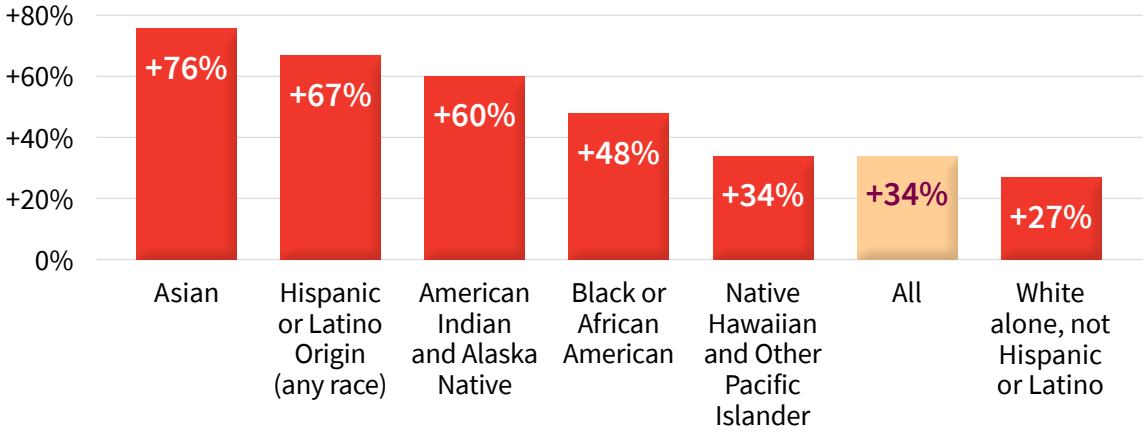
1 Brendan Flinn, "High-Performance Revisited: Examining Long-Term Services and Supports System Performance," AARP Public Policy Institute, November 10, 2022, https://www.longtermscorecard.org/publications/promising-practices/high-performance-revisited.

2 AARP Public Policy Institute analysis of US Census Bureau data.

3 US Census Bureau, "Older People Projected to Outnumber Children for First Time in US History," March 13, 2018, https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html.

4 AARP Public Policy Institute analysis of US Census Bureau data.

EXHIBIT A1 | Growth of 65+ Population by Race/Ethnicity, 2010 to 2019.



Source: Long-Term Services and Supports State Scorecard, 2023.

this population grew from almost 6.9 million to more than 7.4 million, a 13 percent increase. For reference, the adult population regardless of disability status grew by 9 percent over the same period.

As the population grows older and more diverse, there is a greater need for LTSS and more demand for those services and supports to be delivered in a manner that people want and that meets their cultural needs. Over the last decade, that has meant more HCBS relative to institutional settings, which historically have been the primary settings for LTSS. Public opinion polling research consistently demonstrates a public preference among older adults and/or adults of all ages to receive care in the home and community, and specifically not in nursing facilities. A 2021 AARP Research study showed that more than 3 in 4 adults 50+ want to stay in their homes and communities for as long as possible[5], and studies from other organizations have returned similar findings.[6] Particularly after the peak of COVID-19, people want LTSS options outside of nursing facilities[7], and this longstanding consumer sentiment has informed both supply of services and policy to facilitate more HCBS.

THE IMPACT OF COVID-19

The COVID-19 pandemic swept across the United States starting in March 2020, and quickly began impacting nursing homes and other residential LTSS settings. According to the AARP Nursing Home COVID-19 Dashboard, more than 163,000 nursing home residents and more than 2,700 nursing home staff had died of COVID-19 by April 2023.[8] The pandemic exposed long-standing, structural problems facing LTSS and nursing homes in particular. These include inconsistent staffing, lack of sufficient

5 Joanne Binette and Fanni Farago, "Where We Live, Where We Age: Trends in Home and Community Preferences," AARP Research, November 18, 2021, https://www.aarp.org/research/topics/community/info-2021/2021-home-community-preferences.html.

6 AP-NORC Center for Public Affairs Research, "Long-Term Care in America: Americans Want to Age at Home," May 3, 2021, www.apnorc.org/projects/long-term-care-in-america-americans-want-to-age-at-home.

7 The John A. Hartford Foundation, "Age-Friendly Insights: Poll Reveals How Older Adults Feel About Nursing Homes," December 7, 2021, https://www.johnahartford.org/dissemination-center/view/age-friendly-insights-how-do-older-adults-feel-about-nursing-homes.

8 AARP Public Policy Institute, "AARP Nursing Home COVID-19 Dashboard," last modified May 18, 2023, https://www.aarp.org/ppi/issues/caregiving/info-2020/nursing-home-covid-dashboard.html.

oversight, and a low-paid workforce not always equipped with the training it needs. It also showed the danger inherent in congregate settings; nursing homes that housed residents in shared rooms saw more COVID-19 spread.

While no setting or individual could have anticipated the COVID-19 pandemic, the lack of emergency planning specifically in nursing homes left residents and staff highly vulnerable. Moving forward, it will be important for strong LTSS systems to have plans in place to ensure participant safety and continuity of care in the event of emergencies, be it a global pandemic, flu outbreak, natural disaster, or other event. During the COVID-19 pandemic, nursing home occupancy plummeted. Residents were dying of COVID-19, and people who might otherwise have chosen to live in a nursing home did not move into these facilities. In some states, occupancy fell to below 50 percent by mid-2020. Nursing home residency has not recovered even now, more than three years after the pandemic began. As of May 2023, the occupancy has come up to 74 percent, but it is still down from 82 percent just before the pandemic began in March 2020.[9]

In 2022, the National Academies of Science, Engineering and Medicine (NASEM) issued a report on nursing home safety, focused in part on the COVID-19 pandemic, and made several recommendations for future action. The report found that "[t]he way in which the United States finances, delivers, and regulates care in nursing home settings is ineffective, inefficient, fragmented, and unsustainable." The NASEM report resulted in sweeping recommendations across almost every area of nursing home policy, from workforce improvements and increases to minimum staffing policies for facilities, improving cultural competency in facilities, and changing how we finance LTSS.[10] Policymakers are considering their next steps following the NASEM report, and the *Scorecard* could play a role in assessing how states are positioned to act with these recommendations in hand. COVID-19 also had a marked impact on HCBS and the people who relied on this support.

Many providers suspended in-person services, and people who otherwise received support from a personal care aide or at an adult day center no longer had access to that support. This placed further strain on family caregivers who were themselves also dealing with the pandemic- and led to increased acuity among many people who went without HCBS. The federal policy response to COVID-19 prioritized nursing home settings so states had to address HCBS settings. While some states filled the gap, many did not.[11] States did eventually receive dedicated funding for Medicaid HCBS as part of the American Rescue Plan Act[12], and how states choose to use these dollars could affect the strength of their LTSS systems.

9 AARP Public Policy Institute analysis of CMS Care Compare data.

10 National Academies for Science, Engineering, and Medicine, "The National Imperative to Improve Nursing Home Quality," 2022, https://nap.nationalacademies.org/catalog/26526/the-national-imperative-to-improve-nursing-home-quality-honoring-our.

11 Susan C. Reinhard, Brendan Flinn, and Carrie Blakeway Amero, "COVID-19's Impact on Community-Based Long-Term Services and Supports," Generations, April 27, 2022, https://generations.asaging.org/covid-19s-impact-community-based-ltss.

12 American Rescue Plan Act, 117th Congress, HR 1319 https://www.congress.gov/bill/117th-congress/house-bill/1319/text

APPENDIX B | National Advisory Panel and Acknowledgements

The *Scorecard* National Advisory Panel is drawn from a broad range of knowledgeable stakeholders across public, private, and non-profit organizations, and federal government. Their task was to advise the AARP project team on all aspects of the *LTSS State Scorecard*, including expanding and updating the indicator set to reflect changes in available data since the development of the fourth *Scorecard*. We would like to thank the members of the National Advisory Panel:

- Lisa Alecxih, The Lewin Group
- Robert Applebaum, Miami University of Ohio
- Shawn Bloom, National PACE Association
- Jennifer Bowdoin, Centers for Medicare & Medicaid Services/MBHPG
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- Stuart Butler, Brookings Institute
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- Camille Dobson, ADvancing States
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- Lori Gerhard, Administration for Community Living
- Vicki Gottlich, Administration for Community Living
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- David Lindeman, CITRIS Health
- Rose Maljanian, HealthCAWS, Inc.
- Lisa McCracken, Ziegler
- Mary Olsen Baker, Minnesota Department of Human Services
- Lindsay Peterson, University of South Florida
- Elizabeth Priaulx, National Disability Rights Network
- Noelle Neault, Maine Department of Health and Human Services
- Allison Rizer, ATI Advisory
- Bea Rector, Washington State Department of Social and Health Services
- Martha Roherty, ADvancing States
- Marisa Scala-Foley, National Association of Area Agencies on Aging
- Samantha Scotti, National Conference of State Legislators
- Tetyana Shippee, University of Minnesota
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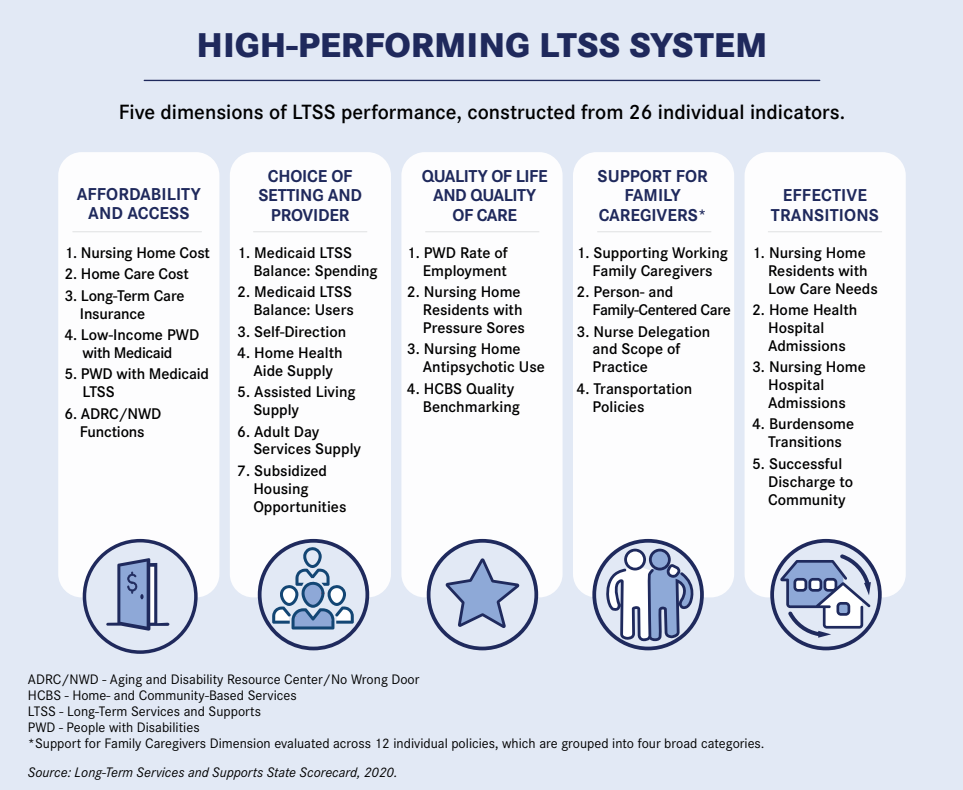
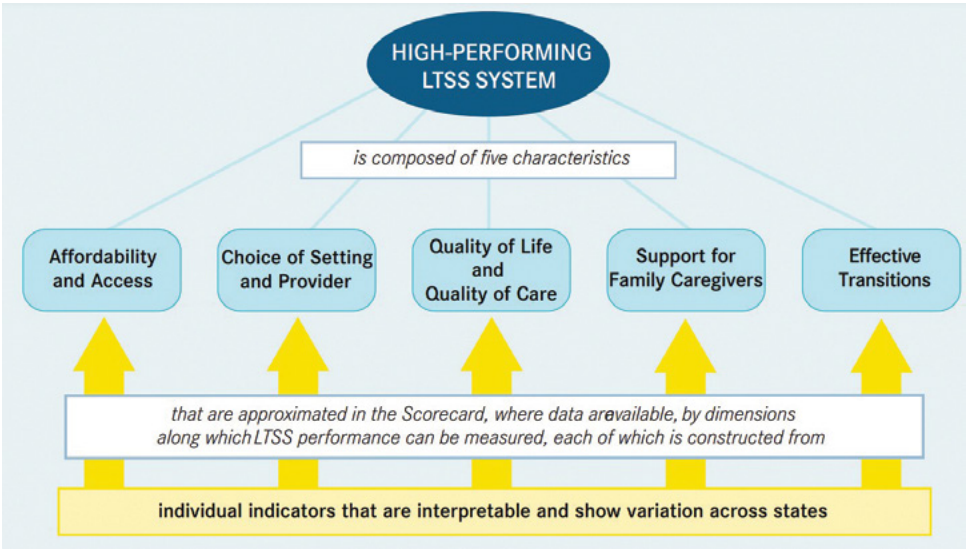
- Jana Lynott, AARP Public Policy Institute
- Tim Murphy, AARP Public Policy Institute
- Jason Tudor, AARP

APPENDIX C | Frameworks from Previous Editions of *LTSS State Scorecard*

2020 Scorecard Framework with Indicators



2014-2020 Scorecard Framework

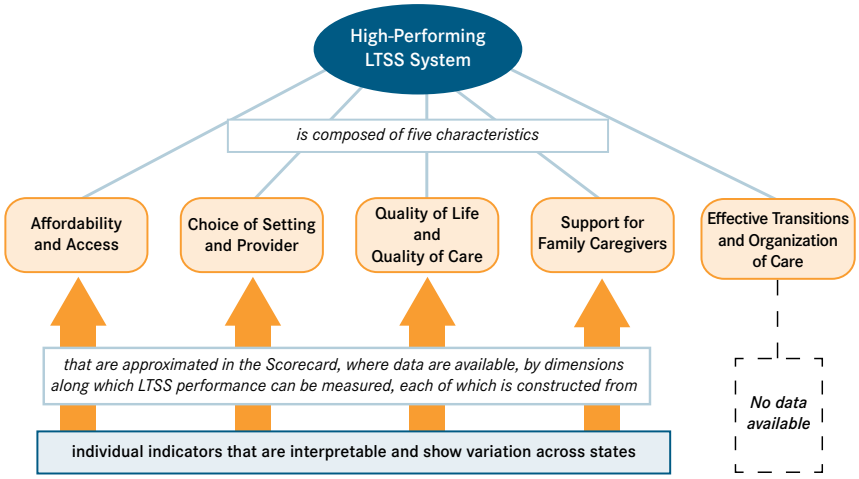


APPENDIX C | Frameworks from Previous Editions of *LTSS State Scorecard* (continued)

2011 Scorecard Framework

Exhibit 4

Framework for Assessing LTSS System Performance



Source: State Long-Term Services and Supports Scorecard, 2011.

APPENDIX D | Methodology Overview (2023)

The scoring and ranking methodology in the *2023 LTSS State Scorecard* is substantially revised from the methodology used in the previous four *Scorecards*. The most significant change is that in earlier editions, states were scored based on their *rank* on each indicator; in the current *Scorecard*, they are now being scored based on the *value*, or *actual level of performance*, for each indicator.

DIMENSIONS AND INDICATORS: The *2023 Scorecard* measures LTSS system performance using 50 indicators across five dimensions. Indicators consist of metrics, which have a numerical scale from best to worst performance, and policies, for which states are credited for having such a policy, or not (some policies have a single intermediate "partial credit" option where it makes sense). The 50 indicators (30 metrics, 20 policies) are grouped into the following dimensions:

- **Affordability and Access** (6 metrics, 1 policy; 7 total indicators)
- **Choice of Setting and Provider** (8 metrics, 3 policies; 11 total indicators)
- **Safety and Quality** (9 metrics, 4 policies; 13 total indicators)
- **Support for Family Caregivers** (1 metric, 11 policies; 12 total indicators)
- **Community Integration** (6 metrics, 1 policy; 7 total indicators)

Indicators had to be important, meaningful, understandable, have a clear directionality, and have comparable data available at the state level. These 50 indicators were selected because they represent the best available measures at the state level. While no single indicator can fully capture LTSS system performance, taken together they provide a useful measure of how state LTSS systems compare across a range of important dimensions.

SCORING METRICS. Raw metric values are transformed to a natural scale, including reverse coding for metrics where a lower value is better. In general, percentages undergo a log odds transformation, supply and other ratio measures undergo a log transformation, and other measures are only adjusted for directionality. Table D.1 shows the transformation used for each metric. The transformed values are then standardized to a "Z score" with mean of 0 and a standard deviation of 1 across all states, so that for scoring purposes each metric has the same weighting as every other metric in the dimension.

EQUITY INDICATORS. Nine metrics are equity indicators, where instead of being scored on the metric value for the entire population, states are scored only for the value of the worst performing racial/ethnic group.

- Five of these metrics divide the population into two groups (non-Hispanic White; and a combination of all other race/ethnicity groups: American Indian/Alaska Native, Asian, Black, Hispanic, Native Hawaiian/Pacific Islander, and multiracial). Where sample size is sufficient for both groups, the indicator value is the lowest of the two groups.
- The other four metrics are calculated at different unit of analysis (nursing facility or neighborhood); for these, the value for the 10% with the highest proportion of residents of each identifiable race/ethnicity group is calculated. The indicator value is for the worst performing 10% subsample.

SCORING POLICIES. Policies are scored 1 for "full credit" for the indicated policy, and 0 for "no credit." This is not necessarily the same as having a no policy. For policy indicators in which an intermediate level of credit makes sense, "partial credit" of 0.5 may be assigned.

INNOVATION POINTS. Six policy indicators are identified as "innovation points" to call attention to policies that only a few states have adopted and thus have potential for significant LTSS system improvement if implemented more widely across the country. The scoring of innovation points is the same as for all other policy indicators.

CALCULATING DIMENSION AND OVERALL PERFORMANCE. Dimension-level performance is calculated by summing the metric Z scores and policy scores for all indicators in the dimension. In order for dimension performance to be based on total performance across many indicators and not dominated by outlier high or low performance in a single metric, metric Z scores are capped at 2 and floored at -2 when summed. A higher dimension score is considered better performance.

Every metric has equal weight in determining dimension performance, and every policy has equal weight. Full policy credit (relative to no credit) is equivalent to one standard deviation difference in metric-level performance.

Overall performance is calculated by summing standardized dimension-level performance, so that every dimension has equal weight in determined overall performance. Dimension Z scores are capped at 2 and floored at -2 when summed.

PERFORMANCE TIERS. At the dimension and overall levels, states are categorized in performance tiers from Tier 1 (best performance) to Tier 5 (worst performance). These tiers provide more context about state performance that individual state ranks. Tiers 2, 3, and 4 represent equal performance ranges, with Tier 1 and Tier 5 showing exceptionally high or low performance. Cut points of approximately +1.5, +0.5, -0.5, and -1.5 standard deviations from the mean are used to classify states by tier (some cut points are adjusted slightly from default values so that there is always a meaningful performance gap between each tier and similar performing states are not separated into different tiers).

TABLE D.1 |

Transformation	Indicators with this transformation
No transformation: **Score = *x*,** **where *x* is the raw metric value**	• Medicaid Buy-in • LTSS Worker Wage Competitiveness • Nursing Home Staffing Levels • Nurse Delegation • Livability Index: Transportation • Livability Index: Housing
Log transformation: **Score = ln(*x*),** **where *x* is the raw metric value**	• Home Care Cost • Nursing Home Cost • Long-Term Care Insurance • Self-Directed Program Enrollment • Home Health Aide Supply • Assisted Living Supply • Adult Day Services Supply • PACE Enrollment (score = 0 if x = 0) • Age-Friendly Health Systems
Log odds transformation: **Score = ln(*x*/(1- *x*)),** **where *x* is the raw metric value**	• ADRC/NWD Functions • Medicaid for Low-Income People with Disabilities • Medicaid LTSS Balance: Spending • NH Residents with Low Care Needs • Home Health Hospital Admissions • NH Hospital Admissions • NH Residents with Pressure Sores • NH Inappropriate Antipsychotic Use • NH Staff Turnover • NH COVID-19 Vaccination: Residents • NH COVID-19 Vaccination: Staff • NH with Top Quality Ratings • Employment Rate for People with Disabilities • Successful Discharge to Community • Access to Housing Assistance for People with Disabilities

APPENDIX E | Detailed Indicator Descriptions

AFFORDABILITY AND ACCESS DIMENSION

Median annual home care private pay cost as a percentage of median household income, ages 65+

Short Name	Home Care Cost		
Description of Value Calculation	The median annual private pay cost of licensed home health aide services (based on 30 hours of care per week multiplied by 52 weeks) divided by the median household income for households headed by someone aged 65 or older.		
Data Source(s)	Cost data for the current year are from the *Genworth 2021 Cost of Care Survey* and income data are from the AARP Public Policy Institute analysis of the *2018 American Community Survey Public Use Microdata Sample*. Reference year cost data are from the *Genworth 2019 Cost of Care Survey*, and income data are from the *2018 American Community Survey*.		
Current Year(s)	2021	**Reference Year(s)**	2019
Type of Indicator	Metric, percent Lower values are better		
Changes to Methodology from 2020 to 2023	Ratios are calculated at the state level. Previously ratios were calculated at the market level and rolled up to the state level across all markets in the state. Data may not be comparable to previous *Scorecards* due the change in methodology.		
Inclusion/Exclusion Criteria for being Counted	N/A		

Median annual nursing home private pay cost as a percentage of median household income, ages 65+

Short Name	Nursing Home Cost		
Description of Value Calculation	The median daily private-room rate (multiplied by 365 days) divided by the median household income for households headed by someone aged 65 or older.		
Data Source(s)	Cost data for the current year are from the *Genworth 2021 Cost of Care Survey* and income data are from the AARP Public Policy Institute analysis of the *2018 American Community Survey Public Use Microdata Sample*. Reference year cost data are from the *Genworth 2019 Cost of Care Survey*, and income data are from the *2018 American Community Survey*.		
Current Year(s)	2021	**Reference Year(s)**	2019
Type of Indicator	Metric, percent Lower values are better		
Changes to Methodology from 2020 to 2023	Ratios are calculated at the state level. Previously ratios were calculated at the market level and rolled up to the state level across all markets in the state. Data may not be comparable to previous *Scorecards* due the change in methodology.		
Inclusion/Exclusion Criteria for being Counted	N/A		

Private long-term care insurance (LTCI) policies in effect per 1,000 people, ages 40+

Short Name	Long-Term Care Insurance Coverage		
Description of Value Calculation	The number of long-term care insurance policies, group and individual stand-alone policies, in force (for people of all ages) per 1,000 population ages 40 or older in the state. This is not exactly the proportion of people ages 40+ with private LTCI, because data on the age of policyholders at the state level are not available. Historically, about three-fourths of group policyholders and nearly all individual policyholders have been ages 40+. LTCI policy data are from the AARP Public Policy Institute analysis of 2021 National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Experience Reporting - Form 5, end-of-year inforce counts, by company type. In addition, California Public Employee Retirement System (CalPERS) group LTCI policies are separately reported as NAIC does not report CalPERS counts. LTCI policy data excludes federal LTCI group policy counts as the Office of Personnel Management would not authorize the release of 2018 data. Population data are from the US Census Bureau Population Estimates, 2021. 2018 baseline LTCI policy and population data are from the same sources.		
Data Source(s)	NAIC Long-Term Care Insurance Experience Reporting Form 5, end-of-year in force counts, by company type (2021 and 2018). 2022 is available at https://content.naic.org/sites/default/files/publication-ltc-lr-care-experience-report.pdf. California total group policy counts separately reported for CalPERS group LTCI policies. CalPERS is not an NAIC reporting company. CalPERS, Long-Term Care Actuarial Valuation, as of June 30, 2021, long-term care program data for participant counts and covered lives, are available at https://www.calpers.ca.gov. CalPERS 2018 Long-Term Care Program Report, March 20, 2018, is available at https://www.calpers.ca.gov/docs/board-agendas/201803/pension/item-4c-attach-1-a.pdf. State-level data exclude federal long-term care insurance group policy counts. US Census Bureau. 2021. "2021 American Community Survey 1-Year Estimates, Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States." https://data.census.gov/table?g=0100000US$0400000&tid=ACSST1Y2021.S0101		
Current Year(s)	2021	**Reference Year(s)**	2018
Type of Indicator	Metric, number, standardized as population rate Higher values are better		
Changes to Methodology from 2020 to 2023	No changes		
Inclusion/Exclusion Criteria for being Counted	N/A		

Aging and Disability Resource Center (ADRC)/No Wrong Door (NWD) Functions (composite indicator, scale 0-100%)

Short Name	ADRC/NWD Functions
Description of Value Calculation	This composite indicator draws from a voluntary, self-reported survey fielded by AARP for each state's ADRC/NWD System. The survey asked state administrators to describe their progress toward developing fully operational NWD Systems using 41 criteria across five dimensions: 1. State Governance and Administration (10 criteria) 2. Populations (5 criteria) 3. Public Outreach and Coordination with Key Referral Sources (8 criteria) 4. Person-Centered Counseling (9 criteria) 5. Streamlined Eligibility for Public Programs (9 criteria) States were awarded a point value on the functional status of each criterion. Each criterion received a maximum of 3 points, ranging from 0 (not in place) to 3 (fully operational statewide). Criteria that were informed by more than one question were scored based on the average of the individual questions. State scores were summed across all criteria to a total of 123 possible points from these functionality criteria. Scores are listed in the *LTSS Scorecard* as a percentage of total possible points, rounded to the nearest whole percent. Following is the list of 41 criteria by function and number of questions for each criterion: I State Governance and Administration (10 criteria) 1. Governor and/or State Legislature's Support to Develop NWD System (1 question) 2. Multistate Agency Coordinating Body (1 question) 3. Formal Assessment of Access Programs and Functions (1 question) 4. Multiyear Plan to Implement NWD System (1 question) 5. External Stakeholder Involvement (1 question) 6. State Funding (1 question) 7. Designation of Entities (1 question) 8. Continuous Quality Improvement (3 questions) 9. Staff Capacity (2 questions) 10. Information Technology (2 questions) II Populations (5 criteria) 1. Older Adult Population (1 question) 2. People with Physical Disabilities (1 question) 3. People with Intellectual and Developmental Disabilities (1 question) 4. People with Mental Illness and Behavioral Health Needs (1 question) 5. Family Caregiver Population (1 question) III Public Outreach and Coordination with Key Referral Sources (8 criteria) 1. Outreach and Marketing Plan (1 question) 2. Searchable Website and 1-800 Phone Number (2 questions) 3. Information and Referral and State Health Insurance Assistance Program (SHIP) (2 questions) 4. Section Q – Local Contact Agencies (1 question) 5. Transitions – Hospitals or Rehab Facilities to Facilitate Transition to Home (1 question)

Aging and Disability Resource Center/No Wrong Door Functions (composite indicator, scale 0-100%) (continued)

Short Name	ADRC/NWD Functions		
Description of Value Calculation	6. Transitions – Youth (1 question) 7. Veterans Administration (VA) Medical Centers to Provide Veteran-Directed HCBS (1 question) 8. Statewide Reach (1 question) IV Person-Centered Counseling (PCC) (9 criteria) 1. Standards are Used to Define PCC (1 question) 2. Management Supports PCC and Planning (1 question) 3. Basic Competencies to Conduct Person-Centered Planning (1 question) 4. Specialized Competencies to Conduct Person-Centered Planning (4 questions) 5. Established Protocols for Developing Person-Centered Plans (1 question) 6. Variety of Organizations to Serve Different LTSS Populations (1 question) 7. Future Planning Needs and Private Pay (2 questions) 8. Follow-up (1 question) 9. Statewide Reach (1 question) V Streamlined Eligibility for Public Programs (9 criteria) 1. Improving Efficiencies (1 question) 2. NWD Protocols (1 question) 3. Application Assistance (1 question) 4. Tracking Procedures (1 question) 5. Ease of Access (2 questions) 6. Targeting People Who Are High Risk of Institutionalization (1 question) 7. Diversion Protocol is in Place (2 questions) 8. Presumptive Eligibility (1 question from a different survey source) 9. Statewide Reach (1 question)		
Data Source(s)	AARP Public Policy Institute, ADRC/NWD state survey conducted in collaboration with The Lewin Group and the US Administration for Community Living" (unpublished, Washington, DC: AARP Public Policy Institute, 2022). Reference data are from 2019 and come from the same source.		
Current Year(s)	2022	**Reference Year(s)**	2019
Type of Indicator	Metric, Composite Indicator, Scale 0-100% Higher values are better		
Changes to Methodology from 2020 to 2023	No changes		
Inclusion/Exclusion Criteria for being Counted	All states that responded to ADRC/NWD survey are counted.		

Percentage of people with Activity of Daily Living (ADL) disability at or below 250 percent of poverty receiving Medicaid or other government assistance health insurance, ages 21+

Short Name	Medicaid for Low-Income People with Disabilities		
Description of Value Calculation	The percentage of people ages 21+ with a self-care difficultly (difficulty dressing or bathing; a reasonable approximation to activities of daily living disability) at or below 250 percent of the poverty threshold who have health insurance through Medicaid, medical assistance, or any kind of government assistance plan for those with low incomes or a disability. We chose 250 percent of poverty in order to fully capture the effect of state policies extending Medicaid eligibility for LTSS up to 300 percent of Supplemental Security Income. The percentage of the target population that has Medicaid or other government assistance health insurance was calculated for each year, and this percentage was averaged across the three "current years" and two "reference years" to create the current and baseline indicator values.		
Data Source(s)	US Census Bureau. 2018–21. "American Community Survey Public Use Microdata Sample." https://www.census.gov/programs-surveys/acs/microdata.html. Data are from AARP Public Policy Institute analysis of 2020–21 American Community Survey Public Use Microdata Sample. The 2018–19 reference data are from the same source.		
Current Year(s)	2020-21	**Reference Year(s)**	2018-19
Type of Indicator	Metric, percent Higher values are better		
Changes to Methodology from 2020 to 2023	No changes		
Inclusion/Exclusion Criteria for being Counted	N/A		

State eligibility policies for the Medicaid Buy-In state option for workers with disabilities (composite indicator, scale 0-100 percent)

Short Name	Medicaid Buy-In		
Description of Value Calculation	The percentage of state policies governing Medicaid Buy-In programs that promote enrollment. Kaiser Family Foundation fielded a survey of states on Medicaid financial eligibility and enrollment policies that included data about Medicaid Buy-In program policies. AARP Public Policy Institute analyzed the data on eligibility policies for state Medicaid Buy-in programs for working people with disabilities, and scored states based on eligibility policies related to individual income limits, individual asset limits, spousal asset limits, and premiums. Those scores are the numerator with a top possible score as the denominator, to derive a percent value for the indicator.		
Data Source(s)	Kaiser Family Foundation. July 11, 2022. "Survey of Medicaid Financial Eligibility and Enrollment Policies for Seniors and People with Disabilities." https://www.kff.org/report-section/medicaid-financial-eligibility-in-pathways-based-on-old-age-or-disability-in-2022-findings-from-a-50-state-survey-issue-brief/. AARP Public Policy Institute identified a set of policy options for program design that promotes enrollment.		
Current Year(s)	2022	**Reference Year(s)**	N/A
Type of Indicator	Metric, Composite indicator, Scale 0-100% Higher values are better		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted	N/A		

State policies that allow presumptive eligibility for Medicaid HCBS

Short Name	Medicaid HCBS Presumptive Eligibility		
Description of Value Calculation	This indicator credits all states that indicate having a presumptive eligibility pathway for their HCBS program(s). AARP Public Policy Institute fielded a survey to state agencies in collaboration with The Lewin Group and US Administration for Community Living that included questions related to HCBS presumptive eligibility. States for which state agency respondents indicated the presence of an HCBS presumptive eligibility pathway. In addition, states identified as having a presumptive eligibility pathway for HCBS in a 2021 AARP Public Policy Institute on the topic received credit.		
Data Source(s)	AARP Public Policy Institute, ADRC/No Wrong Door state survey conducted in collaboration with The Lewin Group and US Administration for Community Living (unpublished, Washington, DC: AARP Public Policy Institute, 2022). AARP Public Policy Institute. April 2021. "Presumptive Eligibility for Medicaid Home and Community-Based Services Can Expand Consumer Options." https://www.aarp.org/pri/topics/health/coverage-access/ltss-choices-presumptive-eligibility-medicaid-home-community-based-services/		
Current Year(s)	2022	**Reference Year(s)**	N/A
Type of Indicator	Policy – Innovation Point		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted	The *Scorecard* includes all permanent HCBS presumptive eligibility policies as well as those that were put in place for the COVID-19 pandemic, which may not be permanent.		

CHOICE OF SETTING AND PROVIDER

Percentage of Medicaid LTSS spending going to HCBS for older people and adults with physical disabilities

Short Name	Medicaid LTSS Balance: Spending		
Description of Value Calculation	The percentage of Medicaid LTSS spending for programs used primarily by older people and adults with physical disabilities going to HCBS programs as opposed to facility-based services. Both current and reference year data are taken from the 2020 LTSS Expenditure Report. The most current data year is 2020 and the reference data year is 2018, where possible. AARP Public Policy Institute included the following services (except as noted below) as primarily used by older people and adults with physical disabilities: nursing homes, other institutional LTSS, home health, personal care, 1915(c) waivers for aged and physically disabled, Community First Choice, Money Follows the Person, PACE, private duty nursing, 195(i), other HCBS LTSS, 1115/1915(b), and 1915(j). AARP Public Policy Institute made the following adjustments to several states to address issues of data quality, completeness, and comparability. Other MLTSS spending was fully allocated to older people and adults with physical disabilities in Delaware, Hawaii, and Tennessee; 13 percent of other MLTSS spending was allocated in Iowa. Other MLTSS spending was excluded in all other states. Community First Choice spending in Oregon was allocated 41 percent to older people and adults with physical disabilities.		
Data Source(s)	Murray, Caitlin, Michelle Eckstein, Debra Lipson, and Andrea Wysocki. "Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2020." Chicago, IL: Mathematica, June 9, 2023		
Current Year(s)	2020	**Reference Year(s)**	2018
Type of Indicator	Metric, percent Higher values are better		
Changes to Methodology from 2020 to 2023	Medicaid LTSS expenditure reports used in previous *Scorecards* were prepared by a different set of authors who made different methodological and classification choices. State-funded LTSS spending was included in prior *Scorecards* but not available for this *Scorecard*. Data are not comparable to previous *Scorecards*.		
Inclusion/Exclusion Criteria for being Counted	Current year data for Pennsylvania, Texas, and Virginia were excluded because of concerns about accuracy/completeness: 2019 data were substituted for TX, metric values are not displayed or ranked for PA and VA. National average data were used for calculating dimension-level performance. Reference year data for New Hampshire, Pennsylvania, and Virginia were excluded because of concerns about accuracy/completeness. Reference year data are not displayed for these states.		

Number of people enrolled in a self-directed HCBS program per 1,000 population with disabilities

Short Name	Self-Directed Program Enrollment		
Description of Value Calculation	The number of people receiving LTSS services through one of several self-directed programs per 1,000 people with any disability. For the current years, the data were collected for the National Inventory of Self-Directed Programs by Applied Self-Direction from October 2022 through February 2023. Reference year data were collected by Applied Self-Direction from April to August 2019. Data sources included state Medicaid waiver information, information from Financial Management Services providers, and telephone interviews with self-directed LTSS program administrators. The self-directed programs people might be enrolled in include Medicaid HCBS waivers (Medicaid program website: https://www.medicaid.gov/medicaid/long-term-services-supports/self-directed-services/index.html), state-funded programs and Veteran Directed Care (program website: https://acl.gov/programs/veteran-directed-home-and-community-based-services/veteran-directed-home-community-based)		
Data Source(s)	The number of people with disabilities is from the 2021 *American Community Survey* for the current year, and the 2018 *American Community Survey* for the reference year. Applied Self-Direction, The 2023 Self-Direction National Inventory: For the 2023 State Scorecard on Long-Term Services and Supports, February 2023 (to be published in late 2023). US Census Bureau, *American Community Survey* (Washington, DC: US Census Bureau, 2018 and 2021). Census population data (all ages) from 2018 and 2021 American Community Survey 1-Year Estimates, Table B18101, Sex by Age by Disability Status, available at https://data.census.gov/cedsci/.		
Current Year(s)	2022-2023	**Reference Year(s)**	2019
Type of Indicator	Metric, number, standardized as population rate Higher values are better		
Changes to Methodology from 2020 to 2023	No changes		
Inclusion/Exclusion Criteria for being Counted	N/A		

Assisted living and residential care units per 1,000 population ages 75+

Short Name	Assisted Living Services Supply
Description of Value Calculation	The number of licensed assisted living and residential care units per 1,000 population ages 75+. Assisted living and residential care units are taken from two National Center for Health Statistics (NCHS) surveys. To be eligible for inclusion in these studies, a residential care community must have been licensed, registered, listed, certified, or otherwise regulated by the state to: • Provide room and board with at least two meals a day and around-the -clock on-site supervision; • Help with personal care such as bathing and dressing or health-related services such as medication management; • Have four or more licensed, certified, or registered beds; • Have at least one resident currently living in the community; and • Serve a predominantly adult population. Excluded were residential care communities licensed to exclusively serve individuals with severe mental illness or intellectual disability/ developmental disability. Nursing homes were also excluded. Data for the current-year (2020) and reference year (2016) assisted living and residential care units are from the *National Study of Long-Term Care Providers Survey*. Reference year data were not available for the District of Columbia and Iowa. The District of Columbia data did not meet confidentiality or reliability standards for NCHS. The vast majority of Iowa's assisted living / residential care facilities were categorically ineligible for the *National Study of Long-Term Care Providers* (NSLTCP) due to the operational definition used in the survey. Both 2016 and 2020 data were not available for Connecticut because the state's licensing structure for assisted living does not permit a unit count. Connecticut has a unique method of licensing assisted living providers; NPALS therefore excludes most residential care providers in the state. AARP Public Policy Institute has estimated the capacity based on data provided by state officials and a 2021 State of Connecticut Performance Audit: Oversight of Connecticut's Assisted Living Facilities. Because publicly reported assisted living and residential care capacity is rounded to the nearest hundred, the capacity per 1,000 people age 75+ was calculated by NCHS and reported rounded to the nearest whole number.

Assisted living and residential care units per 1,000 population ages 75+ (continued)

Short Name	Assisted Living Services Supply		
Data Source(s)	Population data for 2020 (current year) are from the US Census Bureau Population Estimates, 2021 vintage. Baseline 2016 population data are from the same source, 2017 vintage. NCHS (2019, 2022). Analysis based on data from the 2016 *National Survey of Residential Care Facilities* and 2020 *National Post-Acute and Long-Term Care Study* (unpublished). US Census Bureau. 2022. "Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States: April 1, 2020 to July 1, 2021." https://www2.census.gov/programs-surveys/popest/datasets/2020-2021/national/asrh/nc-est2021-agesex-res.csv. US Census Bureau. 2018. "Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States: April 1, 2010 to July 1, 2017." https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html. Connecticut State Performance Audit, https://wp.cga.ct.gov/apa/wp-content/cgacustom/reports/performance/PERFORMANCE_Oversight%20of%20Connecticut%E2%80%99s%20Assisted%20Living%20Facilities_20210922.pdf.		
Current Year(s)	2020	**Reference Year(s)**	2016
Type of Indicator	Metric, number, standardized as population rate Higher values are better		
Changes to Methodology from 2020 to 2023	Imputation of metric value for Connecticut based on data from state		
Inclusion/Exclusion Criteria for being Counted	N/A		

Adult day services total licensed capacity per 10,000 population, ages 65+

Short Name	Adult Day Services Supply
Description of Value Calculation	The maximum number of participants, per 10,000 population ages 65+, allowed at any one time at licensed adult day services centers in each state. Adult day services capacity refers to the maximum number of participants allowed at an adult day services center location. The allowable daily capacity is usually determined by law or by fire code, but may also be a program decision. Adult day capacity data are from two *National Study of Long-Term Care Providers* (NSLTCP) surveys. To be eligible for inclusion in these surveys, all adult day services centers identified as adult day care, adult day services, or adult day health services centers had to: 1) Be included in the National Adult Day Services Association database; 2) Be licensed or certified by the state to provide adult day services, or accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF); or authorized or otherwise set up to participate in Medicaid (Medicaid state plan, Medicaid waiver, or Medicaid managed care) or part of a Program of All-Inclusive Center for the Elderly (PACE); 3) Have one or more average daily attendance of participants based on a typical week; and 4) Have one or more participants enrolled at the center at the location at the time of the survey. Data for current year 2020 and reference year 2016 total licensed adult day services capacity are from the *National Study of Long-Term Care Providers* survey. For several states, data were not available because the estimates did not meet confidentiality or reliability standards for NCHS: For 2020, no estimates for adult day services centers were presented for the District of Columbia, Montana, New Hampshire, South Dakota, Utah, West Virginia, and Wyoming. For 2016, no estimates were presented for the District of Columbia, West Virginia, and Wyoming. For seven states with missing current year estimates, AARP imputed data according to the following procedure: • For Montana, New Hampshire, South Dakota, and Utah, the 2020 metric values were estimated to be the same as in 2016. • For the District of Columbia, West Virginia, and Wyoming, which did not have 2016 estimates to bring forward, the 2020 metric values were estimated to be equal to average value for the four states with missing 2020 values only (Montana, New Hampshire, South Dakota, Utah). Because publicly reported adult day services capacity data are rounded to the nearest hundred, the capacity per 10,000 people ages 65 and older was calculated by NCHS and reported rounded to the nearest whole number.

Adult day services total licensed capacity per 10,000 population, ages 65+ (continued)

Short Name	Adult Day Services Supply		
Data Source(s)	National Center for Health Statistics (2019, 2022). Analysis based on data from the 2016 *National Survey of Residential Care Facilities* and 2020 *National Post-Acute and Long-Term Care Study* (unpublished). US Census Bureau. 2022. "Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States: April 1, 2020 to July 1, 2021." https://www2.census.gov/programs-surveys/popest/datasets/2020-2021/national/asrh/nc-est2021-agesex-res.csv. US Census Bureau. 2018. "Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States: April 1, 2010 to July 1, 2017." https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html. Population data for 2016 (current year) are from the US Census Bureau Population Estimates, 2017 vintage. Baseline 2014 population data are from the same source, 2015 vintage.		
Current Year(s)	2020	**Reference Year(s)**	2016
Type of Indicator	Metric, number, standardized as population rate Higher values are better		
Changes to Methodology from 2020 to 2023	Imputation of values for states with missing data values in the source		
Inclusion/Exclusion Criteria for being Counted	N/A		

Home health and personal care aides per 100 population with an Activity of Daily Living (ADL) disability, ages 18+

Short Name	Home Health Aide Supply		
Description of Value Calculation	The number of personal care, nursing, psychiatric, and home health aide direct care workers currently in the workforce per 100 population ages 18+ with need for assistance with an ADL disability. Aides are those with occupation code 3601 (home health aide), 3602 (personal care aide), 3603 (nursing assistant), or 3605 (orderlies and psychiatric aides). and industry code 8170 (home health care services), 8370 (social services), or 9290 (private households), and who worked in the last 12 months. Current year data are from the 2020 and 2021 *American Community Survey*, *Public Use Microdata Sample* and baseline data from 2018 and 2019 are from the same source. Denominator data are also from the *American Community Survey*, via data.census.gov. 2020 data were not available for the denominator, an average of the 2019 and 2021 values was used in the metric calculation. The supply to population ratio was calculated for each year, and this ratio was averaged across the two "current years" and two "reference years" to create the current and baseline indicator values.		
Data Source(s)	US Census Bureau. 2018–2021. "American Community Survey Public Use Microdata Sample." https://www.census.gov/programs-surveys/acs/microdata.html. US Census Bureau. 2018, 2019, and 2021. "American Community Survey, data table B18106: Sex by Age by Self-Care Difficulty." https://data.census.gov/cedsci/.		
Current Year(s)	2020-2021	**Reference Year(s)**	2018-2019
Type of Indicator	Metric, number, standardized as population rate Higher values are better		
Changes to Methodology from 2020 to 2023	No changes		
Inclusion/Exclusion Criteria for being Counted	N/A		

Percentage of nursing home (NH) residents with low care needs

Short Name	NH Residents with Low Care Needs
Description of Value Calculation	The percentage of nursing home residents who met the criteria of having low care needs. MDS assessments were used to establish the population of residents in all nursing facilities on the first Thursday in April. This measure was calculated from the most recent MDS assessment as of April 2021. Low care status is met if a resident does not require physical assistance in any of the four late-loss ADLs (bed mobility, transferring, using the toilet, and eating) and is not classified in either the "Special Rehab" or "Clinically Complex" Resource Utilization Group (RUG-IV). *Low care status may apply to a resident who is also classified in either of the lowest 2 of the 44 RUG-IV groups. *On October 1, 2019, CMS replaced RUG-IV with a new case mix methodology, the Patient Driven Payment Model (PDPM), and stopped supporting precalculated RUG-IV values via the MDS. To continue utilizing the low care algorithm, RUG-IV values for a given MDS assessment were instead calculated using the last version of the public SAS classification code available from CMS. These data were averaged at the state level following the *LTSS State Scorecard* approach to measuring equity. Equity adjustment: Race/ethnicity is indicated in MDS by a 6 category multiple response variable with choices: • American Indian or Alaska Native • Asian • Black or African American • Hispanic or Latino • Native Hawaiian or Other Pacific Islander • White Residents were classified by race/ethnicity as follows: • Hispanic/Latino: "Hispanic or Latino" is selected • All Other Races/Ethnicities: exactly one race/ethnicity is selected (a resident is classified as "Asian" if and only if "Asian" is selected and no other races/ethnicity is selected) • Multiracial: "Hispanic or Latino" is not selected and two or more other races/ethnicities are selected Data are presented for all residents and for each race/ethnicity group with sufficient sample size to report. Residents without any race/ethnicity category selected are included in all residents but not in any subgroup.

Percentage of nursing home residents with low care needs (continued)

Short Name	NH Residents with Low Care Needs		
Description of Value Calculation	For the equity adjusted metric score, residents are divided into 2 groups: White, and an aggregate grouping of {American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and Multiracial}. The lower performing group (higher percentage of residents with low care needs) is scored and ranked as a performance metric. In the District of Columbia, Maine, New Hampshire, Vermont, and Wyoming the sample size was not sufficient to score both groups. The metric value is therefore shown as N/A and the state is not ranked. The metric value for all nursing home residents is used for calculating dimension-level performance.		
Data Source(s)	Analysis of 2021 MDS 3.0 state-level care data provided by the Changing Long-Term Care in America Project at Brown University in February-April 2023. Brown University (2023). Changing Long Term Care in America Project at Brown University funded in part by the National Institute on Aging (1P01AG027296). Providence, RI: Brown University School of Public Health, http://ltcfocus.org/.		
Current Year(s)	2021	**Reference Year(s)**	N/A
Type of Indicator	Metric – Equity, percent Lower values are better		
Changes to Methodology from 2020 to 2023	Included equity adjustments using race and ethnicity data. Operational definition of the measure has also changed but is intended to be comparable to earlier years.		
Inclusion/Exclusion Criteria for being Counted	N/A		

LTSS direct service worker wage shortfall compared to other entry level jobs

Short Name	LTSS Worker Wage Competitiveness		
Description of Value Calculation	The dollar amount shortfall between the average hourly wage rate paid for direct care jobs and the average hourly wage rate paid for other comparable jobs in each state. In every state, the average hourly wages paid to direct care jobs are lower than the wages paid for other jobs used for comparison. The larger the value, the larger the wage gap. PHI's analyses are based on Job Zones, as defined in the O*NET database. Occupations with similar entry-level requirements to direct care jobs are categorized in Job Zone Two: Some Preparation Needed, whereas jobs with lower entry-level requirements are captured in Job Zone One: Little or No Preparation Needed. Wages for occupations with similar or lower entry-level requirements were calculated as weighted averages of median hourly wages for all occupation in each job zone. Meaningful change over time for this indicator is defined as an improvement (lower value) or decline (high value) in the metric value that is 10 percent or more of the reference year hourly LTSS worker wage.		
Data Source(s)	**Underlying data from:** US Bureau of Labor Statistics, State Occupational Employment and Wage Estimates **Data analyzed/compiled by:** PHI (https://www.phinational.org/policy-research/workforce-data-center/) based on Job Zones as defined by Occupational Information Network (https://www.onetcenter.org/dictionary/25.0/excel/job_zones.html)		
Current Year(s)	2021	**Reference Year(s)**	2019
Type of Indicator	Metric, dollars paid per hour Lower values are better		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted	The direct care workforce comprises personal care aides, home health aides, and nursing assistants. Direct care worker occupational categories are defined by the Standard Occupational Classification (SOC) system developed by the Bureau of Labor Statistics (BLS) at the U.S. Department of Labor (DOL). Workers are classified based on their on-the-job responsibilities, skills, education, and training. Occupation definitions can be found at: http://www.bls.gov/soc.		

Enrollment in Program of All-Inclusive Care for the Elderly (PACE), per 10,000 population, ages 55+

Short Name	PACE Enrollment		
Description of Value Calculation	The number of people enrolled in a PACE program to the state's population of people ages 55+ per 10,000 residents ages 55+.		
Data Source(s)	National PACE Association https://www.npaonline.org/sites/default/files/PDFs/PACE_in_the_States_4.23.pdf US Census Bureau. 2022. "Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States: April 1, 2020 to July 1, 2021." https://www2.census.gov/programs-surveys/popest/datasets/2020-2021/national/asrh/nc-est2021-agesex-res.csv.		
Current Year(s)	2023	Reference Year(s)	2020
Type of Indicator	Metric, number, standardized as population rate Higher values are better		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted	N/A		

State policies that require Medicaid providers to allocate a certain dollar amount or percentage of the rate they are paid to LTSS worker wages

Short Name	LTSS Worker Wage Pass-Through Policies		
Description of Value Calculation	This indicator credits states that have a policy that requires Medicaid-funded employers to pass through a defined amount or percentage of a rate to workers. States with either type of policy in effect received credit.		
Data Source(s)	PHI State Workforce Index https://www.phinational.org/state-index-tool/		
Current Year(s)	2020	Reference Year(s)	N/A
Type of Indicator	Policy		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted	N/A		

Number of residents in Green House® communities plus state and local policies that facilitate Green House® development

Short Name	Green House® Availability and Policies		
Description of Value Calculation	This innovation point gives credit to states that show significant investment and support for small house nursing homes, commonly known as Green Houses. There were three criteria reviewed for scoring. States receive credit for meeting one or more of these criteria. AARP Public Policy Institute and the Green House Project collaborated to identify the inclusion criteria and the states meeting the criteria for this category. The three scoring criteria are: 1. State financial investment in Green Houses 2. State policy that supports Green Houses (e.g., certificate of need moratorium carveouts) 3. High-reach Green House States (>200 beds available or in development statewide)		
Data Source(s)	Green House Project: Email correspondence (January 2023) For more information: https://thegreenhouseproject.org/our-story/who-we-are/		
Current Year(s)	2022	**Reference Year(s)**	N/A
Type of Indicator	Policy – Innovation Point		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted	N/A		

Availability of the Community Aging in Place – Advancing Better Living for Elders (CAPABLE) restorative services model plus state and local policies that facilitate access to CAPABLE

Short Name	CAPABLE Availability		
Description of Value Calculation	This policy innovation point gives credit to states with public investment in the CAPABLE model, including but not limited to funding through a state budget and inclusion in a Medicaid program, as of March 2023. AARP Public Policy Institute and the National Center for CAPABLE Services/ CareSynergy collaborated to identify the inclusion criteria and the states meeting the criteria for this category.		
Data Source(s)	National Center for CAPABLE Services/Care Synergy, correspondence in February and March 2023		
Current Year(s)	2021	**Reference Year(s)**	N/A
Type of Indicator	Policy – Innovation Point		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted	Illinois was the only state to receive credit for a local policy because of the significant investments made supporting CAPABLE services in Chicago.		

SAFETY AND QUALITY

Percentage of home health patients with a hospital admission

Short Name	Home Health Hospital Admissions		
Description of Value Calculation	The percentage of home health stays for patients who have a Medicare claim for an unplanned admission to an acute care hospital during the 60 days following the start of the home health stay. Current year 2021 national and state-level data for how often home health patients had to be admitted to the hospital are from CMS, Home health services data archive. Current data are from the 1/24/2023 archive data, for the data year July 2020 – June 2021. Reference year data are from the 1/4/2020 archive data, for the data year January 2018 – December 2018.		
Data Source(s)	CMS. "Home Health Services Data Archive, archive dates 1/4/2020 and 1/24/2023." https://data.cms.gov/provider-data/archived-data/home-health-services.		
Current Year(s)	2020-2021	**Reference Year(s)**	2018
Type of Indicator	Metric, percent Lower values are better		
Changes to Methodology from 2020 to 2023	No changes		
Inclusion/Exclusion Criteria for being Counted	N/A		

Percentage of long-stay nursing home residents hospitalized within a six-month period

Short Name	NH Hospital Admissions
Description of Value Calculation	This is the percent of long-stay residents (residing in a nursing home for at least 90 consecutive days) who were ever hospitalized within six months of baseline assessment. The study population was identified using data from MDS 3.0, which captures data on nursing home resident assessments, and the Medicare Provider Analysis and Review (MedPAR) file for inpatient hospital claims between January 1, 2020 and December 31, 2020. These data were averaged at the state level following the *LTSS State Scorecard* approach to measuring equity. Equity adjustment: Race/ethnicity is indicated in MDS by a 6 category multiple response variable with choices: • American Indian or Alaska Native • Asian • Black or African American • Hispanic or Latino • Native Hawaiian or Other Pacific Islander • White Residents were classified by race/ethnicity as follows: • Hispanic/Latino: "Hispanic or Latino" is selected • All Other Races/Ethnicities: exactly one race/ethnicity is selected (a resident is classified as "Asian" if and only if "Asian" is selected and no other races/ethnicity is selected) • Multiracial: "Hispanic or Latino" is not selected and two or more other races/ethnicities are selected Data are presented for all residents and for each race/ethnicity group with sufficient sample size to report. Residents without any race/ethnicity category selected are included in all residents but not in any subgroup. For the equity adjusted metric score, residents are divided into 2 groups: white, and an aggregate grouping of {American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and Multiracial}. The lower performing group (higher percentage of residents with hospital admission) is scored and ranked as a performance metric. In Vermont, the sample size was not sufficient to score both groups. The metric value is therefore shown as N/A and the state is not ranked. The metric value for all nursing home residents is used for calculating dimension-level performance.

Percentage of long-stay nursing home residents hospitalized within a six-month period (continued)

Short Name	NH Hospital Admissions		
Data Source(s)	Analysis of 2020 MDS 3.0 state-level care data provided by the Changing Long-Term Care in America Project at Brown University in February-April 2023. Brown University (2023). Changing Long Term Care in America Project at Brown University funded in part by the National Institute on Aging (1P01AG027296). Providence, RI: Brown University School of Public Health, http://ltcfocus.org/.		
Current Year(s)	2021	Reference Year(s)	N/A
Type of Indicator	Metric – Equity, percent Lower values are better		
Changes to Methodology from 2020 to 2023	Included equity adjustments using race and ethnicity data.		
Inclusion/Exclusion Criteria for being Counted	N/A		

Percentage of high-risk nursing home residents with pressure sores

Short Name	NH Residents with Pressure Sores
Description of Value Calculation	Percentage of high-risk nursing home residents impaired in bed mobility or transfer, comatose, or suffering malnutrition who have pressure sores (stage 2–4 or unstageable) on target assessment. The indicator measures prevalence among high-risk residents present in the facility as of the first Thursday of April 2021. Data includes stage 2–4 and unstageable pressure ulcer conditions. Unstageable pressure sores may be open or closed wounds that are completely covered with eschar (hard, black, dead tissue) or a non-removable dressing or device, making them difficult to diagnosis. These data were averaged at the state level following the *LTSS State Scorecard* approach to measuring equity. Equity adjustment: Race/ethnicity is indicated in MDS by a 6 category multiple response variable with choices: • American Indian or Alaska Native • Asian • Black or African American • Hispanic or Latino • Native Hawaiian or Other Pacific Islander • White Residents were classified by race/ethnicity as follows: • Hispanic/Latino: “Hispanic or Latino” is selected • All Other Races/Ethnicities: exactly one race/ethnicity is selected (a resident is classified as “Asian” if and only if “Asian” is selected and no other races/ethnicity is selected) • Multiracial: “Hispanic or Latino” is not selected and two or more other races/ethnicities are selected Data are presented for all residents and for each race/ethnicity group with sufficient sample size to report. Residents without any race/ethnicity category selected are included in all residents but not in any subgroup. For the equity adjusted metric score, residents are divided into 2 groups: white, and an aggregate grouping of {American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and Multiracial}. The lower performing group (higher percentage of residents with pressure sores) is scored and ranked as a performance metric. In Idaho, Maine, New Hampshire, Vermont, and Wyoming the sample size was not sufficient to score both groups. The metric value is therefore shown as N/A and the state is not ranked. The metric value for all nursing home residents is used for calculating dimension-level performance.

Percentage of high-risk nursing home residents with pressure sores (continued)

Short Name	NH Residents with Pressure Sores		
Data Source(s)	Analysis of 2021 MDS 3.0 state-level care data provided by the Changing Long-Term Care in America Project at Brown University in February-April 2023. Brown University (2023). Changing Long Term Care in America Project at Brown University funded in part by the National Institute on Aging (1P01AG027296). Providence, RI: Brown University School of Public Health, http://ltcfocus.org/.		
Current Year(s)	2021	**Reference Year(s)**	N/A
Type of Indicator	Metric – Equity, percent Lower values are better		
Changes to Methodology from 2020 to 2023	Included equity adjustments using race and ethnicity data. Operational definition may have changed; data do not appear to be comparable to previous *Scorecards*.		
Inclusion/Exclusion Criteria for being Counted	N/A		

Percentage of nursing home residents who are inappropriately receiving an antipsychotic medication

Short Name	NH Inappropriate Antipsychotic Use
Description of Value Calculation	The percentage of nursing home residents who are inappropriately receiving antipsychotic medication on target assessment. Criteria for inappropriate use excludes nursing home residents with a diagnosis of schizophrenia or bipolar disorder. The indicator measures prevalence among residents present in the facility as of the first Thursday of April 2021. These data were averaged at the state level following the *LTSS State Scorecard* approach to measuring equity. Equity adjustment: Race/ethnicity is indicated in MDS by a 6 category multiple response variable with choices: • American Indian or Alaska Native • Asian • Black or African American • Hispanic or Latino • Native Hawaiian or Other Pacific Islander • White Residents were classified by race/ethnicity as follows: • Hispanic/Latino: "Hispanic or Latino" is selected • All Other Races/Ethnicities: exactly one race/ethnicity is selected (a resident is classified as "Asian" if and only if "Asian" is selected and no other races/ethnicity is selected) • Multiracial: "Hispanic or Latino" is not selected and two or more other races/ethnicities are selected Data are presented for all residents and for each race/ethnicity group with sufficient sample size to report. Residents without any race/ethnicity category selected are included in all residents but not in any subgroup. For the equity adjusted metric score, residents are divided into 2 groups: white, and an aggregate grouping of {American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and Multiracial}. The lower performing group (higher percentage of residents with inappropriate antipsychotic given) is scored and ranked as a performance metric. In Maine and Vermont, the sample size was not sufficient to score both groups. The metric value is therefore shown as N/A and the state is not ranked. The metric value for all nursing home residents is used for calculating dimension-level performance.

Percentage of nursing home residents who are inappropriately receiving an antipsychotic medication (continued)

Short Name	NH Inappropriate Antipsychotic Use		
Data Source(s)	Analysis of 2021 MDS 3.0 state-level care data provided by the Changing Long-Term Care in America Project at Brown University in February-April 2023. Brown University (2023). Changing Long Term Care in America Project at Brown University funded in part by the National Institute on Aging (1P01AG027296). Providence, RI: Brown University School of Public Health, http://ltcfocus.org/.		
Current Year(s)	2021	**Reference Year(s)**	N/A
Type of Indicator	Metric – Equity, percent Lower values are better		
Changes to Methodology from 2020 to 2023	Included equity adjustments using race and ethnicity data. Operational definition of the measure has also changed and is not comparable to previous *Scorecards*.		
Inclusion/Exclusion Criteria for being Counted	N/A		

State average turnover of nursing staff in nursing homes

Short Name	NH Staff Turnover		
Description of Value Calculation	The percentage of nursing staff who worked at a nursing home but stopped working there over a 12-month period, aggregated to the state level. The data includes all nursing home nursing staff levels: registered nurses, licensed practical nurses, and certified nursing assistants. The turnover data include all nursing staff who leave the facility, on either a voluntary or involuntary basis. For more detail on the turnover data specifications, please see *Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical Users' Guide:* https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf (pg. 11).		
Data Source(s)	CMS Nursing Home Care Compare published in January 2023. https://www.medicare.gov/care-compare/		
Current Year(s)	2022	**Reference Year(s)**	N/A
Type of Indicator	Metric, percent Lower values are better		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted	N/A		

Percentage of nursing home residents who are up-to-date on COVID-19 vaccination

Short Name	NH COVID-19 Vaccinations: Residents		
Description of Value Calculation	The percentage of nursing home residents who were up to date on their COVID-19 vaccinations as of the week ending February 19, 2023, as reported by the AARP Nursing Home COVID-19 Dashboard released on March 16, 2023. Up to date means that the individual has either received an updated (bivalent) booster dose, or completed their primary series less than 2 months ago.		
Data Source(s)	AARP, Nursing Home COVID-19 Dashboard, https://www.aarp.org/ppi/issues/caregiving/info-2020/nursing-home-covid-dashboard.html.		
Current Year(s)	2023	Reference Year(s)	N/A
Type of Indicator	Metric, percent Higher values are better		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted	N/A		

Percentage of nursing home health care staff who are up-to-date on COVID-19 vaccination

Short Name	NH COVID-19 Vaccinations: Staff		
Description of Value Calculation	The percentage of nursing home health care staff who were up to date on their COVID-19 vaccinations as of the week ending February 19, 2023, as reported by the AARP Nursing Home COVID-19 Dashboard released on March 16, 2023. Up to date means that the individual has either received an updated (bivalent) booster dose, or completed their primary series less than 2 months ago.		
Data Source(s)	AARP, Nursing Home COVID-19 Dashboard, https://www.aarp.org/ppi/issues/caregiving/info-2020/nursing-home-covid-dashboard.html.		
Current Year(s)	2023	Reference Year(s)	N/A
Type of Indicator	Metric, percent Higher values are better		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted	N/A		

Percentage of nursing home residents living in a facility with a 5-star rating on Centers for Medicare & Medicaid Services Nursing Home Care Compare Quality Star ratings

Short Name	Nursing Home Residents in Living in NHs with Top Quality Ratings
Description of Value Calculation	The percentage of nursing home residents in each state living in a nursing home that received a 5-star rating in its most recent survey as of the first Thursday of April 2021. These data were averaged at the state level following the *LTSS State Scorecard* approach to measuring equity. Equity adjustment: Race/ethnicity is indicated in MDS by a six-category multiple response variable with choices: • American Indian or Alaska Native • Asian • Black or African American • Hispanic or Latino • Native Hawaiian or Other Pacific Islander • White Residents were classified by race/ethnicity as follows: • Hispanic/Latino: "Hispanic or Latino" is selected • All Other Races/Ethnicities: exactly one race/ethnicity is selected (a resident is classified as "Asian" if and only if "Asian" is selected and no other races/ethnicity is selected) • Multiracial: "Hispanic or Latino" is not selected and two or more other races/ethnicities are selected Data are presented for all residents and for each race/ethnicity group with sufficient sample size to report. Residents without any race/ethnicity category selected are included in all residents but not in any subgroup. For the equity adjusted metric score, residents are divided into two groups: white, and an aggregate grouping of {American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and Multiracial}. The lower performing group (lowest percentage of residents living in a 5-star facility) is scored and ranked as a performance metric. In New Hampshire and Vermont, the sample size was not sufficient to score both groups. The metric value is therefore shown as N/A and the state is not ranked. The metric value for all nursing home residents is used for calculating dimension-level performance.

Percentage of nursing home residents living in a facility with a 5-star rating on Centers for Medicare & Medicaid Services Nursing Home Care Compare Quality Star ratings (continued)

Short Name	NH Inappropriate Antipsychotic Use		
Data Source(s)	Analysis of 2021 MDS 3.0 state-level care data provided by the Changing Long-Term Care in America Project at Brown University in February-April 2023. Brown University (2023). Changing Long Term Care in America Project at Brown University funded in part by the National Institute on Aging (1P01AG027296). Providence, RI: Brown University School of Public Health, http://ltcfocus.org/.		
Current Year(s)	2022	Reference Year(s)	N/A
Type of Indicator	Metric – Equity, percent Higher values are better		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted	N/A		

Nursing home direct care staff hours per resident per day

Short Name	NH Staffing Levels
Description of Value Calculation	The number of direct-care staff hours per resident day, including Registered Nurse (RN), Licensed Practical Nurse (LPN), and Certified Nursing Assistant (CNA) hours. This measure was calculated from the Payroll Based Journal (PBJ) Public Use File (PUF), which is based on data submitted by nursing homes to CMS. PBJ PUFs are published quarterly and report information on staffing hours for each day in the quarter, along with resident census information derived from the Minimum Data Set (MDS). The indicator measures weekday staffing (excluding weekends) during the calendar week containing the first Thursday of April 2021. These data were averaged at the state level following the *LTSS State Scorecard* approach to measuring equity. Equity adjustment: Race/ethnicity is indicated in MDS by a 6 category multiple response variable with choices: • American Indian or Alaska Native • Asian • Black or African American • Hispanic or Latino • Native Hawaiian or Other Pacific Islander • White Residents were classified by race/ethnicity as follows: • Hispanic/Latino: "Hispanic or Latino" is selected • All Other Races/Ethnicities: exactly one race/ethnicity is selected (a resident is classified as "Asian" if and only if "Asian" is selected and no other races/ethnicity is selected) • Multiracial: "Hispanic or Latino" is not selected and two or more other races/ethnicities are selected Data are presented for all residents and for each race/ethnicity group for the 10 percent of facilities nationally and within each state that have the most admissions among each group. For the equity adjusted metric score, residents are divided into 6 groups: White, American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and Multiracial. The lowest performing group is scored and ranked as a performance metric.

Nursing home direct care staff hours per resident per day (continued)

Short Name	NH Staffing Levels		
Data Source(s)	Analysis of 2021 MDS 3.0 state-level care data provided by the Changing Long-Term Care in America Project at Brown University in February-April 2023. Brown University (2023). Changing Long Term Care in America Project at Brown University funded in part by the National Institute on Aging (1P01AG027296). Providence, RI: Brown University School of Public Health, http://ltcfocus.org/.		
Current Year(s)	2021	**Reference Year(s)**	N/A
Type of Indicator	Metric – Equity, number of hours, standardized as per person per day rate Higher values are better		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted	N/A		

HCBS quality cross-state benchmarking capability: Use of National Core Indicators – Aging/Disability survey for one or more HCBS programs

Short Name	HCBS Quality Benchmarking: NCI-AD™		
Description of Value Calculation	This indicator credits states identified as current participants by the National Core Indicators – Aging/Disability (NCI-AD) project, for fielding a survey for one or more LTSS programs in the state.		
Data Source(s)	NCI-AD (ADVancing States): https://nci-ad.org/states/ and https://nci-ad.org/resources/reports/		
Current Year(s)	2023	Reference Year(s)	2019
Type of Indicator	Policy		
Changes to Methodology from 2020 to 2023	Disaggregated from the *2020 Scorecard* HCBS Quality Benchmarking indicator. Simplified to give credit for use of this survey tool without consideration for sample size.		
Inclusion/Exclusion Criteria for being Counted	N/A		

HCBS quality cross-state benchmarking capability: use of HCBS Consumer Assessment of Healthcare Providers and Services survey for one or more HCBS programs

Short Name	HCBS Quality Benchmarking: HCBS CAHPS®		
Description of Value Calculation	This indicator credits states for fielding the HCBS Consumer Assessment of Healthcare Providers and Services (CAHPS) survey for one or more HCBS program in 2020, 2021, 2022, and/or 2023.		
Data Source(s)	CMS Medicaid Benefits and Health Programs Group and The Lewin Group, tracked as part of Lewin's contract to develop and maintain HCBS Measures (Email correspondence, May 2023)		
Current Year(s)	2022-23	Reference Year(s)	2017-18
Type of Indicator	Policy		
Changes to Methodology from 2020 to 2023	Disaggregated from the *2020 Scorecard* HCBS Quality Benchmarking indicator.		
Inclusion/Exclusion Criteria for being Counted	N/A		

HCBS quality cross-state benchmarking capability: National Committee for Quality Assurance Statewide Accreditation for one or more HCBS programs

Short Name	HCBS Quality Benchmarking: NCQA		
Description of Value Calculation	This indicator credits states for having National Committee for Quality Assurance (NCQA) Statewide accreditation for Case Management for LTSS or NCQA LTSS Distinction.		
Data Source(s)	NCQA Statewide: Email correspondence, January 2023. Currently updated data available at: https://www.ncqa.org/public-policy/work-with-states-map/		
Current Year(s)	2023	**Reference Year(s)**	2020
Type of Indicator	Policy		
Changes to Methodology from 2020 to 2023	Disaggregated from the *2020 Scorecard* HCBS Quality Benchmarking indicator.		
Inclusion/Exclusion Criteria for being Counted	N/A		

State has an Enhanced State Hazard Mitigation Plan (SHMP) approved by FEMA and uses a social vulnerability index to help SHMP account for older adults and people with disabilities

Short Name	State Emergency Management Plans		
Description of Value Calculation	This indicator credits states that have an active FEMA approved Enhanced State Hazard Mitigation Plan, which also includes community-level analysis of their state's vulnerable populations using a social vulnerability index that identifies older adults and people with disabilities as among these vulnerable populations.		
Data Source(s)	FEMA State Hazard Mitigation Plans https://www.fema.gov/emergency-managers/risk-management/hazard-mitigation-planning/status		
Current Year(s)	2023	**Reference Year(s)**	N/A
Type of Indicator	Policy – Innovation Point		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted	State must have an active FEMA approved Enhanced State Hazard Mitigation Plan (SHMP) and include the use of a social vulnerability index in their SHMP that identifies older adults and people with disabilities as especially vulnerable to disaster.		

SUPPORTING FAMILY CAREGIVERS

Nursing tasks that nurses may delegate to a direct care aide

Short Name	Nurse Delegation
Description of Value Calculation	This indicator is based on state policies that allow nurses to delegate some health maintenance tasks to other LTSS workers (out of 22 possible tasks), based on responses to a survey of State Boards of Nursing that asked which of the following tasks can be performed by a direct care aide through delegation by a registered nurse.

Medication Administration	**Tube Feeding and Gastric Care**
1. Oral medication	12. Nasogastric tube feeding
2. PRN medication	13. Gastrostomy tube feeding
3. Pre-filled insulin/insulin pen	14. Administer enema
4. Draw up insulin	**Bladder Regimen and Skin/ Appliance Care**
5. Other injectable medication	15. Perform intermittent catheterization
6. Glucometer testing	16. In-dwelling catheter care
7. Medication through tubes	17. Perform ostomy care including skin care and changing appliance
8. Insertion of suppositories	**Respiratory Care**
9. Eye/ear drops	18. Perform nebulizer treatment
Wound Care	19. Administer oxygen therapy
10. Non-sterile/clean	20. Oral suctioning
11. Sterile	21. Tracheostomy suctioning
	22. Perform ventilator respiratory care

Scoring: States received 1 point for each of the 22 health maintenance tasks that can be delegated by a registered nurse to an LTSS direct care worker for a total of 22 points.

Current year 2022 data collected from the AARP Public Policy Institute survey on nurse delegation in home settings. Ten state Boards of Nursing did not respond to the 2022 nurse delegation survey. 2019 survey responses were reused for New Hampshire, New Jersey, New Mexico, Tennessee, and Wisconsin. 2016 survey responses were reused for Arkansas and Idaho. 2013 survey responses were reused for Georgia, Minnesota, and Vermont.

Meaningful change over time for this indicator is defined as any increase or decrease in the number of tasks able to be delegated (not 10 percent change).

Nursing tasks that nurses may delegate to a direct care aide (continued)

Short Name	Nurse Delegation		
Data Source(s)	AARP Public Policy Institute. Unpublished, 2019, 2022. "Survey on Nurse Delegation in Home Settings."		
Current Year(s)	2022	**Reference Year(s)**	2019
Type of Indicator	Metric, number Higher values are better		
Changes to Methodology from 2020 to 2023	Disaggregated from the *2020 Scorecard* Nurse Delegation and Scope of Practice indicator. Increased the number of scored tasks from 16 to 22.		
Inclusion/Exclusion Criteria for being Counted	N/A		

Nurse practitioner scope of practice

Short Name	Nurse Scope of Practice		
Description of Value Calculation	This indicator gives states credit for policies that allow nurse practitioners to practice to the fullest extent of their education and training. Scope of practice includes three levels of authority: (a) Under full practice authority, the NP is permitted to evaluate patients, diagnose, order, and interpret diagnostic tests, initiate and manage treatments, and prescribe medications; (b) Reduced practice requires a collaborative practice agreement with a physician specifying the scope of practice allowed; and (c) Restricted practice requires a physician to oversee all care provided by the NP. **Scoring:** States that permit full scope of practice received 1.0 point, states that permit reduced scope of practice received 0.5 points, and states that have restricted practice received 0 points. Current year 2023 data from AARP Public Policy Institute analysis of nurse practitioner state practices, American Association of Nurse Practitioners, *Nurse Practitioner State Practice Environment*. Reference year 2019 data from same source.		
Data Source(s)	American Association of Nurse Practitioners. 2019, 2022. "Nurse Practitioner State Practice Environment." https://www.aanp.org/legislation-regulation/state-legislation/state-practice-environment.		
Current Year(s)	2023	**Reference Year(s)**	2019
Type of Indicator	Policy		
Changes to Methodology from 2020 to 2023	Disaggregated from the *2020 Scorecard* Nurse Delegation and Scope of Practice indicator.		
Inclusion/Exclusion Criteria for being Counted	N/A		

Family Responsibility Protected Classification

Short Name	Family Responsibility Protected Classification		
Description of Value Calculation	This policy indicator credits statewide laws that protect family caregivers from employment discrimination, which are defined as: a statewide law expressly including family responsibilities, including care provided to aging parents or ill or disabled spouses of family members, as a protected classification in the context that prohibits discrimination against employees who have family responsibilities. **Scoring:** States with a statewide anti-discrimination law that protects family caregivers receive 1 point, and states without a statewide law receive 0 points. Current year 2023 data are from Center for WorkLife Law (WLL) at the University of California San Francisco, legal analysis. Reference year 2020 data are from WLL at the University of California San Francisco (formely Hastings College of the Law), *Work Life Law: State Law/Legislation Tracking* from AARP Public Policy Institute.		
Data Source(s)	Center for WorkLife Law at the University of California, San Francisco. 2022. "State Law/Legislation Tracking." https://worklifelaw.org/wp-content/uploads/2022/11/FRD-Law-Table.pdf, https://worklifelaw.org/projects/family-caregiver-discrimination/. WLL provided an update with data gathered in 2023 (Email correspondence, May 2023)		
Current Year(s)	2023	**Reference Year(s)**	2020
Type of Indicator	Policy		
Changes to Methodology from 2020 to 2023	Disaggregated from the *2020 Scorecard* Supporting Working Family Caregivers indicator. Simplified scoring, including to only credit statewide laws.		
Inclusion/Exclusion Criteria for being Counted	N/A		

State Exceeds Federal Family Medical Leave Act

Short Name	State Exceeds Federal Family Medical Leave Act		
Description of Value Calculation	This policy indicator credits states that exceed federal Family Medical Leave Act (FMLA) requirements in the following categories: covered employers, covered employee eligibility, covered relationships, length of leave allowed. **Scoring:** States received 1 point for statewide laws that exceeded federal FMLA requirements by exceeding one or more of the aforementioned categories. Current year 2022 data from *National Conference of State Legislators: State Family Medical Leave Laws* and AARP Public Policy Institute independent research to verify status of laws in 2023. Reference year 2019 data are from *Raising Expectations: A State-by-State Analysis of Laws That Help Working Family Caregivers* and AARP Public Policy Institute independent research to verify status of laws in 2019.		
Data Source(s)	National Council of State Legislatures https://www.ncsl.org/labor-and-employment/state-family-and-medical-leave-laws		
Current Year(s)	2022	**Reference Year(s)**	2019
Type of Indicator	Policy		
Changes to Methodology from 2020 to 2023	Disaggregated from the *2020 Scorecard* Supporting Working Family Caregivers indicator. Simplified scoring, including to only credit statewide laws.		
Inclusion/Exclusion Criteria for being Counted	Local policies that exceed FMLA requirements, which were included in previous editions of the *Scorecard*, are now excluded from the *2023 Scorecard*.		

Statewide paid family leave enacted

Short Name	Paid Family Leave		
Description of Value Calculation	This indicator credits states that have enacted paid family leave on a statewide basis. **Scoring:** States received 1.0 point for statewide laws mandating paid family leave. Current year 2022 data from *National Partnership for Women & Families: State Paid Family & Medical Leave Insurance Laws*, October 2022 and A Better Balance: Comparative Chart of Paid Family and Medical Leave Laws in the Untied States Reference year 2019 data from *Raising Expectations: A State-by-State Analysis of Laws That Help Working Family Caregivers* and AARP Public Policy Institute internal communications with State Advocacy & Strategy Integration and independent research to verify status of laws in 2019.		
Data Source(s)	A Better Balance https://www.abetterbalance.org/resources/paid-family-leave-laws-chart/ National Partnership for Women & Families https://nationalpartnership.org/wp-content/uploads/2023/02/state-paid-family-leave-laws.pdf		
Current Year(s)	2022-2023	**Reference Year(s)**	2019
Type of Indicator	Policy		
Changes to Methodology from 2020 to 2023	Disaggregated from the *2020 Scorecard* Supporting Working Family Caregivers indicator. Simplified scoring, including to only credit statewide laws.		
Inclusion/Exclusion Criteria for being Counted	Local policies that require paid family leave, which were included in previous editions of the *Scorecard*, are now excluded from the *2023 Scorecard*.		

Statewide policy mandating provision of paid sick days or leave

Short Name	Mandatory Paid Sick Days		
Description of Value Calculation	This indicator gives credit to states with statewide policies mandating that employees be provided paid sick days. **Scoring:** States received 1.0 point for statewide laws mandating paid family leave. Current year 2023 data are from the Society for Human Resource Management		
Data Source(s)	Society for Human Resource Management https://www.shrm.org/resourcesandtools/legal-and-compliance/employment-law/pages/state-local-paid-sick-leave-chart.aspx		
Current Year(s)	2023	**Reference Year(s)**	2019
Type of Indicator	Policy		
Changes to Methodology from 2020 to 2023	Disaggregated from the *2020 Scorecard* Supporting Working Family Caregivers indicator. Simplified scoring, including to only credit statewide laws.		
Inclusion/Exclusion Criteria for being Counted	Local policies that require mandatory paid sick days, which were included in previous *Scorecards*, are now excluded from the *2023 Scorecard*.		

Statewide policy that allows for paid sick time to be used to care for someone else

Short Name	Flexible Sick Days		
Description of Value Calculation	This indicator gives credit to states with statewide policies mandating that employees have flexibility in using sick days for themselves or another person. **Scoring:** States received 1.0 point for statewide laws mandating flexible sick days Current year 2022 data from *A Better Balance: Overview of Paid Sick Time Laws* in the United States and AARP Public Policy Institute independent research to verify status of laws in 2023. Reference year 2018 data are from *Raising Expectations: A State-by-State Analysis of Laws That Help Working Family Caregivers* and AARP Public Policy Institute internal communications with State Advocacy & Strategy Integration and independent research to verify status of laws in 2019.		
Data Source(s)	A Better Balance https://www.abetterbalance.org/paid-sick-time-laws/?export		
Current Year(s)	2022	**Reference Year(s)**	2018
Type of Indicator	Policy		
Changes to Methodology from 2020 to 2023	Disaggregated from the *2020 Scorecard* Supporting Working Family Caregivers indicator. Simplified scoring, including to only credit statewide laws.		
Inclusion/Exclusion Criteria for being Counted	Local policies that require mandatory flexible sick days, which were included in previous *Scorecards*, are now excluded from the *2023 Scorecard*.		

States with unemployment insurance laws that provide good cause for separation for family caregiving

Short Name	Unemployment Insurance for Family Caregivers		
Description of Value Calculation	This indicator gives credit to states that have unemployment insurance laws or regulations that consider job loss due to an illness or disability of a member of the individual's immediate family as "good cause." **Scoring:** States received 1 point if unemployment insurance laws or regulations include illness or disability of a member of the individual's immediate family as "good cause" for voluntarily leaving a job. Current year 2022 data are obtained from *US Department of Labor Comparison of State Unemployment Laws 2022*. Reference year 2019 data are obtained from communications with Richard McHugh, formerly with the National Employment Law Project. Richard McHugh unpublished internal communications, 2019. Re-scored using updated methodology in 2023.		
Data Source(s)	US Department of Labor https://oui.doleta.gov/unemploy/comparison/2020-2029/comparison2022.asp		
Current Year(s)	2022	**Reference Year(s)**	2019
Type of Indicator	Policy		
Changes to Methodology from 2020 to 2023	Disaggregated from the *2020 Scorecard* Supporting Working Family Caregivers indicator. Simplified scoring, including to only credit statewide laws.		
Inclusion/Exclusion Criteria for being Counted	Local policies that require unemployment insurance for family caregivers, which were included in previous *Scorecards*, are now excluded from the *2023 Scorecard*.		

Spousal Impoverishment Protections

Short Name	Spousal Impoverishment Protections		
Description of Value Calculation	This indicator gives credit for states that, under the Medicaid Community Spouse Resource Allowance (CSRA), provide the most allowance for community spouses – the spouse of a Medicaid applicant that is not applying for Medicaid LTSS. These policies are designed to prevent the impoverishment of community spouses in the event their spouses need Medicaid LTSS. States receive full credit for allowing a community spouse to retain the maximum allowance set by the federal government ($148,620 in 2023). All other states set their asset limits to the federal minimum, except for Illinois, which received half credit in 2023 for allowing community spouses to retain 100 percent of their $120,780 asset limit, significantly more than the federal minimum but less than the maximum.		
Data Source(s)	American Council on Aging https://www.medicaidplanningassistance.org/community-spouse-resource-allowance/		
Current Year(s)	2023	**Reference Year(s)**	N/A
Type of Indicator	Policy		
Changes to Methodology from 2020 to 2023	Disaggregated from the *2020 Scorecard* Person- and Family-Centered Care indicator. Simplified scoring and included only asset protection limits.		
Inclusion/Exclusion Criteria for being Counted	N/A		

Caregiver Advise, Record, Enable (CARE) Act Legislation passed into law

Short Name	Caregiver Advise, Record, Enable (CARE) Act Legislation		
Description of Value Calculation	This indicator gives credit to states that have passed Caregiver Advise, Record, Enable (CARE) Act legislation and the bill is signed into law. The CARE Act helps family caregivers from the moment their loved ones go into the hospital to when they return home. The CARE Act requires hospitals to: (1) Record the name of the family caregiver on the medical record of a loved one; (2) Inform the family caregivers when the patient is to be discharged; and (3) Provide the family caregiver with education and instruction of the medical tasks he or she will need to perform for the patient at home. **Scoring:** States that pass CARE Act legislation and had a bill signed into law received 1.0 point. Current year 2023 data are obtained from *AARP Public Policy Institute: Valuing the Invaluable: 2023 Update Strengthening Supports for Family Caregivers*. Reference year 2019 data are obtained from AARP State Advocacy & Strategy Integration internal communications. AARP State Advocacy & Strategy Integration unpublished internal communications, 2019, 2023.		
Data Source(s)	AARP Public Policy Institute, Valuing the Invaluable 2023 https://www.aarp.org/content/dam/aarp/ppi/2023/3/valuing-the-invaluable-2023-update.doi.10.26419-2Fppi.00082.006.pdf		
Current Year(s)	2023	**Reference Year(s)**	2019
Type of Indicator	Policy		
Changes to Methodology from 2020 to 2023	Disaggregated from the *2020 Scorecard* Person- and Family-Centered Care indicator.		
Inclusion/Exclusion Criteria for being Counted	N/A		

Availability of respite to family caregivers as service through Medicaid HCBS waivers

Short Name	Respite Care through Medicaid Waivers		
Description of Value Calculation	This policy gives credit to states that offer respite care benefits through one or more Medicaid HCBS waivers. **Scoring:** • 1 point for states that offer respite care benefits with no arbitrary cap/ limit on hours or days; limits only set by the person-centered plan • 0.5 point (maximum of 1 point) for states that offer respite care benefits with any sort of cap or limit not from the person-centered plan • 0 points (maximum of 1 point) for states that do not have respite benefit.		
Data Source(s)	National Academy for State Health Policy State Caps on Respite Waiver Services Vary Greatly, July 2022 https://nashp.org/state-caps-on-respite-waiver-services-vary-greatly/		
Current Year(s)	2022	**Reference Year(s)**	N/A
Type of Indicator	Policy		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted			

Availability of state caregiver tax credits

Short Name	State Caregiver Tax Credits		
Description of Value Calculation	This innovation point gives states credit for providing tax credits for family caregivers' out-of-pocket expenses. **Scoring:** ▫ 1 point for states with a law that reflect the following provisions: o Provides tax credits to cover out-of-pocket expenses of taxpayers caring for family members age 18 or over experiencing difficulty with at least one activity of daily living, o Covered expenses include (not exclusive, but must include some of these items): ■home modifications to keep the care recipient mobile, safe, and able to continue living in community, ■purchase of lease of assistive devices and equipment to assist with activities of daily living ■hiring of direct care workers. ▫ 0 points for states that do not offer caregiver tax credits, or do not offer tax credits including the provisions above.		
Data Source(s)	AARP review of existing state tax policy		
Current Year(s)	2023	**Reference Year(s)**	N/A
Type of Indicator	Policy – Innovation Point		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted			

COMMUNITY INTEGRATION

Rate of employment for adults with Activities of Daily Living (ADL) disabilities ages 18-64 relative to rate of employment for adults without ADL disabilities ages 18-64

Short Name	Employment Rate for People with Disabilities		
Description of Value Calculation	The relative rate of employment (full or part time) for people ages 18 to 64 with a self-care difficulty (difficulty dressing or bathing; a reasonable approximation to ADL disability) compared with the rate of employment of people ages 18 to 64 without a self-care difficulty. The employment rate is calculated as the percentage of all people who are employed, including those who are not in the labor force, as many people with disabilities are not in the labor force even though they may have the skills and desire to work. For example, if a state value is 20 percent, it means that the employment rate for people with disabilities is one-fifth as high as that for people without disabilities. The ratio of employment rate for adults with ADL disability to adults without ADL disability was calculated for each year, and this ratio was averaged across the three "current years" and three "reference years" to create the current and baseline indicator values. Current year 2021 data are from 2021 and come from the American Community Survey, US Census Bureau. Reference data 2018-2019 are from 2018 and 2019 from the same source.		
Data Source(s)	US Census Bureau. 2018, 2019, 2021. "American Community Survey data table B18120." https://data.census.gov/cedsci/.		
Current Year(s)	2021	**Reference Year(s)**	2018-19
Type of Indicator	Metric, ratio of percents Higher values are better		
Changes to Methodology from 2020 to 2023	No changes		
Inclusion/Exclusion Criteria for being Counted	N/A		

Percentage of people admitted to nursing homes who were successfully discharged to the community within 100 days

Short Name	Successful Discharge to Community
Description of Value Calculation	This is a claims-based outcome measure of the proportion of Medicare beneficiaries, ages 55+, who successfully discharged to the community from a post-acute care (PAC) skilled nursing facility (SNF) and had no subsequent MDS assessment from any facility during the 30 days following discharge to the community. The denominator for this rate is the Total Admissions, defined as the total number of admissions to the facility for persons 55 and older for individuals with available risk factors within 18 days of the entry date (NOT taken from the discharge assessment), from hospitals, during the year (A1800=03, indicating 'entered from hospital') who did not have an MDS assessment from any facility during the previous 100 days (i.e. these were new nursing home admissions and does not include residents hospitalized from a facility). The entry date was determined using 2 variables: A1600 (entry date) and A0310F=01 (indicating 'entry tracking records'). The numerator is the number of these admissions who were discharged alive to the community (A2100='01') from the same facility within 100 days of entry from a hospital and who did not have any subsequent MDS assessment from any facility during the 30 days following discharge to the community. These data were averaged at the state level following the *LTSS State Scorecard* approach to measuring equity. Equity adjustment: Race/ethnicity is indicated in MDS by a 6 category multiple response variable with choices: • American Indian or Alaska Native • Asian • Black or African American • Hispanic or Latino • Native Hawaiian or Other Pacific Islander • White Residents were classified by race/ethnicity as follows: • Hispanic/Latino: "Hispanic or Latino" is selected • All Other Races/Ethnicities: exactly one race/ethnicity is selected (a resident is classified as "Asian" if and only if "Asian" is selected and no other races/ethnicity is selected) • Multiracial: "Hispanic or Latino" is not selected and two or more other races/ethnicities are selected Data are presented for all residents and for each race/ethnicity group for the 10 percent of facilities nationally and within each state that have the most admissions among each group.

Percentage of people admitted to nursing homes who were successfully discharged to the community within 100 days (continued)

Short Name	Successful Discharge to Community		
Description of Value Calculation	For the equity adjusted metric score, residents are divided into 6 groups: White, American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Other Pacific Islander, and Multiracial. The lowest performing group is scored and ranked as a performance metric.		
Data Source(s)	Analysis of 2021 MDS 3.0 state-level care data provided by the Changing Long-Term Care in America Project at Brown University in February-April 2023. Brown University (2023). Changing Long Term Care in America Project at Brown University funded in part by the National Institute on Aging (1P01AG027296). Providence, RI: Brown University School of Public Health, http://ltcfocus.org/.		
Current Year(s)	2020	**Reference Year(s)**	N/A
Type of Indicator	Metric – Equity, percent Higher values are better		
Changes to Methodology from 2020 to 2023	Included equity adjustments using race and ethnicity data. Operational definition of the measure has also changed and is not comparable to previous *Scorecards*.		
Inclusion/Exclusion Criteria for being Counted	N/A		

Livability Index: Transportation Category Score, Composite Indicator (Scale 0-100)

Short Name	Livability Index: Transportation
Description of Value Calculation	The Livability Index Transportation category score is a composite score of 11 indicators (7 metrics, 4 policies) in the AARP Livability Index: Metrics 1. Frequency of local transit service 2. ADA-accessible stations and vehicles 3. Walk trips 4. Congestion 5. Household transportation costs 6. Speed limits 7. Crash rate Policies 1. State and local Complete Streets policies 2. State human services transportation coordination 3. State volunteer driver policies 4. State and local plans to create age-friendly communities Equity adjustment: The top 10 percent of all neighborhoods (census block groups) in each state with nonzero population with the highest percentage of population that is Asian, Black, Hispanic, and White were identified. For some states, more than 10 percent of non-zero-population block groups were 100 percent white; in these states all such block groups were included. The Transportation category score for each 10 percent selection of block groups was then calculated using the exact same methodology used to calculate Livability Index scores at other geographies, which is a population-weighted average of all component block groups. Category scores for the state and each 10 percent selections are displayed. For the equity adjusted metric score, the lowest of the four 10 percent selections is scored and ranked. AARP Public Policy Institute (2023). Calculations are based on AARP Livability Index Neighborhood Level Scores (unpublished). The Livability Index is a tool designed to evaluate every US communities' livability from neighborhood to neighborhood. Some indicators look as far down as the census block, block group, tract, or high school district, while others use data sources at higher levels of geography such as metro area, city, or county. For the *Scorecard*, we aggregated scores across neighborhoods to provide a state-level rating for transportation. However, transportation systems vary across neighborhoods, cities, counties and regions within a state. To search for a home or neighborhood by zip code, visit (https://livabilityindex.aarp.org/.

Livability Index: Transportation Category Score, Composite Indicator (Scale 0-100) (continued)

Short Name	Livability Index: Transportation		
Data Source(s)	**Underlying data from:** US Environmental Protection Agency, US Federal Transit Authority, US Federal Highway Administration, Texas Transportation Institute, US Department of Housing and Urban Development, and National Highway Traffic Safety Administration **Data analyzed/complied by:** AARP Public Policy Institute (https://www.aarp.org/ppi/) for AARP Livability Index (https://livabilityindex.aarp.org/)		
Current Year(s)	2022	**Reference Year(s)**	N/A
Type of Indicator	Metric – Equity, Composite Indicator, Scale 0-100 Higher values are better		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted	Please see Methodology for Livability Index: (https://livabilityindex.aarp.org/scoring)		

Livability Index: Housing Category Score, Composite Indicator (Scale 0-100)

Short Name	Livability Index: Housing
Description of Value Calculation	The Livability Index Transportation category score is a composite score of 11 housing indicators (5 metrics, 6 policies) in the AARP Livability Index: Metrics 1. Zero-step entrances 2. Availability of multi-family housing 3. Housing costs 4. Housing cost burden 5. Availability of subsidized housing Policies 1. State and local inclusive design laws 2. State and local housing trust funds 3. State manufactured housing protections 4. State foreclosure prevention and protection 5. State accessory dwelling unit support 6. State and local plans to create age-friendly communities Equity adjustment: The top 10 percent of all neighborhoods (census block groups) in each state with nonzero population with the highest percentage of population that is Asian, Black, Hispanic, and White were identified. For some states, more than 10 percent of non-zero-population block groups were 100 percent white; in these states all such block groups were included. The Housing category score for each 10 percent selection of block groups was then calculated using the exact same methodology used to calculate Livability Index scores at other geographies, which is a population-weighted average of all component block groups. Category scores for the state and each 10 percent selections are displayed. For the equity adjusted metric score, the lowest of the four 10 percent selections is scored and ranked. AARP Public Policy Institute (2023). Calculations are based on AARP Livability Index Neighborhood Level Scores (unpublished). The Livability Index is a tool designed to evaluate every US communities' livability from neighborhood to neighborhood. Some indicators look as far down as the census block, block group, tract, or high school district, while others use data sources at higher levels of geography such as metro area, city, or county. For the *Scorecard*, we aggregated scores across neighborhoods to provide a state-level rating for transportation. However, transportation systems vary across neighborhoods, cities, counties and regions within a state. To search for a home or neighborhood by zip code, visit https://livabilityindex.aarp.org/.

Livability Index: Housing Category Score, Composite Indicator (Scale 0-100)
(continued)

Short Name	Livability Index: Housing		
Data Source(s)	**Underlying data from:** U.S. Census Bureau, Public and Affordable Housing Research Corporation and the National Low Income Housing Coalition's 2020 National Housing Preservation Database **Data analyzed/complied by:** AARP Public Policy Institute (https://www.aarp.org/ppi/) for AARP Livability Index (https://livabilityindex.aarp.org/)		
Current Year(s)	2022	**Reference Year(s)**	N/A
Type of Indicator	Metric – Equity, Composite Indicator, Scale 0-100 Higher values are better		
Changes to Methodology from 2020 to 2023	New Indicator. The *2020 LTSS State Scorecard* included a metric of subsidized housing opportunities that was largely based on the subsidized housing indicator in the Livability Index, which is 1 of the 11 components of the Housing category score. In 2023, that indicator was replaced with complete category score.		
Inclusion/Exclusion Criteria for being Counted	Please see Methodology for Livability Index: (https://livabilityindex.aarp.org/scoring)		

Percentage of people with disabilities eligible for housing assistance and enrolled

Short Name	Access to Housing Assistance for People with Disabilities		
Description of Value Calculation	The percentage of low-income people with disabilities who are eligible for public housing assistance who receive public housing assistance. An individual is defined as low-income if their household income is at or below their state's average 80 percent area median income (AMI) limit (as defined by the U.S. Department of Housing and Urban Development in years 2020-2022). People with disabilities are defined as those who may have difficulty with activities of daily living or were not working for all or part of the year due to a disability or illness (as defined by the CPS). Individuals receiving housing assistance are defined as those who are 1) paying lower rent because a government entity is paying part of the cost or 2) living in public housing owned by a public agency (as defined by the CPS). The Urban Institute provided these data to the AARP Public Policy Institute. Race/ethnicity data are available for state review but not included in the scoring calculation for this measure.		
Data Source(s)	Urban Institute analysis of Current Population Survey data (2020–22).		
Current Year(s)	2020-2022	**Reference Year(s)**	N/A
Type of Indicator	Metric, percent Higher values are better		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted	N/A		

Presence of age-friendly health sites as designated by the Institute for Healthcare Improvement per population, age 65+

Short Name	Age-Friendly Health Systems		
Description of Value Calculation	The estimated number of age-friendly health sites as designated by the Institute for Healthcare Improvement (IHI) present in a state per 10,000 population, ages 65+.		
Data Source(s)	The John A. Hartford Foundation https://www.johnahartford.org/ahimap/. U.S. Census Bureau https://data.census.gov/table?g=0100000US$0400000&tid=ACSST1Y2021.S0101.		
Current Year(s)	2023	**Reference Year(s)**	N/A
Type of Indicator	Metric, number, standardized as population rate Higher values are better		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted	N/A		

Existence of Multisector Plan on Aging or comparable statewide strategic plan

Short Name	Multisector Plans for Aging		
Description of Value Calculation	This innovation point gives states credit for developing and/or implementing a multisector plan for aging, as defined by the SCAN Foundation, or have executive orders or legislation to initiate development of a multisector plans for aging. Scoring: • 1 point for states that have developed and/or implemented a multisector plan for aging • 0.5 point (maximum of 1 point) for states that have legislation or an executive order • 0 points (maximum of 1 point) to states that are in the process of fostering a plan or have no plan		
Data Source(s)	The SCAN Foundation (https://www.thescanfoundation.org/initiatives/multisector-plan-aging/)		
Current Year(s)	2020-2022	**Reference Year(s)**	N/A
Type of Indicator	Policy – Innovation Point		
Changes to Methodology from 2020 to 2023	N/A – New indicator		
Inclusion/Exclusion Criteria for being Counted	N/A		

APPENDIX F | Measuring Change Over Time

One of the main goals of this report is to assess how state long-term services and supports (LTSS) systems improved or declined between the *2020 Scorecard* and the *2023 Scorecard*. State ranks at the dimension and overall levels reflect our best point-in time measurements of performance, but should not be directly compared between the current *Scorecard* and prior *Scorecards* because of changes in the scoring methodology (new for this edition), the indicator set, and in the definition of individual indicators between editions. When looking to assess actual change in performance, the *Scorecard* authors recommend using indicators with a consistent definition over time and/or reference year data that are comparable to the most current data using for scoring and ranking. Table F.1 below shows a comparison of the indicators (metrics and policies) in the *2020* and *2023 Scorecards*.

TABLE F.1 | Comparison of Indicator Sets for the *2020* and *2023 State LTSS Scorecards*

Dimension	*2020 Scorecard* Indicator	*2023 Scorecard* Indicator	Reference Year Data Available?	Change from *2020 Scorecard*
Affordability and Access	Home Care Cost	Home Care Cost	Yes	Revised indicator methodology
	Nursing Care Cost	Nursing Home Cost	Yes	Revised indicator methodology
	Long-Term Care Insurance	Long-Term Care Insurance	Yes	
	ADRC/NWD Functions	ADRC/NWD Functions	Yes	
	Low-Income PWD with Medicaid	Medicaid for Low-Income People with Disabilities	Yes	
	Not included	Medicaid Buy-In	No	New Indicator
	Not included	Medicaid HCBS Presumptive Eligibility	No	New Indicator
	PWD with Medicaid LTSS	*Not included*	*N/A*	*Removed*
Choice of Setting and Provider	Medicaid LTSS Balance: Spending	Medicaid LTSS Balance: Spending	Yes	Data source not comparable to previous editions
	Self-Direction	Self-Directed Program Enrollment	Yes	
	Assisted Living Supply	Assisted Living Supply	Yes	
	Adult Day Services Supply	Adult Day Services Supply	Yes	
	Home Health Aide Supply	Home Health Aide Supply	Yes	

TABLE F.1 | Comparison of Indicator Sets for the *2020* and *2023 State LTSS Scorecards* (continued)

Dimension	*2020 Scorecard* Indicator	*2023 Scorecard* Indicator	Reference Year Data Available?	Change from *2020 Scorecard*
Choice of Setting and Provider	*Moved Dimensions*	NH Residents with Low Care Needs	No	Previously in Effective Transitions
	Not included	LTSS Worker Wage Competitiveness	Yes	New Indicator
	Not included	PACE Enrollment	Yes	New Indicator
	Not included	LTSS Worker Wage Pass-Through	No	New Indicator
	Not included	Green House® Availability	No	New Indicator
	Not included	CAPABLE Availability	No	New Indicator
	Medicaid LTSS Balance: Users	*Not included*	*N/A*	*Removed*
	Subsidized Housing Opportunities	*Not included*	*N/A*	*Replaced with new indicator in Community Integration (Livability Index: Housing)*
Safety and Quality (formerly Quality of Life and Quality of Care)	*Moved Dimensions*	Home Health Hospital Admissions	Yes	Previously in Effective Transitions
	Moved Dimensions	NH Hospital Admissions	No	Previously in Effective Transitions
	Nursing Home Resident with Pressure Sores	NH Residents with Pressure Sores	No	Data not comparable to previous editions
	Nursing Home Antipsychotic Use	NH Inappropriate Antipsychotic Use	No	Source definition changed
	Not included	NH Staff Turnover	No	New Indicator
	Not included	NH COVID-19 Vaccinations: Residents	No	New Indicator
	Not included	NH COVID-19 Vaccinations: Staff	No	New Indicator
	Not included	NH with Top Quality Ratings	No	New Indicator
	Not included	NH Staffing Levels	No	New Indicator

TABLE F.1 | Comparison of Indicator Sets for the *2020* and *2023 State LTSS Scorecards* (continued)

Dimension	*2020 Scorecard* Indicator	*2023 Scorecard* Indicator	Reference Year Data Available?	Change from *2020 Scorecard*
Safety and Quality (formerly Quality of Life and Quality of Care)	HCBS Quality Benchmarking	HCBS Quality Benchmarking: NCI-AD™	Yes	Disaggregated
		HCBS Quality Benchmarking: HCBS CAHPS®	Yes	
		HCBS Quality Benchmarking: NCQA	Yes	
	Not included	State Emergency Management Plans	No	New Indicator
	PWD Rate of Employment	*Moved Dimensions*	Yes	Moved to Community Integration
Supporting Family Caregivers	Nurse Delegation and Scope of Practice	Nurse Delegation	Yes	Disaggregated
		Nurse Scope of Practice	Yes	
	Supporting Working Caregivers	Family Responsibility Protected Classification	Yes	Disaggregated
		State Exceeds Federal FMLA	Yes	
		Paid Family Leave	Yes	
		Mandatory Paid Sick Days	Yes	
		Flexible Sick Days	Yes	
		Unemployment Insurance for Family Caregivers	Yes	
	Person-and Family Centered Care	Spousal Impoverishment Protections	No	Disaggregated
		CARE Act Legislation	Yes	
	Transportation Policies	*Not included*	*N/A*	*Replaced with new indicator in Community Integration (Livability Index: Transportation)*
	Not included	Respite Care through Medicaid Waivers	No	New Indicator
	Not included	State Caregiver Tax Credits	No	New Indicator

TABLE F.1 | Comparison of Indicator Sets for the *2020* and *2023 State LTSS Scorecards* (continued)

Dimension	*2020 Scorecard* Indicator	*2023 Scorecard* Indicator	Reference Year Data Available?	Change from *2020 Scorecard*
Community Integration (formerly Effective Transitions)	*Moved Dimensions*	Employment Rate for People with Disabilities	Yes	Previously in Quality of Life and Quality of Care
	Successful Discharge to Community	Successful Discharge to Community	No	Revised indicator definition
	Not included	Livability Index: Transportation	No	New Indicator
	Not included	Livability Index: Housing	No	New Indicator
	Not included	Access to Housing Assistance for People with Disabilities	No	New Indicator
	Not included	Age-Friendly Health Systems	No	New Indicator
	Not included	Multisector Plans for Aging	No	New Indicator
	Nursing Home Residents with Low Care Needs	*Moved Dimensions*	No	Moved to Choice of Setting and Provider
	Home Health Hospital Admissions	*Moved Dimensions*	Yes	Moved to Safety and Quality
	Nursing Home Hospital Admissions	*Moved Dimensions*	No	Moved to Safety and Quality
	Burdensome Transitions	*Not included*	*N/A*	*Removed*

In previous *Scorecards*, policy indicators were aggregated into groups to create composite indicators that were treated equivalently to metrics. For example, the *Support for Family Caregivers* dimension in the *2020 Scorecard* comprised 12 policies that were grouped into 4 categories, some with many scoring options to differentiate states. The resulting scores were often difficult to interpret. In this *Scorecard*, all policies are disaggregated and typically scored [1,0] or [full credit, no credit] for each policy. For some policies, a single intermediate category reflecting partial policy credit was used.

Note that even when the indicator is continued from one *Scorecard* to the next, the data in one *Scorecard* may not be directly comparable, due to changes in data source, methodology, data years and/or updated information. Indicator level comparisons should always use the reference year data in the current *Scorecard*, not the value in the previous *Scorecard*, and users are encouraged to read Appendix E for detailed methodology of individual indicators.

MEASURING CHANGE AT THE INDICATOR LEVEL

Change in performance can be directly measured at the indicator level. The *Scorecard* includes reference year data (typically 3 years prior to the most current data) for 26 of the 50 indicators. In all cases, current data are 2020 or later, and reference data are 2019 or earlier, in order for the effects of the COVID-19 pandemic to be observed. However, all observed changes are not necessarily caused by COVID-19.

For these 26 indicators, the *Scorecard* reports both current data and reference data, and identifies meaningful change (either positive or negative), typically by a 10% or greater change in metric performance (or 10% change in odds ratio for percentages), or any change for policy indicators. Any exceptions or additional details about identifying meaningful indicator-level change is explained in Appendix E. Appendix data tables show current and reference values for each trended indicator, and also indicate the magnitude of changes by a green check mark for a substantial improvement, a red X for a substantial decline, and a black two-headed arrow for little or no change.

The *Scorecard* also identifies meaningful change at the national level. For metrics, this calculation is the same as the at the state level, typically a 10% or more change in performance. For policy indicators, meaningful positive change is defined as an increase in the number of states getting policy credit (full or partial) while negative change is defined as a decrease in the number of states with policy credit.

APPENDIX G | Overall State Rankings and Performance Tiers and Across Five Dimensions of LTSS

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

Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX H | Number of States Showing Change in Performance between 2020 to 2023 *LTSS State Scorecards*, by Indicator

Indicator	Improvement	Decline	About the Same	Missing Data
AFFORDABILITY AND ACCESS				
Home Care Cost	0	28	23	0
Nursing Home Cost	2	45	4	0
Long-Term Care Insurance	1	49	1	0
ADRC/NWD Functions	34	11	6	0
Medicaid for Low-Income People with Disabilities	21	23	7	0
CHOICE OF SETTING AND PROVIDER				
Medicaid LTSS Balance: Spending	21	21	6	3
Self-Directed Program Enrollment	35	10	6	0
Home Health Aide Supply	18	17	16	0
Assisted Living Supply	24	19	5	3
Adult Day Services Supply	9	14	21	7
LTSS Worker Wage Competitiveness	0	50	1	0
PACE Enrollment	12	34	5	0
SAFETY AND QUALITY				
Home Health Hospital Admissions	32	18	1	0
HCBS Quality Benchmarking: NCI-AD™	8	39	4	0
HCBS Quality Benchmarking: NCQA	5	46	0	0
HCBS Quality Benchmarking: HCBS CAHPS®	4	42	5	0
SUPPORT FOR FAMILY CAREGIVERS				
Nurse Delegation	10	40	1	0
Nurse Scope of Practice	5	46	0	0
Family Responsibility Protected Classification	4	47	0	0
State Exceeds Federal FMLA	1	50	0	0
Paid Family Leave	3	48	0	0
Mandatory Paid Sick Days	5	46	0	0
Flexible Sick Days	1	50	0	0
Unemployment Insurance for Family Caregivers	1	50	0	0
CARE Act Legislation	2	49	0	0
CARE Act Legislation	29	5	17	0
COMMUNITY INTEGRATION				
Employment Rate for People with Disabilities	13	23	15	0

Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX I | Summary of Change in Performance by State

State	Across All Dimensions, Number of Indicators for Which States Improved, Declined, or Stayed About the Same:			
	Improve	About the Same	Decline	No Trend
United States	**17**	**6**	**3**	**1**
Alabama	6	17	3	0
Alaska	5	17	4	0
Arizona	5	17	4	0
Arkansas	6	19	1	0
California	6	20	0	0
Colorado	9	16	1	0
Connecticut	3	19	3	1
Delaware	10	14	2	0
District of Columbia	4	17	3	2
Florida	4	20	2	0
Georgia	9	17	0	0
Hawaii	3	22	1	0
Idaho	6	16	4	0
Illinois	3	20	3	0
Indiana	9	17	0	0
Iowa	5	19	1	1
Kansas	9	15	2	0
Kentucky	8	17	1	0
Louisiana	7	15	4	0
Maine	9	14	3	0
Maryland	5	15	6	0
Massachusetts	5	19	2	0
Michigan	4	19	3	0
Minnesota	5	18	3	0
Mississippi	6	16	4	0
Missouri	8	18	0	0
Montana	3	19	3	1
Nebraska	7	17	2	0
Nevada	3	18	5	0
New Hampshire	5	18	1	2
New Jersey	3	21	2	0
New Mexico	7	17	2	0
New York	9	14	3	0
North Carolina	2	17	7	0
North Dakota	3	20	3	0
Ohio	3	19	4	0
Oklahoma	5	18	3	0
Oregon	4	20	2	0
Pennsylvania	2	23	0	1
Rhode Island	7	17	2	0
South Carolina	3	21	2	0
South Dakota	6	16	3	1
Tennessee	4	20	2	0
Texas	5	18	3	0
Utah	7	16	2	1
Vermont	1	21	4	0
Virginia	5	18	2	1
Washington	7	17	2	0
West Virginia	2	19	4	1
Wisconsin	4	20	2	0
Wyoming	5	18	2	1

Note: Showing change in 26 indicators where there is comparable current and reference year data.
Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX J | Indicator Data: Affordability and Access

	Median annual home care private pay cost as a percentage of median household income ages 65+				Median annual nursing home private pay cost as a percentage of median household income ages 65+				Private long-term care insurance policies in effect per 1,000 people ages 40+			
State	2019	2021	Rank	Change	2019	2021	Rank	Change	2018	2021	Rank	Change
United States	**73%**	**83%**		✗	**209%**	**213%**		↔	**41**	**40**		↔
Alabama	67%	75%	9	✗	195%	201%	16	↔	30	28	42	↔
Alaska	78%	74%	7	↔	606%	595%	51	↔	23	24	49	↔
Arizona	78%	82%	23	↔	194%	177%	7	↔	27	26	43	↔
Arkansas	78%	85%	31	↔	193%	200%	15	↔	26	24	48	↔
California	75%	80%	19	↔	219%	235%	35	↔	41	39	25	↔
Colorado	72%	88%	35	✗	200%	198%	14	↔	49	47	19	↔
Connecticut	64%	73%	6	✗	286%	302%	48	↔	61	60	10	↔
Delaware	66%	72%	5	↔	235%	249%	41	↔	50	48	16	↔
District of Columbia	67%	76%	10	✗	200%	209%	21	↔	137	132	1	↔
Florida	70%	78%	15	✗	231%	231%	33	↔	28	26	45	↔
Georgia	68%	74%	8	↔	181%	188%	11	↔	31	29	40	↔
Hawaii	60%	63%	1	↔	226%	227%	30	↔	107	102	3	↔
Idaho	74%	89%	37	✗	217%	220%	27	↔	27	25	46	↔
Illinois	76%	85%	30	✗	167%	167%	2	↔	51	50	12	↔
Indiana	82%	83%	25	↔	234%	223%	28	↔	33	30	38	↔
Iowa	86%	95%	46	↔	183%	186%	10	↔	86	81	6	↔
Kansas	73%	80%	18	✗	157%	172%	5	↔	72	70	9	↔
Kentucky	77%	93%	41	✗	226%	227%	29	↔	31	30	39	↔
Louisiana	69%	76%	11	✗	176%	182%	8	↔	31	31	37	↔
Maine	97%	101%	49	↔	292%	292%	45	↔	53	50	13	↔
Maryland	59%	63%	2	↔	189%	219%	26	✗	48	46	20	↔
Massachusetts	77%	85%	29	↔	285%	285%	44	↔	51	50	14	↔
Michigan	79%	93%	45	✗	240%	244%	37	↔	34	33	35	↔
Minnesota	94%	106%	51	✗	260%	294%	46	✗	75	74	8	↔
Mississippi	78%	81%	21	↔	231%	228%	31	↔	28	26	44	↔
Missouri	79%	84%	26	↔	158%	153%	1	↔	52	49	15	↔
Montana	82%	93%	42	✗	203%	205%	20	↔	48	47	18	↔
Nebraska	85%	90%	38	↔	193%	205%	19	↔	97	91	5	↔
Nevada	70%	81%	22	✗	221%	232%	34	↔	23	21	50	↔
New Hampshire	82%	86%	32	↔	234%	244%	38	↔	41	40	24	↔
New Jersey	65%	76%	12	✗	233%	239%	36	↔	46	43	21	↔
New Mexico	81%	81%	20	↔	224%	213%	23	↔	40	40	23	↔
New York	81%	86%	33	↔	297%	301%	47	↔	41	38	26	↔
North Carolina	71%	78%	16	✗	209%	214%	25	↔	36	35	32	↔
North Dakota	93%	99%	47	↔	307%	320%	49	↔	99	91	4	↔
Ohio	81%	89%	36	✗	212%	213%	22	↔	39	37	29	↔
Oklahoma	80%	92%	40	✗	155%	170%	3	↔	31	29	41	↔
Oregon	87%	93%	44	↔	246%	248%	40	↔	38	37	28	↔
Pennsylvania	81%	84%	28	↔	274%	277%	43	↔	38	35	31	↔
Rhode Island	85%	93%	43	↔	257%	229%	32	✓	36	33	33	↔
South Carolina	73%	77%	14	↔	202%	202%	17	↔	35	33	34	↔
South Dakota	91%	101%	50	✗	180%	191%	13	↔	106	102	2	↔
Tennessee	74%	83%	24	✗	204%	205%	18	↔	41	38	27	↔
Texas	67%	77%	13	✗	157%	174%	6	✗	33	32	36	↔
Utah	64%	78%	17	✗	157%	183%	9	✗	27	24	47	↔
Vermont	82%	87%	34	↔	263%	249%	42	↔	43	43	22	↔
Virginia	64%	70%	3	↔	176%	189%	12	↔	57	54	11	↔
Washington	85%	92%	39	↔	213%	214%	24	↔	49	76	7	✓
West Virginia	71%	71%	4	↔	349%	354%	50	↔	23	17	51	✗
Wisconsin	85%	99%	48	✗	246%	246%	39	↔	48	47	17	↔
Wyoming	88%	84%	27	↔	192%	170%	4	✓	38	36	30	↔

KEY FOR CHANGE: ✓ Performance Improvement ↔ Little or No Change in Performance ✗ Performance Decline ✱ No Trend Available

Note: Policy indicators are not ranked because the two or three scoring possibilities do not make for meaningful distribution of ranks.
For United States values, policy indicators display a count of states with any policy credit received.
Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX J | Indicator Data: Affordability and Access (continued)

	Aging and Disability Resource Center/No Wrong Door Functions (composite indicator, scale 0-100%)				Percentage of people with Activity of Daily Living (ADL) disability at or below 250% of poverty receiving Medicaid or other government assistance health insurance, ages 21+				State eligibility policies for the Medicaid Buy-In state option for workers with disabilities (composite indicator, scale 0-100%)		State policies that allow presumptive eligibility for Medicaid HCBS
State	2019	2022	Rank	Change	2018-19	2020-21	Rank	Change	2022	Rank	2022
United States	**67%**	**72%**		✓	**57.5%**	**59.1%**		↔	**48%**		**11 States**
Alabama	89%	92%	7	✓	46.7%	48.2%	49	↔	0%	49	
Alaska	41%	53%	44	✓	67.1%	71.5%	4	✓	43%	25	
Arizona	64%	58%	39	X	57.0%	53.9%	38	X	71%	10	
Arkansas	57%	66%	35	✓	57.5%	58.6%	24	↔	100%	1	
California	37%	42%	46	✓	66.2%	67.9%	6	↔	14%	43	Full
Colorado	52%	56%	40	✓	57.2%	57.8%	28	↔	86%	3	Full
Connecticut	90%	91%	9	✓	65.3%	66.0%	8	↔	57%	13	
Delaware	77%	82%	20	✓	50.6%	63.5%	11	✓	29%	36	
District of Columbia	86%	89%	10	✓	79.5%	73.3%	2	X	100%	1	
Florida	82%	80%	23	X	53.1%	53.3%	40	↔	14%	43	
Georgia	81%	86%	15	✓	51.0%	54.1%	36	✓	29%	36	
Hawaii	79%	77%	26	↔	49.8%	58.2%	26	✓	29%	36	
Idaho	43%	65%	36	✓	46.5%	55.2%	31	✓	57%	13	
Illinois	46%	81%	22	✓	52.6%	53.9%	37	↔	86%	3	Full
Indiana	57%	64%	37	✓	55.6%	58.4%	25	✓	29%	36	Full
Iowa	43%	55%	41	✓	52.8%	52.1%	43	↔	43%	25	
Kansas	63%	71%	31	✓	48.0%	54.1%	35	✓	57%	13	
Kentucky	83%	87%	14	✓	58.5%	57.9%	27	↔	29%	36	
Louisiana	56%	72%	30	✓	59.9%	64.8%	10	✓	43%	25	
Maine	52%	55%	42	✓	66.1%	76.8%	1	✓	29%	36	
Maryland	84%	84%	19	↔	57.6%	58.7%	23	↔	57%	13	
Massachusetts	93%	93%	5	↔	70.3%	71.3%	5	↔	86%	3	
Michigan	70%	68%	33	↔	63.2%	62.4%	14	↔	71%	10	Full
Minnesota	92%	92%	6	↔	59.3%	59.3%	20	↔	86%	3	Full
Mississippi	83%	87%	12	✓	56.1%	61.6%	15	✓	71%	10	
Missouri	82%	85%	18	✓	51.4%	49.9%	47	↔	43%	25	
Montana	44%	44%	45	↔	49.4%	60.7%	16	✓	57%	13	
Nebraska	53%	55%	43	✓	48.6%	56.1%	30	✓	14%	43	
Nevada	66%	66%	34	↔	47.7%	52.5%	42	✓	14%	43	
New Hampshire	95%	95%	3	↔	51.6%	57.3%	29	✓	14%	43	
New Jersey	82%	88%	11	✓	57.3%	59.2%	21	↔	86%	3	Full
New Mexico	33%	41%	47	✓	61.1%	67.3%	7	✓	57%	13	
New York	75%	87%	13	✓	70.3%	73.0%	3	✓	86%	3	
North Carolina	24%	21%	50	X	51.3%	52.6%	41	↔	43%	25	
North Dakota	54%	73%	29	✓	59.3%	48.2%	48	X	29%	36	
Ohio	96%	96%	2	↔	58.0%	59.3%	19	↔	57%	13	Full
Oklahoma	60%	61%	38	↔	41.4%	42.7%	51	↔	14%	43	
Oregon	88%	91%	8	✓	57.4%	60.1%	18	✓	43%	25	Full
Pennsylvania	82%	86%	17	✓	58.4%	59.0%	22	↔	43%	25	
Rhode Island	62%	86%	16	✓	72.2%	65.5%	9	X	57%	13	Full
South Carolina	46%	37%	48	X	47.7%	47.7%	50	↔	0%	49	
South Dakota	78%	78%	24	↔	55.3%	52.0%	45	X	57%	13	
Tennessee	58%	74%	28	✓	50.8%	54.1%	34	✓	0%	49	
Texas	74%	78%	25	✓	53.8%	54.5%	32	↔	43%	25	
Utah	28%	31%	49	✓	49.4%	52.1%	44	✓	43%	25	
Vermont	73%	69%	32	X	67.4%	62.6%	13	X	57%	13	
Virginia	83%	82%	21	X	48.7%	54.4%	33	✓	43%	25	
Washington	93%	95%	4	✓	58.3%	63.0%	12	✓	86%	3	Full
West Virginia	62%	77%	27	✓	58.2%	53.4%	39	X	43%	25	
Wisconsin	92%	97%	1	✓	61.6%	60.6%	17	↔	57%	13	
Wyoming	13%	20%	51	✓	52.9%	50.6%	46	↔	57%	13	

KEY FOR CHANGE: ✓ Performance Improvement ↔ Little or No Change in Performance X Performance Decline ✱ No Trend Available

Note: Policy indicators are not ranked because the two or three scoring possibilities do not make for meaningful distribution of ranks.
For United States values, policy indicators display a count of states with any policy credit received.
Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX K | Indicator Data: Choice of Setting and Provider

	Percentage of Medicaid LTSS spending going to HCBS for older people and adults with physical disabilities				Number of people enrolled in a self-directed HCBS program per 1,000 population with disabilities				Assisted living and residential care units per 1,000 population ages 75+			
State	2018	2020	Rank	Change	2019	2022-23	Rank	Change	2016	2020	Rank	Change
United States	**49.8%**	**53.3%**		✓	**30.4**	**35.8**		✓	**48**	**55**		✓
Alabama	16.3%	14.6%	48	✗	2.6	8.3	34	✓	26	30	47	✓
Alaska	44.4%	39.9%	23	✗	35.2	26.2	16	✗	89	64	17	✗
Arizona	39.9%	44.2%	16	✓	3.5	1.7	49	✗	51	71	12	✓
Arkansas	36.3%	35.1%	28	↔	5.7	4.5	42	✗	35	38	41	↔
California	79.9%	83.2%	1	✓	149.1	168.0	1	✓	60	70	14	✓
Colorado	40.7%	61.4%	7	✓	15.0	17.0	23	✓	52	65	16	✓
Connecticut	40.9%	42.0%	19	↔	8.0	16.1	25	✓	*	38†	41	✱
Delaware	31.9%	36.9%	25	✓	12.9	15.4	26	✓	30	26	48	✗
District of Columbia	55.9%	56.5%	9	↔	8.0	20.9	18	✓	*	38	41	✱
Florida	21.4%	32.5%	33	✓	1.7	4.9	40	✓	47	48	31	↔
Georgia	30.0%	34.4%	30	✓	2.7	3.0	47	✓	55	54	26	↔
Hawaii	30.0%	33.3%	32	✓	23.1	23.8	17	↔	26	40	38	✓
Idaho	39.1%	41.6%	21	✓	11.6	17.0	22	✓	82	61	19	✗
Illinois	44.9%	46.1%	15	↔	46.5	28.9	14	✗	41	56	24	✓
Indiana	20.1%	23.2%	43	✓	0.4	0.4	51	↔	52	72	11	✓
Iowa	19.2%	27.6%	38	✓	26.5	29.7	13	✓	*	55	25	✱
Kansas	34.8%	42.0%	20	✓	24.4	27.8	15	✓	87	84	6	↔
Kentucky	13.6%	18.4%	47	✓	13.7	16.5	24	✓	39	43	35	✓
Louisiana	22.1%	22.3%	44	↔	1.9	3.1	46	✓	20	25	49	✓
Maine	32.7%	35.1%	29	✓	5.5	7.5	36	✓	61	61	19	↔
Maryland	32.7%	38.0%	24	✓	1.6	3.8	43	✓	58	50	29	✗
Massachusetts	58.3%	56.0%	11	↔	49.2	61.2	4	✓	34	39	39	✓
Michigan	34.2%	29.4%	36	✗	36.1	49.4	9	✓	48	47	33	↔
Minnesota	72.0%	72.1%	4	↔	60.6	63.7	2	↔	90	138	1	✓
Mississippi	29.2%	28.2%	37	↔	6.8	7.9	35	✓	33	33	46	↔
Missouri	45.4%	43.4%	18	↔	47.2	56.4	7	✓	43	52	27	✓
Montana	37.3%	36.6%	26	↔	16.2	19.1	20	✓	80	74	9	↔
Nebraska	28.7%	32.2%	34	✓	12.8	11.8	32	↔	73	90	5	✓
Nevada	36.3%	33.5%	31	✗	2.7	2.3	48	✗	38	39	39	↔
New Hampshire	*	13.5%	49	✱	12.6	14.0	30	✓	59	62	18	↔
New Jersey	53.7%	56.1%	10	✓	20.6	31.1	11	✓	35	34	45	↔
New Mexico	63.5%	56.6%	8	✗	10.9	14.3	29	✓	34	35	44	↔
New York	56.3%	65.1%	6	✓	38.0	60.4	6	✓	27	20	51	✗
North Carolina	43.9%	40.7%	22	✗	2.6	3.3	45	✓	53	50	29	↔
North Dakota	17.9%	19.0%	46	↔	5.6	5.7	39	↔	102	97	4	↔
Ohio	45.3%	46.8%	14	↔	1.5	1.3	50	✗	59	74	9	✓
Oklahoma	27.7%	27.0%	39	↔	2.7	3.5	44	✓	39	48	31	✓
Oregon	66.2%	67.6%	5	✱	49.6	47.3	10	↔	95	114	2	✓
Pennsylvania	*	**	**	✱	13.3	13.0	31	↔	58	58	22	↔
Rhode Island	43.9%	49.5%	13	✓	10.8	19.9	19	✓	49	57	23	✓
South Carolina	32.8%	31.0%	35	↔	4.0	7.1	37	✓	37	51	28	✓
South Dakota	23.1%	25.2%	41	✓	1.6	17.1	21	✓	72	80	7	✓
Tennessee	25.1%	36.2%	27	✓	4.0	4.6	41	✓	41	45	34	↔
Texas	41.9%	44.1%	17	↔	4.4	5.8	38	✓	33	43	35	✓
Utah	21.6%	19.9%	45	↔	8.9	10.5	33	✓	58	71	12	✓
Vermont	74.1%	73.2%	3	↔	51.3	55.0	8	↔	62	68	15	↔
Virginia	*	**	**	✱	27.0	30.4	12	✓	45	59	21	✓
Washington	73.0%	76.2%	2	✓	43.2	60.8	5	✓	85	78	8	↔
West Virginia	22.8%	23.4%	42	↔	8.0	15.1	28	✓	24	22	50	↔
Wisconsin	48.8%	50.2%	12	↔	64.0	61.6	3	↔	84	109	3	✓
Wyoming	24.9%	25.7%	40	↔	14.5	15.3	27	↔	37	43	35	✓

KEY FOR CHANGE: ✓ Performance Improvement ↔ Little or No Change in Performance ✗ Performance Decline ✱ No Trend Available

* data not available (including concerns about data quality) or not calculated due to missing data needed for calculation.
** indicator not calculated. An imputed value was used for scoring, but not displayed or ranked.
† Data not available or not comparable in original source. AARP estimated values based on additional information (see Appendix E for imputation details).
†† Due to small sample size of one or more racial/ethnic groups, this indicator could not be calculated. An imputed value was used for scoring, but is not displayed or ranked. All available data are shown on ltsschoices.AARP.org
Note: Policy indicators are not ranked because the two or three scoring possibilities do not make for meaningful distribution of ranks. For United States values, policy indicators display a count of states with any policy credit received.
Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX K | Indicator Data: Choice of Setting and Provider (continued)

	Adult day services total licensed capacity per 10,000 population ages 65+				Home health and personal care aides per 100 population with an Activity of Daily Living (ADL) disability, ages 18+				Percentage of nursing home residents with low care needs (race/ethnicity data available)		LTSS direct service worker wage shortfall compared to other entry level jobs			
State	2016	2020	Rank	Change	2018-19	2020-21	Rank	Change	2021	Rank	2019	2021	Rank	Change
United States	**61**	**54**		✗	**23.2**	**24.8**		↔	**8.8%**					
Alabama	9	8	46	✗	8.0	8.7	51	↔	12.3%	30	$3.40	$3.48	39	↔
Alaska	52	49	16	↔	23.6	21.2	26	✗	11.6%	27	$2.05	$1.58	2	↔
Arizona	8	5	50	✗	23.1	21.9	23	↔	10.5%	24	$2.75	$2.37	16	↔
Arkansas	14	21	32	✓	15.6	18.2	31	✓	14.4%	35	$2.46	$2.44	17	↔
California	171	154	1	↔	28.6	30.8	6	↔	11.4%	26	$3.86	$4.19	48	↔
Colorado	53	50	15	↔	25.6	30.1	7	✓	16.8%	41	$2.48	$2.66	23	↔
Connecticut	34	27	27	✗	32.6	28.5	9	✗	15.8%	37	$2.94	$2.97	31	↔
Delaware	39	67	8	✓	20.1	14.8	42	✗	10.1%	23	$2.32	$3.02	32	↔
District of Columbia	*	13†	42	*	17.8	20.4	28	✓	††	††	$4.36	$5.03	51	↔
Florida	31	32	25	↔	13.5	15.2	40	✓	8.8%	18	$1.89	$2.50	20	↔
Georgia	38	60	10	✓	12.6	15.2	39	✓	8.9%	19	$2.47	$2.69	24	↔
Hawaii	98	100	4	↔	17.4	13.5	44	✗	3.4%	1	$4.67	$3.27	37	↔
Idaho	71	41	21	✗	20.0	26.9	12	✓	13.8%	34	$2.65	$3.18	35	↔
Illinois	21	20	33	↔	25.8	23.6	18	↔	7.3%	15	$3.27	$2.83	28	↔
Indiana	17	19	35	✓	18.5	18.2	30	↔	4.5%	5	$2.81	$3.90	43	↔
Iowa	21	20	33	↔	15.5	15.8	37	↔	14.8%	36	$2.08	$2.45	18	↔
Kansas	8	9	45	✓	18.8	21.4	25	✓	21.2%	43	$3.09	$3.56	40	↔
Kentucky	72	67	8	↔	9.8	10.8	50	↔	5.5%	7	$2.30	$1.75	4	↔
Louisiana	34	18	36	✗	21.5	18.2	29	✗	9.8%	22	$4.34	$4.88	50	↔
Maine	16	18	36	✓	26.5	22.8	20	✗	††	††	$2.36	$1.90	6	↔
Maryland	122	97	5	✗	20.4	22.2	22	↔	4.4%	4	$2.06	$3.02	32	↔
Massachusetts	99	59	12	✗	27.2	31.9	5	✓	12.4%	31	$2.44	$1.95	8	↔
Michigan	23	18	36	✗	17.2	17.8	32	↔	11.0%	25	$2.42	$1.94	7	↔
Minnesota	66	51	14	✗	34.7	38.7	2	✓	16.7%	40	$2.84	$3.64	41	↔
Mississippi	67	60	10	✗	10.9	12.8	48	✓	12.7%	32	$2.71	$2.86	30	↔
Missouri	44	40	22	↔	20.8	23.4	19	✓	25.3%	46	$3.87	$4.08	46	↔
Montana	7	7†	47	*	23.6	17.3	35	✗	20.0%	42	$2.06	$2.28	13	↔
Nebraska	59	27	27	✗	20.5	17.3	34	✗	12.2%	29	$2.77	$2.29	14	↔
Nevada	36	45	18	✓	11.5	13.4	45	✓	8.9%	20	$1.15	$2.32	15	↔
New Hampshire	23	23†	31	*	20.7	27.5	10	✓	††	††	$2.11	$1.56	1	↔
New Jersey	134	126	2	↔	21.7	23.8	16	↔	16.6%	39	$2.37	$3.21	36	↔
New Mexico	20	55	13	✓	36.7	34.5	4	↔	16.3%	38	$1.34	$3.93	44	✗
New York	45	34	24	✗	49.6	55.7	1	✓	5.9%	8	$3.06	$4.12	47	↔
North Carolina	31	24	30	✗	15.6	16.7	36	↔	4.1%	3	$3.35	$2.75	26	↔
North Dakota	48	46	17	↔	25.5	21.2	27	✗	13.4%	33	$3.23	$2.23	12	↔
Ohio	26	15	40	✗	20.6	21.8	24	↔	7.3%	14	$3.09	$3.67	42	↔
Oklahoma	34	27	27	✗	13.6	14.2	43	↔	22.5%	45	$3.39	$2.58	21	↔
Oregon	6	5	50	✗	27.1	23.7	17	✗	7.2%	13	$2.41	$2.74	25	↔
Pennsylvania	66	69	6	↔	29.9	35.2	3	✓	7.3%	16	$2.78	$2.17	11	↔
Rhode Island	61	69	6	✓	18.6	15.2	41	✗	11.8%	28	$2.04	$1.79	5	↔
South Carolina	46	43	19	↔	14.5	12.8	47	✗	7.2%	12	$2.94	$2.84	29	↔
South Dakota	18	18†	36	*	11.0	13.4	46	✓	22.1%	44	$1.43	$1.65	3	↔
Tennessee	20	15	40	✗	15.0	15.4	38	↔	5.1%	6	$2.82	$2.82	27	↔
Texas	125	108	3	✗	26.1	29.1	8	✓	7.0%	11	$4.54	$4.33	49	↔
Utah	6	6†	48	*	10.6	11.2	49	↔	3.6%	2	$2.21	$2.16	9	↔
Vermont	61	42	20	✗	33.0	27.1	11	✗	††	††	$1.95	$2.16	9	↔
Virginia	32	28	26	✗	20.4	22.4	21	↔	7.4%	17	$3.30	$3.96	45	↔
Washington	12	6	48	✗	27.2	24.2	15	✗	6.4%	9	$3.57	$2.48	19	↔
West Virginia	*	13†	42	*	20.1	17.5	33	✗	9.3%	21	$3.75	$3.15	34	↔
Wisconsin	38	37	23	↔	22.9	25.3	13	✓	6.8%	10	$3.13	$2.61	22	↔
Wyoming	*	13†	42	*	31.1	25.0	14	✗	††	††	$3.67	$3.38	38	↔

KEY FOR CHANGE: ✓ Performance Improvement ↔ Little or No Change in Performance ✗ Performance Decline * No Trend Available

* data not available (including concerns about data quality) or not calculated due to missing data needed for calculation.
** indicator not calculated. An imputed value was used for scoring, but not displayed or ranked.
† Data not available or not comparable in original source. AARP estimated values based on additional information (see Appendix E for imputation details).
†† Due to small sample size of one or more racial/ethnic groups, this indicator could not be calculated. An imputed value was used for scoring, but is not displayed or ranked. All available data are shown on ltsschoices.AARP.org
Note: Policy indicators are not ranked because the two or three scoring possibilities do not make for meaningful distribution of ranks.
For United States values, policy indicators display a count of states with any policy credit received.
Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX K | Indicator Data: Choice of Setting and Provider (continued)

	Enrollment in Program of All-Inclusive Care for the Elderly (PACE), per 10,000 population, ages 55+				State policies that require Medicaid provides to allocate a certain dollar amount or percentage of reimbursements to LTSS worker wages	Number of residents in Green House® communities plus state and local policies that facilitate Green House® development	Availability of the Community Aging in Place – Advancing Better Living for Elders (CAPABLE) restorative services model plus state and local policies that facilitate access to CAPABLE
State	2020	2023	Rank	Change	2022	2022	2021
United States	**5.7**	**6.5**		✓	**21 States**	**10 States**	**7 States**
Alabama	1.1	1.2	29	↔			
Alaska	0.0	0.0	33	↔			
Arizona	0.0	0.0	33	↔	Full		
Arkansas	3.5	5.6	18	✓		Full	
California	9.3	15.7	4	✓	Full		
Colorado	29.9	27.5	1	↔	Full	Full	Full
Connecticut	0.0	0.0	33	↔	Full	Full	Full
Delaware	7.8	8.8	10	✓			
District of Columbia	0.0	0.0	33	↔	Full		
Florida	3.2	3.4	21	↔			
Georgia	0.0	0.0	33	↔			
Hawaii	0.0	0.0	33	↔			
Idaho	0.0	0.0	33	↔			
Illinois	0.0	0.0	33	↔	Full		Full
Indiana	2.3	2.3	25	↔	Full	Full	
Iowa	6.3	6.6	14	↔			
Kansas	7.5	10.5	8	✓	Full	Full	
Kentucky	0.0	0.1	31	✓			
Louisiana	3.6	2.9	23	X			
Maine	0.0	0.0	33	↔	Full		
Maryland	0.9	0.8	30	X			
Massachusetts	24.0	24.2	2	↔	Full		Full
Michigan	11.2	14.2	5	✓	Full	Full	
Minnesota	0.0	0.0	33	↔	Full		
Mississippi	0.0	0.0	33	↔		Full	
Missouri	0.0	0.1	32	✓			
Montana	0.0	0.0	33	↔	Full		
Nebraska	4.0	3.6	20	↔			
Nevada	0.0	0.0	33	↔			
New Hampshire	0.0	0.0	33	↔			
New Jersey	4.2	4.5	19	↔			
New Mexico	6.1	7.4	12	✓			
New York	9.9	9.8	9	↔	Full	Full	Full
North Carolina	7.3	6.2	16	X			
North Dakota	8.9	8.7	11	↔			
Ohio	1.6	1.7	26	✓		Full	
Oklahoma	5.4	6.6	15	✓			Full
Oregon	12.6	13.9	6	↔			
Pennsylvania	18.2	18.3	3	↔	Full		
Rhode Island	10.3	11.0	7	↔	Full	Full	
South Carolina	3.0	3.1	22	↔			
South Dakota	0.0	0.0	33	↔			
Tennessee	1.4	1.3	28	↔	Full		
Texas	1.7	1.6	27	↔	Full		
Utah	0.0	0.0	33	↔			
Vermont	0.0	0.0	33	↔			Full
Virginia	5.9	6.7	13	✓			
Washington	4.2	5.8	17	✓	Full		
West Virginia	0.0	0.0	33	↔			
Wisconsin	3.2	2.8	24	X	Full		
Wyoming	7.8	0.0	33	X			

KEY FOR CHANGE: ✓ Performance Improvement ↔ Little or No Change in Performance X Performance Decline ✱ No Trend Available

* data not available (including concerns about data quality) or not calculated due to missing data needed for calculation.
** indicator not calculated. An imputed value was used for scoring, but not displayed or ranked.
† Data not available or not comparable in original source. AARP estimated values based on additional information (see Appendix E for imputation details).
†† Due to small sample size of one or more racial/ethnic groups, this indicator could not be calculated. An imputed value was used for scoring, but is not displayed or ranked. All available data are shown on ltsschoices.AARP.org
Note: Policy indicators are not ranked because the two or three scoring possibilities do not make for meaningful distribution of ranks. For United States values, policy indicators display a count of states with any policy credit received.
Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX L | Indicator Data: Safety and Quality

	Percentage of home health patients with a hospital admission				Percentage of long-stay nursing home residents hospitalized within a six-month period (race/ethnicity data available)		Percentage of high-risk nursing home residents with pressure sores (race/ethnicity data available)		Percentage of nursing home residents who are inappropriately receiving an antipsychotic medication (race/ethnicity data available)	
State	2018	2021	Rank	Change	2021	Rank	2021	Rank	2021	Rank
United States	**15.6%**	**14.1%**		✓	**17.9%**		**11.8%**		**10.3%**	
Alabama	16.7%	14.8%	36	✓	15.9%	17	13.0%	33	16.0%	47
Alaska	14.6%	13.2%	9	✓	14.5%	10	10.7%	17	14.5%	44
Arizona	14.0%	13.2%	9	↔	16.6%	20	14.2%	42	7.2%	2
Arkansas	16.3%	15.1%	45	↔	17.6%	28	12.5%	29	8.2%	7
California	14.1%	13.2%	9	↔	19.5%	40	11.6%	23	6.6%	1
Colorado	14.5%	12.5%	4	✓	11.8%	1	7.1%	1	11.7%	32
Connecticut	16.5%	15.0%	41	✓	15.7%	16	9.2%	10	11.6%	30
Delaware	15.0%	14.1%	22	↔	15.5%	13	8.3%	4	8.1%	6
District of Columbia	14.0%	15.3%	47	✗	18.2%	32	14.3%	43	7.3%	3
Florida	15.1%	14.1%	22	↔	23.1%	49	11.2%	20	8.5%	9
Georgia	16.5%	14.6%	31	✓	17.1%	24	14.0%	40	13.0%	42
Hawaii	14.1%	13.3%	13	↔	13.4%	4	7.2%	2	10.6%	22
Idaho	13.8%	12.3%	2	✓	12.8%	3	††	††	11.3%	27
Illinois	15.8%	14.8%	36	↔	19.1%	36	11.8%	24	10.7%	23
Indiana	15.7%	14.1%	22	✓	16.7%	21	10.0%	12	9.7%	16
Iowa	15.8%	13.4%	14	✓	12.2%	2	10.1%	13	12.2%	38
Kansas	16.7%	14.6%	31	✓	16.1%	18	13.5%	36	10.3%	18
Kentucky	16.0%	14.8%	36	↔	19.5%	39	11.3%	22	12.1%	34
Louisiana	16.3%	14.8%	36	✓	21.2%	47	12.6%	32	10.4%	19
Maine	15.5%	12.6%	6	✓	27.5%	50	††	††	††	††
Maryland	15.1%	13.2%	9	✓	17.5%	25	13.2%	34	11.0%	25
Massachusetts	17.1%	15.6%	50	✓	18.1%	30	9.1%	9	12.5%	40
Michigan	15.5%	14.5%	29	↔	20.7%	44	11.9%	25	9.4%	13
Minnesota	16.3%	12.9%	8	✓	14.5%	9	8.6%	7	12.2%	35
Mississippi	16.7%	15.0%	41	✓	22.0%	48	15.4%	46	15.4%	45
Missouri	16.1%	14.6%	31	✓	17.1%	23	11.0%	19	11.6%	31
Montana	14.7%	12.5%	4	✓	21.0%	46	13.8%	37	12.2%	37
Nebraska	15.9%	14.0%	21	✓	14.0%	7	8.6%	5	12.2%	36
Nevada	15.6%	15.0%	41	↔	20.3%	43	14.1%	41	9.7%	15
New Hampshire	17.0%	15.0%	41	✓	20.8%	45	††	††	25.0%	49
New Jersey	15.7%	14.7%	35	↔	19.4%	38	12.0%	26	7.7%	4
New Mexico	14.4%	13.7%	18	↔	15.7%	14	10.7%	16	11.1%	26
New York	16.4%	14.8%	36	✓	18.2%	31	12.4%	28	8.8%	11
North Carolina	15.5%	14.1%	22	✓	18.7%	35	13.5%	35	9.5%	14
North Dakota	15.3%	13.4%	14	✓	14.5%	11	14.7%	44	22.6%	48
Ohio	15.5%	14.5%	29	↔	17.5%	26	10.6%	15	9.1%	12
Oklahoma	15.5%	13.6%	16	✓	18.6%	33	12.2%	27	8.3%	8
Oregon	14.3%	12.3%	2	✓	16.4%	19	9.3%	11	10.4%	20
Pennsylvania	16.7%	15.4%	49	↔	17.6%	29	10.5%	14	11.9%	33
Rhode Island	16.5%	14.6%	31	✓	15.2%	12	9.1%	8	12.6%	41
South Carolina	15.9%	14.2%	26	✓	19.2%	37	12.5%	30	12.3%	39
South Dakota	16.2%	15.1%	45	↔	13.8%	6	13.8%	38	15.9%	46
Tennessee	16.2%	15.6%	50	↔	20.0%	41	13.9%	39	11.5%	28
Texas	15.1%	13.7%	18	✓	18.6%	34	10.7%	18	7.8%	5
Utah	13.6%	12.8%	7	↔	13.7%	5	7.8%	3	8.6%	10
Vermont	15.9%	14.4%	28	✓	††	††	††	††	††	††
Virginia	15.8%	14.2%	26	✓	17.6%	27	12.5%	31	10.8%	24
Washington	14.7%	12.1%	1	✓	17.1%	22	8.6%	6	10.2%	17
West Virginia	16.5%	15.3%	47	↔	15.7%	15	15.4%	45	11.5%	29
Wisconsin	15.2%	13.7%	18	✓	20.1%	42	11.2%	21	10.5%	21
Wyoming	15.6%	13.6%	16	✓	14.5%	8	††	††	14.5%	43

KEY FOR CHANGE: ✓ Performance Improvement ↔ Little or No Change in Performance ✗ Performance Decline ✱ No Trend Available

†† Due to small sample size of one or more racial/ethnic groups, this indicator could not be calculated. An imputed value was used for scoring, but is not displayed or ranked. All available data are shown on ltsschoices.AARP.org

Note: Policy indicators are not ranked because the two or three scoring possibilities do not make for meaningful distribution of ranks. For United States values, policy indicators display a count of states with any policy credit received.

Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX L | Indicator Data: Safety and Quality (continued)

	State average turnover of nursing staff in nursing homes		Percentage of nursing home residents who are up-to-date on COVID-19 vaccination		Percentage of nursing home health care staff who are up-to-date on COVID-19 vaccination		Percentage of nursing home residents living in a facility with a 5-star rating on Centers for Medicare & Medicaid Services Nursing Home Care Compare Quality Star ratings (race/ethnicity data available)		Nursing home direct care staff hours per resident per day (race/ethnicity data available)	
State	2022	Rank	2023	Rank	2023	Rank	2021	Rank	2021	Rank
United States	**53.9%**		**52.9%**		**21.8%**		**16.0%**		**3.31**	
Alabama	52.2%	15	48.2%	43	10.7%	51	19.0%	21	3.03	35
Alaska	54.7%	26	69.9%	5	22.9%	17	37.6%	2	4.70	1
Arizona	55.0%	28	34.3%	51	13.9%	44	20.2%	19	3.80	5
Arkansas	56.3%	35	57.0%	25	13.4%	47	12.1%	31	3.50	12
California	47.8%	7	58.0%	24	43.2%	2	23.0%	15	4.10	3
Colorado	58.7%	44	64.4%	12	36.2%	8	21.8%	17	3.28	23
Connecticut	43.9%	2	59.9%	18	18.8%	31	11.8%	33	3.11	31
Delaware	46.9%	5	72.1%	3	20.0%	27	35.1%	3	3.39	16
District of Columbia	46.3%	4	60.9%	16	44.8%	1	16.3%	26	4.13	2
Florida	54.0%	23	35.8%	50	13.4%	46	25.2%	12	3.75	6
Georgia	54.0%	23	50.7%	39	15.2%	40	7.0%	42	2.98	37
Hawaii	39.3%	1	71.6%	4	38.9%	4	49.6%	1	3.48	13
Idaho	56.1%	32	55.8%	27	18.1%	36	24.9%	13	3.38	18
Illinois	52.1%	14	59.8%	19	30.6%	9	6.0%	44	2.58	48
Indiana	57.4%	39	51.8%	37	15.3%	39	5.4%	47	2.86	40
Iowa	56.1%	32	67.4%	9	20.3%	25	16.7%	25	3.09	33
Kansas	57.4%	39	55.4%	29	17.0%	37	12.0%	32	2.76	45
Kentucky	56.7%	37	55.3%	30	14.1%	42	8.2%	36	3.08	34
Louisiana	55.4%	29	53.1%	34	15.7%	38	2.5%	49	2.99	36
Maine	55.5%	30	59.6%	20	21.4%	19	33.3%	5	3.56	10
Maryland	49.3%	9	61.5%	15	27.3%	11	17.1%	24	3.34	20
Massachusetts	47.1%	6	67.8%	8	39.5%	3	21.5%	18	3.44	14
Michigan	53.1%	18	49.1%	41	13.7%	45	15.4%	27	3.19	25
Minnesota	50.9%	12	69.5%	6	20.9%	20	29.2%	8	3.32	21
Mississippi	52.4%	16	45.8%	45	11.4%	49	5.6%	46	3.14	29
Missouri	60.4%	46	50.9%	38	15.0%	41	4.7%	48	2.62	46
Montana	63.2%	51	57.0%	26	19.7%	29	33.7%	4	2.44	50
Nebraska	56.1%	32	66.6%	11	18.1%	35	28.4%	10	2.54	49
Nevada	53.7%	21	39.6%	49	18.6%	34	7.0%	43	3.60	9
New Hampshire	51.7%	13	66.8%	10	25.0%	14	††	††	3.09	32
New Jersey	48.8%	8	59.5%	21	37.6%	5	22.8%	16	3.54	11
New Mexico	61.2%	49	53.6%	32	37.3%	6	24.5%	14	2.81	42
New York	45.0%	3	50.6%	40	22.5%	18	25.6%	11	3.31	22
North Carolina	57.2%	38	54.9%	31	18.6%	33	7.7%	37	2.95	39
North Dakota	53.1%	18	74.9%	2	20.1%	26	18.3%	22	3.83	4
Ohio	58.1%	42	43.2%	47	12.9%	48	7.6%	39	3.17	28
Oklahoma	61.0%	48	52.0%	36	20.5%	21	8.8%	35	2.59	47
Oregon	54.6%	25	53.3%	33	25.2%	13	33.2%	6	3.66	8
Pennsylvania	50.7%	11	55.7%	28	18.8%	32	5.7%	45	3.18	26
Rhode Island	49.8%	10	58.0%	23	30.1%	10	17.4%	23	2.97	38
South Carolina	57.7%	41	47.0%	44	14.0%	43	13.4%	28	3.39	17
South Dakota	53.8%	22	76.8%	1	20.3%	24	12.5%	29	2.36	51
Tennessee	55.7%	31	45.7%	46	10.7%	50	11.5%	34	3.18	27
Texas	59.7%	45	39.8%	48	20.3%	23	7.4%	41	2.77	44
Utah	60.4%	46	48.8%	42	23.3%	16	28.5%	9	3.38	19
Vermont	61.3%	50	69.0%	7	36.2%	7	††	††	3.41	15
Virginia	56.5%	36	52.7%	35	19.9%	28	12.5%	30	2.78	43
Washington	54.9%	27	59.1%	22	23.8%	15	30.8%	7	3.75	7
West Virginia	52.6%	17	62.6%	13	19.4%	30	7.7%	38	3.11	30
Wisconsin	53.1%	18	60.7%	17	20.4%	22	7.5%	40	3.23	24
Wyoming	58.4%	43	62.6%	14	25.3%	12	19.1%	20	2.86	41

KEY FOR CHANGE: ✓ Performance Improvement ↔ Little or No Change in Performance X Performance Decline ✱ No Trend Available

†† Due to small sample size of one or more racial/ethnic groups, this indicator could not be calculated. An imputed value was used for scoring, but is not displayed or ranked. All available data are shown on ltsschoices.AARP.org

Note: Policy indicators are not ranked because the two or three scoring possibilities do not make for meaningful distribution of ranks.
For United States values, policy indicators display a count of states with any policy credit received.
Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX L | Indicator Data: Safety and Quality (continued)

	HCBS quality cross-state benchmarking capability: Use of National Core Indicators –Aging/ Disability survey for one or more HCBS programs			HCBS quality cross-state benchmarking capability: use of HCBS Consumer Assessment of Healthcare Providers and Services survey for one or more HCBS programs			HCBS quality cross-state benchmarking capability: National Committee for Quality Assurance Statewide Accreditation for one or more HCBS programs			State has an Enhanced State Hazard Mitigation Plan approved by FEMA and uses a social vulnerability index to help SHMP account for older adults and people with disabilities
State	2019	2023	Change	2017-18	2022-23	Change	2020	2023	Change	2023
United States	**19 States**	**23 States**	✓	**11 States**	**10 States**	✗	**7 States**	**12 States**	✓	**9 States**
Alabama		Full	✓			↔	Full	Full	↔	
Alaska			↔			↔			↔	
Arizona			↔	Full	Full	↔		Full	✓	
Arkansas			↔		Full	✓			↔	
California			↔			↔			↔	Full
Colorado	Full	Full	↔			↔			↔	Full
Connecticut			↔	Full	Full	↔			↔	
Delaware	Full	Full	↔		Full	✓			↔	
District of Columbia			↔			↔			↔	
Florida			↔	Full	Full	↔			↔	
Georgia	Full	Full	↔			↔			↔	Full
Hawaii			↔			↔			↔	
Idaho			↔			↔			↔	
Illinois			↔	Full		✗			↔	
Indiana	Full	Full	↔		Full	✓		Full	✓	
Iowa			↔			↔		Full	✓	
Kansas	Full	Full	↔	Full	Full	↔	Full	Full	↔	
Kentucky		Full	✓			↔			↔	
Louisiana			↔		Full	✓			↔	
Maine	Full		✗			↔			↔	
Maryland			↔	Full		✗			↔	
Massachusetts			↔			↔	Full	Full	↔	
Michigan		Full	✓			↔		Full	✓	
Minnesota	Full	Full	↔			↔			↔	
Mississippi	Full		✗	Full		✗			↔	
Missouri		Full	✓			↔			↔	Full
Montana			↔			↔			↔	
Nebraska	Full	Full	↔			↔			↔	
Nevada	Full		✗			↔			↔	
New Hampshire			↔	Full		✗			↔	
New Jersey	Full	Full	↔	Full		✗			↔	
New Mexico			↔			↔			↔	
New York			↔			↔			↔	
North Carolina	Full		✗			↔	Full	Full	↔	Full
North Dakota		Full	✓			↔			↔	Full
Ohio	Full	Full	↔			↔		Full	✓	
Oklahoma		Full	✓			↔			↔	
Oregon	Full	Full	↔			↔			↔	
Pennsylvania			↔	Full	Full	↔	Full	Full	↔	Full
Rhode Island			↔			↔			↔	
South Carolina			↔			↔			↔	
South Dakota		Full	✓			↔			↔	Full
Tennessee	Full	Full	↔			↔	Full	Full	↔	
Texas	Full	Full	↔			↔			↔	
Utah		Full	✓			↔			↔	
Vermont	Full	Full	↔			↔			↔	
Virginia			↔			↔	Full	Full	↔	
Washington	Full	Full	↔			↔			↔	Full
West Virginia			↔	Full	Full	↔			↔	
Wisconsin	Full	Full	↔			↔			↔	
Wyoming			↔			↔			↔	

KEY FOR CHANGE: ✓ Performance Improvement ↔ Little or No Change in Performance ✗ Performance Decline ✱ No Trend Available

†† Due to small sample size of one or more racial/ethnic groups, this indicator could not be calculated. An imputed value was used for scoring, but is not displayed or ranked. All available data are shown on ltsschoices.AARP.org
Note: Policy indicators are not ranked because the two or three scoring possibilities do not make for meaningful distribution of ranks.
For United States values, policy indicators display a count of states with any policy credit received.
Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX M | Indicator Data: Support for Family Caregivers

	Health maintenance tasks that nurses may delegate to a direct care aide				Nurse practitioner scope of practice			Family Responsibility Protected Classification			State Exceeds Federal FMLA (Family Medical Leave Act)		
State	2019	2022	Rank	Change	2019	2023	Change	2020	2023	Change	2019	2022	Change
United States	**14**	**15**		✓	**39 States**	**40 States**	✓	**3 States**	**7 States**	✓	**10 States**	**11 States**	✓
Alabama	2	13	34	✓	Partial	Partial	↔			↔			↔
Alaska	16	16	29	↔	Full	Full	↔		Full	✓			↔
Arizona	17	17	24	↔	Full	Full	↔			↔			↔
Arkansas	20	20	16	↔	Partial	Partial	↔			↔			↔
California	3	3	45	↔			↔			↔		Full	✓
Colorado	22	22	1	↔	Full	Full	↔			↔			↔
Connecticut	3	3	45	↔	Full	Full	↔	Full	Full	↔	Full	Full	↔
Delaware	5	5	42	↔	Partial	Full	✓	Full	Full	↔			↔
District of Columbia	13	13	34	↔	Full	Full	↔	Full	Full	↔	Full	Full	↔
Florida	0	0	49	↔			↔			↔			↔
Georgia	19	19	17	↔			↔			↔			↔
Hawaii	17	17	24	↔	Full	Full	↔			↔	Full	Full	↔
Idaho	22	22	1	↔	Full	Full	↔			↔			↔
Illinois	2	11	40	✓	Partial	Partial	↔			↔			↔
Indiana	0	15	31	✓	Partial	Partial	↔			↔			↔
Iowa	21	21	12	↔	Full	Full	↔			↔			↔
Kansas	8	8	41	↔	Partial	Full	✓			↔			↔
Kentucky	18	19	17	✓	Partial	Partial	↔			↔			↔
Louisiana	12	15	31	✓	Partial	Partial	↔			↔			↔
Maine	11	12	37	✓	Full	Full	↔		Full	✓	Full	Full	↔
Maryland	17	18	20	✓	Full	Full	↔			↔			↔
Massachusetts	3	3	45	↔		Full	✓			↔			↔
Michigan	17	17	24	↔			↔			↔			↔
Minnesota	22	22	1	↔	Full	Full	↔		Full	✓	Full	Full	↔
Mississippi	4	5	42	✓	Partial	Partial	↔			↔			↔
Missouri	22	22	1	↔			↔			↔			↔
Montana	22	22	1	↔	Full	Full	↔			↔			↔
Nebraska	22	22	1	↔	Full	Full	↔			↔			↔
Nevada	21	21	12	↔	Full	Full	↔			↔			↔
New Hampshire	16	16	29	↔	Full	Full	↔			↔			↔
New Jersey	22	22	1	↔	Partial	Partial	↔			↔	Full	Full	↔
New Mexico	22	22	1	↔	Full	Full	↔			↔			↔
New York	15	15	31	↔	Partial	Full	✓		Full	✓			↔
North Carolina	21	12	37	X			↔			↔			↔
North Dakota	18	18	20	↔	Full	Full	↔			↔			↔
Ohio	12	12	37	↔	Partial	Partial	↔			↔			↔
Oklahoma	18	18	20	↔			↔			↔			↔
Oregon	22	22	1	↔	Full	Full	↔			↔	Full	Full	↔
Pennsylvania	0	0	49	↔	Partial	Partial	↔			↔			↔
Rhode Island	0	0	49	↔	Full	Full	↔			↔	Full	Full	↔
South Carolina	3	3	45	↔			↔			↔			↔
South Dakota	16	18	20	✓	Full	Full	↔			↔			↔
Tennessee	4	4	44	↔			↔			↔			↔
Texas	21	21	12	↔			↔			↔			↔
Utah	19	19	17	↔	Partial	Full	✓			✓			↔
Vermont	22	22	1	↔	Full	Full	↔			↔	Full	Full	↔
Virginia	17	17	24	↔			↔			↔			↔
Washington	21	21	12	↔	Full	Full	↔			↔			↔
West Virginia	13	13	34	↔	Partial	Partial	↔			↔			↔
Wisconsin	22	22	1	↔	Partial	Partial	↔			↔	Full	Full	↔
Wyoming	16	17	24	✓	Full	Full	↔			↔			↔

KEY FOR CHANGE: ✓ Performance Improvement ↔ Little or No Change in Performance X Performance Decline ✱ No Trend Available

Note: Policy indicators are not ranked because the two or three scoring possibilities do not make for meaningful distribution of ranks.
For United States values, policy indicators display a count of states with any policy credit received.
Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX M | Indicator Data: Support for Family Caregivers (continued)

	Statewide paid family leave enacted			Statewide policy mandating provision of paid sick days or leave			Statewide policy that allows for paid sick time to be used to care for someone else			States with unemployment insurance laws that provide good cause for separation for family caregiving		
State	2019	2022	Change	2019	2023	Change	2018	2022	Change	2019	2022	Change
United States	**9 States**	**12 States**	✓	**13 States**	**18 States**	✓	**17 States**	**18 States**	✓	**26 States**	**27 States**	✓
Alabama			↔			↔			↔			↔
Alaska			↔			↔			↔	Full	Full	↔
Arizona			↔	Full	Full	↔	Full	Full	↔	Full	Full	↔
Arkansas			↔			↔			↔	Full	Full	↔
California	Full	Full	↔	Full	Full	↔	Full	Full	↔	Full	Full	↔
Colorado		Full	✓		Full	✓		Full	✓	Full	Full	↔
Connecticut	Full	Full	↔	Full	Full	↔	Full	Full	↔	Full	Full	↔
Delaware		Full	✓			↔			↔	Full	Full	↔
District of Columbia	Full	Full	↔	Full	Full	↔	Full	Full	↔	Full	Full	↔
Florida			↔			↔			↔			↔
Georgia			↔			↔			↔			↔
Hawaii			↔			↔			↔	Full	Full	↔
Idaho			↔			↔			↔			↔
Illinois			↔			↔			↔	Full	Full	↔
Indiana			↔			↔			↔			↔
Iowa			↔			↔			↔			↔
Kansas			↔			↔			↔	Full	Full	↔
Kentucky			↔			↔			↔			↔
Louisiana			↔			↔			↔			↔
Maine			↔		Full	✓	Full	Full	↔	Full	Full	↔
Maryland		Full	✓	Full	Full	↔	Full	Full	↔			↔
Massachusetts	Full	Full	↔	Full	Full	↔	Full	Full	↔	Full	Full	↔
Michigan			↔	Full	Full	↔	Full	Full	↔			↔
Minnesota			↔		Full	✓	Full	Full	↔	Full	Full	↔
Mississippi			↔			↔			↔			↔
Missouri			↔			↔			↔			↔
Montana			↔			↔			↔			↔
Nebraska			↔			↔			↔		Full	✓
Nevada			↔	Full	Full	↔			↔	Full	Full	↔
New Hampshire			↔			↔			↔	Full	Full	↔
New Jersey	Full	Full	↔	Full	Full	↔	Full	Full	↔			↔
New Mexico			↔		Full	✓	Full	Full	↔			↔
New York	Full	Full	↔		Full	✓	Full	Full	↔	Full	Full	↔
North Carolina			↔			↔			↔			↔
North Dakota			↔			↔			↔			↔
Ohio			↔			↔			↔			↔
Oklahoma			↔			↔			↔	Full	Full	↔
Oregon	Full	Full	↔	Full	Full	↔	Full	Full	↔	Full	Full	↔
Pennsylvania			↔			↔			↔	Full	Full	↔
Rhode Island	Full	Full	↔	Full	Full	↔	Full	Full	↔	Full	Full	↔
South Carolina			↔			↔			↔	Full	Full	↔
South Dakota			↔			↔			↔			↔
Tennessee			↔			↔			↔			↔
Texas			↔			↔			↔			↔
Utah			↔			↔			↔	Full	Full	↔
Vermont			↔	Full	Full	↔	Full	Full	↔			↔
Virginia			↔			↔			↔	Full	Full	↔
Washington	Full	Full	↔	Full	Full	↔	Full	Full	↔	Full	Full	↔
West Virginia			↔			↔			↔			↔
Wisconsin			↔			↔	Full	Full	↔	Full	Full	↔
Wyoming			↔			↔			↔			↔

KEY FOR CHANGE: ✓ Performance Improvement ↔ Little or No Change in Performance X Performance Decline ✱ No Trend Available

Note: Policy indicators are not ranked because the two or three scoring possibilities do not make for meaningful distribution of ranks.
For United States values, policy indicators display a count of states with any policy credit received.
Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX M | Indicator Data: Support for Family Caregivers (continued)

	Spousal Impoverishment Protections	CARE (Caregiver, Advise, Inform and Enable) Act Legislation passed into law			Availability of respite to family caregivers as service through Medicaid HCBS waivers	Availability of state caregiver tax credits
State	2023	2019	2023	Change	2022	2023
United States	**13 States**	**41 States**	**43 States**	✓	**48 States**	**6 States**
Alabama				↔	Partial	
Alaska	Full	Full	Full	↔	Partial	
Arizona			Full	✓	Full	
Arkansas		Full	Full	↔	Partial	
California	Full	Full	Full	↔	Partial	
Colorado	Full	Full	Full	↔	Partial	
Connecticut		Full	Full	↔	Partial	
Delaware		Full	Full	↔	Partial	
District of Columbia		Full	Full	↔	Partial	
Florida	Full			↔	Full	
Georgia	Full		Full	✓	Partial	Full
Hawaii	Full	Full	Full	↔	Full	
Idaho				↔	Full	
Illinois	Partial	Full	Full	↔	Partial	
Indiana		Full	Full	↔	Full	
Iowa		Full	Full	↔	Partial	
Kansas		Full	Full	↔		
Kentucky		Full	Full	↔	Partial	
Louisiana	Full	Full	Full	↔	Partial	
Maine		Full	Full	↔	Partial	
Maryland		Full	Full	↔	Partial	
Massachusetts	Full	Full	Full	↔	Full	
Michigan		Full	Full	↔	Partial	
Minnesota	Full	Full	Full	↔	Partial	
Mississippi	Full	Full	Full	↔	Partial	
Missouri		Full	Full	↔	Full	Full
Montana		Full	Full	↔	Partial	Full
Nebraska		Full	Full	↔	Partial	
Nevada		Full	Full	↔	Partial	
New Hampshire		Full	Full	↔	Partial	
New Jersey		Full	Full	↔	Partial	Full
New Mexico		Full	Full	↔	Partial	
New York		Full	Full	↔	Partial	
North Carolina				↔	Partial	
North Dakota		Full	Full	↔	Partial	Full
Ohio		Full	Full	↔	Full	
Oklahoma		Full	Full	↔	Full	
Oregon		Full	Full	↔		
Pennsylvania		Full	Full	↔	Partial	
Rhode Island		Full	Full	↔		
South Carolina				↔	Partial	Full
South Dakota				↔	Partial	
Tennessee		Full	Full	↔	Partial	
Texas		Full	Full	↔	Partial	
Utah		Full	Full	↔	Partial	
Vermont	Full			↔	Partial	
Virginia		Full	Full	↔	Partial	
Washington		Full	Full	↔	Full	
West Virginia		Full	Full	↔	Partial	
Wisconsin				↔	Full	
Wyoming	Full	Full	Full	↔	Partial	

KEY FOR CHANGE: ✓ Performance Improvement ↔ Little or No Change in Performance ✗ Performance Decline ✱ No Trend Available

Note: Policy indicators are not ranked because the two or three scoring possibilities do not make for meaningful distribution of ranks.
For United States values, policy indicators display a count of states with any policy credit received.
Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX N | Indicator Data: Community Integration

	Rate of employment for adults with ADL disabilities ages 18-64 relative to rate of employment for adults without ADL disabilities ages 18-64				Percentage of people admitted to nursing homes who were successfully discharged to the community within 100 days (race/ethnicity data available)		Livability Index: Transportation Category Score (race/ethnicity data available)	
State	2018-19	2021	Rank	Change	2020	Rank	2022	Rank
United States	**21.6%**	**21.6%**		↔	**44.7%**		**47**	
Alabama	15.9%	17.0%	46	↔	44.7%	20	41	49
Alaska	29.0%	36.3%	1	✓	6.7%	51	40	50
Arizona	19.3%	25.8%	14	✓	36.3%	34	46	30
Arkansas	16.5%	19.9%	37	✓	34.4%	40	44	44
California	20.8%	19.5%	38	↔	38.5%	29	49	20
Colorado	23.5%	25.2%	15	↔	38.1%	32	50	15
Connecticut	26.5%	25.2%	16	↔	52.3%	1	46	34
Delaware	21.4%	27.0%	12	✓	33.4%	41	45	37
District of Columbia	18.8%	29.7%	7	✓	28.6%	47	69	1
Florida	21.4%	24.5%	17	✓	45.6%	18	47	26
Georgia	19.7%	24.5%	18	✓	38.2%	31	41	48
Hawaii	27.1%	27.0%	11	↔	36.0%	37	54	4
Idaho	26.2%	19.3%	41	✗	43.3%	22	48	22
Illinois	21.4%	22.9%	22	↔	36.3%	35	47	24
Indiana	21.1%	22.4%	27	↔	48.3%	10	45	39
Iowa	25.9%	22.6%	24	✗	43.3%	23	51	13
Kansas	24.1%	22.1%	29	✗	30.6%	46	48	23
Kentucky	17.0%	18.9%	43	✓	47.4%	13	42	46
Louisiana	21.4%	21.5%	32	↔	37.2%	33	47	29
Maine	15.6%	13.7%	51	✗	45.9%	17	52	9
Maryland	27.6%	24.3%	19	✗	51.0%	5	46	32
Massachusetts	21.6%	19.4%	40	✗	48.0%	11	50	17
Michigan	18.4%	16.9%	47	↔	49.4%	6	44	45
Minnesota	30.9%	31.1%	4	↔	38.3%	30	50	16
Mississippi	18.1%	16.1%	48	✗	31.0%	43	38	51
Missouri	18.9%	20.6%	35	✓	36.3%	36	45	40
Montana	38.6%	30.2%	6	✗	30.9%	44	56	3
Nebraska	21.3%	27.5%	10	✓	35.4%	39	50	18
Nevada	24.9%	18.9%	42	✗	40.7%	27	51	11
New Hampshire	23.3%	31.0%	5	✓	41.0%	25	47	25
New Jersey	21.2%	21.8%	31	↔	51.4%	4	53	5
New Mexico	22.3%	27.6%	9	✓	44.7%	21	51	12
New York	21.1%	17.7%	45	✗	35.7%	38	52	7
North Carolina	21.3%	22.3%	28	↔	51.7%	2	45	42
North Dakota	35.7%	32.7%	3	✗	20.0%	50	53	6
Ohio	25.0%	20.0%	36	✗	46.8%	14	45	35
Oklahoma	26.3%	22.1%	30	✗	32.0%	42	46	31
Oregon	20.9%	22.6%	25	↔	47.6%	12	50	19
Pennsylvania	20.2%	20.7%	34	↔	49.2%	7	48	21
Rhode Island	15.3%	15.4%	49	↔	45.3%	19	61	2
South Carolina	19.8%	18.8%	44	↔	39.3%	28	46	33
South Dakota	41.6%	26.4%	13	✗	27.4%	48	51	14
Tennessee	19.8%	19.5%	39	↔	48.5%	9	42	47
Texas	22.4%	23.7%	21	↔	42.9%	24	45	41
Utah	28.5%	34.1%	2	✓	40.9%	26	51	10
Vermont	24.0%	22.4%	26	↔	46.0%	16	52	8
Virginia	25.5%	24.0%	20	↔	48.5%	8	44	43
Washington	23.6%	22.7%	23	↔	46.4%	15	45	36
West Virginia	18.7%	13.9%	50	✗	30.8%	45	45	38
Wisconsin	21.2%	21.1%	33	↔	51.5%	3	47	28
Wyoming	29.6%	29.4%	8	↔	24.5%	49	47	27

KEY FOR CHANGE: ✓ Performance Improvement ↔ Little or No Change in Performance ✗ Performance Decline ✱ No Trend Available

Note: Policy indicators are not ranked because the two or three scoring possibilities do not make for meaningful distribution of ranks.
For United States values, policy indicators display a count of states with any policy credit received.
Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX N | Indicator Data: Community Integration (continued)

	Livability Index: Housing Category Score (race/ethnicity data available)		Percent of people with disabilities eligible for housing assistance but not enrolled		Presence of age-friendly health sites as designated by the Institute for Healthcare Improvement per population age 65+		Existence of Multisector Plan on Aging or comparable statewide strategic plan
State	2022	Rank	2020-22	Rank	2023	Rank	2023
United States	**48**		**15.6%**		**53**		**8 States**
Alabama	49	22	14.0%	26	10	47	
Alaska	44	39	17.4%	19	10	46	
Arizona	55	4	10.0%	45	46	29	
Arkansas	53	9	11.0%	41	23	40	
California	42	41	17.0%	20	28	37	Full
Colorado	42	43	13.4%	30	13	45	Full
Connecticut	39	47	17.4%	18	68	11	
Delaware	49	23	11.7%	36	60	14	
District of Columbia	42	45	42.6%	1	233	2	
Florida	51	14	7.9%	51	50	19	
Georgia	49	20	13.4%	29	38	35	
Hawaii	37	50	20.4%	10	128	4	
Idaho	48	26	14.1%	25	22	42	
Illinois	42	42	13.3%	31	56	15	
Indiana	50	16	20.8%	8	306	1	
Iowa	53	10	12.2%	34	19	43	
Kansas	49	24	11.6%	38	67	12	
Kentucky	50	18	11.5%	40	44	31	
Louisiana	50	17	10.6%	44	17	44	
Maine	55	5	19.2%	14	125	5	
Maryland	39	46	19.6%	12	54	16	
Massachusetts	37	49	29.3%	4	95	7	Full
Michigan	43	40	14.2%	24	49	21	
Minnesota	48	27	29.3%	3	48	25	
Mississippi	52	12	11.6%	39	6	51	
Missouri	48	28	13.7%	27	42	32	Partial
Montana	53	11	14.9%	23	23	39	
Nebraska	54	8	13.0%	32	221	3	
Nevada	46	33	12.7%	33	46	28	
New Hampshire	46	31	20.6%	9	75	10	
New Jersey	38	48	19.4%	13	49	23	
New Mexico	49	19	8.7%	48	28	38	
New York	45	35	28.2%	5	76	8	Partial
North Carolina	47	29	11.9%	35	62	13	Partial
North Dakota	57	1	16.7%	21	120	6	
Ohio	47	30	18.0%	15	49	22	
Oklahoma	49	25	9.2%	46	39	33	
Oregon	46	32	19.8%	11	52	17	
Pennsylvania	54	7	16.7%	22	49	20	
Rhode Island	35	51	31.8%	2	75	9	
South Carolina	46	34	8.3%	49	52	18	
South Dakota	55	3	21.4%	7	6	50	
Tennessee	45	36	10.8%	43	46	27	
Texas	52	13	10.8%	42	45	30	
Utah	45	37	9.0%	47	39	34	Partial
Vermont	51	15	23.7%	6	23	41	Partial
Virginia	42	44	13.7%	28	48	24	
Washington	44	38	17.9%	16	47	26	
West Virginia	57	2	8.1%	50	8	49	
Wisconsin	49	21	17.6%	17	28	36	
Wyoming	54	6	11.6%	37	10	48	

KEY FOR CHANGE: ✓ Performance Improvement ↔ Little or No Change in Performance X Performance Decline ✱ No Trend Available

Note: Policy indicators are not ranked because the two or three scoring possibilities do not make for meaningful distribution of ranks.
For United States values, policy indicators display a count of states with any policy credit received.
Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX O | Detailed Indicator Data: Private Pay Affordability

State	Median Household Income Ages 65+, 2018	Median Annual Cost of Care, 2021		Median Cost as a Percentage of Median Household Income*	
		Nursing Home Private Room	30 Hours/Week of Home Care	Nursing Home Private Room	30 Hours/Week of Home Care
United States	**$50,969**	**$108,405**	**$42,120**	**213%**	**83%**
Alabama	$41,927	$84,315	$31,200	201%	75%
Alaska	$63,567	$378,140	$46,800	595%	74%
Arizona	$54,411	$96,360	$44,460	177%	82%
Arkansas	$40,247	$80,300	$34,320	200%	85%
California	$62,083	$146,000	$49,920	235%	80%
Colorado	$59,069	$116,800	$52,260	198%	88%
Connecticut	$60,217	$182,135	$43,680	302%	73%
Delaware	$60,707	$151,110	$43,680	249%	72%
District of Columbia	$60,159	$125,925	$45,240	209%	76%
Florida	$50,014	$115,705	$39,000	231%	78%
Georgia	$48,559	$91,250	$35,880	188%	74%
Hawaii	$74,606	$169,360	$46,800	227%	63%
Idaho	$49,731	$109,500	$44,460	220%	89%
Illinois	$51,393	$85,775	$43,680	167%	85%
Indiana	$46,803	$104,390	$39,000	223%	83%
Iowa	$48,171	$89,425	$45,240	186%	95%
Kansas	$47,612	$81,760	$38,220	172%	80%
Kentucky	$42,134	$95,630	$39,000	227%	93%
Louisiana	$39,946	$72,635	$30,420	182%	76%
Maine	$46,314	$135,050	$46,800	292%	101%
Maryland	$66,528	$146,000	$42,120	219%	63%
Massachusetts	$57,075	$162,425	$48,360	285%	85%
Michigan	$48,534	$118,260	$45,240	244%	93%
Minnesota	$53,323	$156,950	$56,160	294%	106%
Mississippi	$38,527	$87,600	$31,200	228%	81%
Missouri	$46,550	$71,175	$39,000	153%	84%
Montana	$47,180	$96,725	$43,680	205%	93%
Nebraska	$48,587	$99,645	$43,680	205%	90%
Nevada	$51,777	$120,085	$42,120	232%	81%
New Hampshire	$59,123	$144,175	$50,700	244%	86%
New Jersey	$61,139	$146,000	$46,722	239%	76%
New Mexico	$47,049	$100,375	$37,440	213%	81%
New York	$52,702	$158,775	$45,240	301%	86%
North Carolina	$45,982	$98,550	$35,880	214%	78%
North Dakota	$47,170	$151,110	$46,550	320%	99%
Ohio	$46,269	$98,550	$41,340	213%	89%
Oklahoma	$43,065	$73,000	$39,780	170%	92%
Oregon	$53,732	$133,225	$49,920	248%	93%
Pennsylvania	$48,257	$133,955	$40,560	277%	84%
Rhode Island	$52,485	$120,450	$48,360	229%	93%
South Carolina	$47,463	$95,995	$36,660	202%	77%
South Dakota	$47,737	$91,250	$48,360	191%	101%
Tennessee	$44,943	$91,980	$37,440	205%	83%
Texas	$48,825	$85,045	$37,440	174%	77%
Utah	$59,711	$109,500	$46,800	183%	78%
Vermont	$53,579	$133,225	$46,800	249%	87%
Virginia	$58,282	$109,865	$40,529	189%	70%
Washington	$58,752	$125,560	$53,820	214%	92%
West Virginia	$41,438	$146,730	$29,250	354%	71%
Wisconsin	$47,407	$116,800	$46,800	246%	99%
Wyoming	$53,974	$91,615	$45,240	170%	84%

*These ratios are calculated at the state level, previously at the market level, which will account for value differences with previous *Scorecard* reports. Data: Genworth 2021 Cost of Care Survey; 2021 American Community Survey, Table B19049.
Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX P | Detailed Indicator Data: ADRC/NWD Functions, 2023

State	State Governance and Administration (10 criteria)	Target Populations (5 criteria)	Public Outreach and Coordination (8 criteria)	Person-Centered Counseling (9 criteria)	Streamlined Eligibility for Public Programs (9 criteria)	Overall Percentage Score	Rank
United States	**66%**	**81%**	**69%**	**83%**	**64%**	**72%**	
Alabama	91%	93%	85%	99%	89%	92%	7
Alaska	49%	87%	38%	69%	37%	53%	44
Arizona	21%	67%	48%	98%	61%	58%	39
Arkansas	47%	100%	40%	81%	76%	66%	35
California	43%	67%	40%	44%	28%	42%	46
Colorado	56%	67%	63%	53%	50%	56%	40
Connecticut	89%	100%	98%	94%	78%	91%	9
Delaware	73%	87%	71%	96%	85%	82%	20
District of Columbia	92%	93%	92%	90%	80%	89%	10
Florida	69%	100%	63%	96%	78%	80%	23
Georgia	97%	100%	88%	89%	63%	86%	15
Hawaii	80%	80%	83%	79%	67%	77%	26
Idaho	57%	13%	88%	96%	50%	65%	36
Illinois	65%	100%	54%	100%	93%	81%	22
Indiana	52%	73%	63%	81%	57%	64%	37
Iowa	55%	73%	58%	69%	30%	55%	41
Kansas	53%	100%	69%	84%	65%	71%	31
Kentucky	95%	100%	73%	90%	80%	87%	14
Louisiana	63%	73%	88%	81%	56%	72%	30
Maine	39%	73%	60%	74%	39%	55%	42
Maryland	74%	87%	83%	98%	81%	84%	19
Massachusetts	90%	100%	98%	100%	81%	93%	5
Michigan	54%	100%	60%	75%	67%	68%	33
Minnesota	90%	93%	96%	99%	83%	92%	6
Mississippi	89%	100%	83%	98%	70%	87%	12
Missouri	85%	100%	67%	100%	78%	85%	18
Montana	16%	67%	50%	61%	39%	44%	45
Nebraska	54%	73%	65%	62%	30%	55%	43
Nevada	44%	93%	71%	81%	57%	66%	34
New Hampshire	97%	100%	92%	100%	89%	95%	3
New Jersey	91%	73%	65%	100%	100%	88%	11
New Mexico	6%	60%	25%	90%	37%	41%	47
New York	86%	100%	88%	96%	70%	87%	13
North Carolina	0%	47%	25%	46%	2%	21%	50
North Dakota	76%	67%	67%	80%	72%	73%	29
Ohio	98%	100%	85%	99%	96%	96%	2
Oklahoma	60%	40%	63%	80%	56%	61%	38
Oregon	92%	100%	75%	99%	93%	91%	8
Pennsylvania	80%	100%	83%	99%	74%	86%	17
Rhode Island	91%	93%	69%	99%	80%	86%	16
South Carolina	44%	27%	42%	35%	31%	37%	48
South Dakota	71%	100%	71%	93%	67%	78%	24
Tennessee	82%	93%	75%	71%	57%	74%	28
Texas	83%	67%	83%	73%	78%	78%	25
Utah	34%	27%	29%	35%	26%	31%	49
Vermont	33%	73%	71%	93%	80%	69%	32
Virginia	89%	100%	71%	95%	59%	82%	21
Washington	91%	100%	100%	93%	94%	95%	4
West Virginia	79%	100%	63%	89%	63%	77%	27
Wisconsin	97%	93%	92%	100%	100%	97%	1
Wyoming	2%	27%	31%	44%	4%	20%	51

Note: ADRC/NWD = Aging and Disability Resource Center/No Wrong Door.
Data: AARP PPI (2022), ADRC/No Wrong Door state survey conducted in collaboration with The Lewin Group and US Administration for Community Living (unpublished). Washington, DC: AARP Public Policy Institute.
Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX Q | Detailed Indicator Data: Health Maintenance Tasks Able to be Delegated to LTSS Workers

State	Health Maintenance Tasks, 2022 (1 point each task)												
	Administer Oral Medications	Administer Medication on an as Needed Basis	Administer Medication via Pre-Filled Insulin or Insulin Pen	Draw up Insulin for Dosage Measurement	Other Injectable Medication	Administer Glucometer Test	Administer Medication through Tubes	Insert Suppository	Administer Eye/Ear Drops	Non-Sterile/ Clean Wound Care	Sterile Wound Care	Nasogastric Tube Feeding	Gastrostomy Tube Feeding
Alabama	Y	Y			Y	Y		Y	Y	Y			
Alaska	Y	Y	Y	Y	Y	Y	Y	Y	Y				Y
Arizona	Y	Y	Y	Y	Y	Y		Y	Y	Y			Y
Arkansas	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y
California						Y				Y			
Colorado	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Connecticut						Y							
Delaware						Y				Y			
District of Columbia	Y	Y	Y		Y	Y		Y	Y	Y			
Florida													
Georgia	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y
Hawaii	Y	Y	Y			Y	Y	Y	Y	Y			Y
Idaho	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Illinois	Y		Y			Y						Y	Y
Indiana	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			
Iowa	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y
Kansas						Y		Y	Y				
Kentucky	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	—	Y
Louisiana	Y	—	Y			Y		Y	Y	Y			Y
Maine	Y		Y			Y		Y	Y	Y			Y
Maryland	Y	Y	Y	Y	Y	Y	—	Y	Y	Y			Y
Massachusetts						Y				Y			
Michigan	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Minnesota	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Mississippi						Y							—
Missouri	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Montana	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nebraska	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nevada	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
New Hampshire	Y	Y	Y		Y	Y	Y	Y	Y	Y			Y
New Jersey	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
New Mexico	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
New York	Y	Y	Y		Y	Y		Y	Y	Y			Y
North Carolina	—	—	—	—	—	Y	—	—	—	Y	Y		Y
North Dakota	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y
Ohio						Y		Y	Y	Y	Y		Y
Oklahoma	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y	Y
Oregon	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Pennsylvania													
Rhode Island													
South Carolina													
South Dakota	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y
Tennessee	Y	Y											
Texas	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y
Utah	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			—
Vermont	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Virginia	Y	Y	Y	Y		Y		Y	Y	Y	Y		Y
Washington	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y
West Virginia	Y	Y	Y			Y	Y	Y	Y				Y
Wisconsin	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Wyoming	Y	Y				Y	Y	Y	Y	Y	Y	Y	Y

LEGEND: ■ Improvement from last Scorecard — Baseline data revised due to survey reporting update

Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX Q | Detailed Indicator Data: Health Maintenance Tasks Able to be Delegated to LTSS Workers (continued)

State	Health Maintenance Tasks, 2022 (1 point each task)											
	Administer Enema	Perform Intermittent Catheterization	In-dwelling Catheter Care	Perform Ostomy Care Including Skin Care and Changing Appliance	Perform Nebulizer Treatment	Administer Oxygen Therapy	Oral Suctioning	Tracheostomy Suctioning	Perform Ventilator Respiratory Care	Total Number of Tasks Able to be Delegated 2022	Change from 2019	Rank 2019
Alabama	Y		Y	Y	Y	Y	Y			13	11	34
Alaska	Y	Y		Y	Y	Y			Y	16		29
Arizona	Y	Y	Y	Y	Y	Y	Y			17		24
Arkansas	Y	Y	Y	Y	Y	Y	Y	Y	Y	20		16
California	Y									3		45
Colorado	Y	Y	Y	Y	Y	Y	Y	Y	Y	22		1
Connecticut			Y	Y						3		45
Delaware		Y	Y	Y						5		42
District of Columbia	Y		Y	Y		Y	Y			13		34
Florida												49
Georgia	Y	Y	Y	Y	Y	Y	Y	Y		19		17
Hawaii	Y	Y	Y	Y	Y	Y	Y		Y	17		24
Idaho	Y	Y	Y	Y	Y	Y	Y	Y	Y	22		1
Illinois	Y		Y	Y		Y	Y	Y		11	9	40
Indiana	Y	Y	Y	Y			Y			15	15	31
Iowa	Y	Y	Y	Y	Y	Y	Y	Y	Y	21		12
Kansas	Y	Y	Y			Y	Y			8		41
Kentucky	Y	Y	Y	Y	Y	Y	Y	—	—	19	1	17
Louisiana	Y	Y	Y	Y	Y		Y	Y	Y	15	3	31
Maine	Y	Y	Y	Y		Y				12	1	37
Maryland	Y	Y	Y	Y	Y	Y	Y	Y		18	1	20
Massachusetts				Y						3		45
Michigan	Y	Y	Y	Y						17		24
Minnesota	Y	Y	Y	Y	Y	Y	Y	Y	Y	22		1
Mississippi	Y	—	Y	Y			Y			5	1	42
Missouri	Y	Y	Y	Y	Y	Y	Y	Y	Y	22		1
Montana	Y	Y	Y	Y	Y	Y	Y	Y	Y	22		1
Nebraska	Y	Y	Y	Y	Y	Y	Y	Y	Y	22		1
Nevada	Y	Y	Y	Y	Y	Y	Y	Y		21		12
New Hampshire	Y	Y	Y	Y		Y	Y			16		29
New Jersey	Y	Y	Y	Y	Y	Y	Y	Y	Y	22		1
New Mexico	Y	Y	Y	Y	Y	Y	Y	Y	Y	22		1
New York	Y		Y	Y	Y	Y	Y			15		31
North Carolina	Y	Y	Y	Y	Y	Y	Y	Y	—	12	-9	37
North Dakota	Y	Y	Y	Y	Y		Y	Y		18		20
Ohio	Y	Y	Y	Y			Y	Y		12		37
Oklahoma	Y	Y		Y	Y	Y	Y	Y		18		20
Oregon	Y	Y	Y	Y	Y	Y	Y	Y	Y	22		1
Pennsylvania												49
Rhode Island												49
South Carolina	Y		Y	Y						3		45
South Dakota	Y	Y	Y	Y	Y	Y	Y			18	2	20
Tennessee			Y				Y			4		44
Texas	Y	Y	Y	Y	Y	Y	Y	Y	Y	21		12
Utah	Y	Y	Y	Y	Y	Y	Y	Y	Y	19		17
Vermont	Y	Y	Y	Y	Y	Y	Y	Y	Y	22		1
Virginia	Y		Y	Y	Y	Y	Y	Y		17		24
Washington	Y	Y	Y	Y	Y	Y	Y	Y	Y	21		12
West Virginia	Y			Y	Y			Y	Y	13		34
Wisconsin	Y	Y	Y	Y	Y	Y	Y	Y	Y	22		1
Wyoming	Y		Y	Y	Y	Y	Y	Y		17	1	24

LEGEND: ■ Improvement from last Scorecard — Baseline data revised due to survey reporting update

Source: Long-Term Services and Supports State Scorecard, 2023.

APPENDIX R | Additional Information About Family Caregiver Support Policies at the Local Level

SUPPORT FOR FAMILY CAREGIVERS:

Family Responsibility Discrimination Protections

The following 36 states have at least one city or county with laws or policies that provide some degree of protection against discrimination against workers with family responsibilities: Some of these states also have a statewide policy. In many of these localities, policies apply only to parents of minor children. In some, family responsibility or familial status is not explicitly defined but can be assumed to include family caregiving arrangements broadly. It is unclear if legal action by a family caregiver of an older family member would hold up in the areas where familial status is undefined.

Alabama	Indiana	Mississippi	Oklahoma
Alaska*	Iowa	Missouri	Oregon
Arizona	Kansas	Montana	Pennsylvania
California	Kentucky	New Hampshire	South Dakota
Colorado	Maine*	New Jersey*	Texas
Connecticut*	Maryland	New Mexico	Virginia
Florida	Massachusetts	New York*	Washington
Georgia	Michigan	North Carolina	West Virginia
Illinois	Minnesota*	Ohio	Wisconsin*

*State also has a statewide law

Data collected in 2023 by the Worklife Law at University of California Law, San Francisco. For more information contact the *LTSS Scorecard* team at: longtermscorecard@aarp.org

SUPPORT FOR FAMILY CAREGIVERS:

Paid Sick Leave

The following seven states have at least one city or county with laws or policies that provide some degree of paid sick leave:

California*	Berkeley, Emeryville, Los Angeles, Oakland, San Diego, San Francisco, Santa Monica
Illinois	Chicago, Cook County
Maryland*	Montgomery County
Minnesota	Bloomington, Duluth, Minneapolis, Saint Paul
Pennsylvania	Allegheny County, Philadelphia, Pittsburgh
New York*	New York City
Washington*	Seattle, Takoma

*State also has a statewide law

Data published by A Better Balance in 2022. For more information, see A Better Balance at: https://www.abetterbalance.org/our-issues/paid-sick-time

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