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Twenty Years Later: Implications of *Olmstead v. L.C.* on Medicaid's Role in Providing Long-Term Services and Supports

It has been 20 years since the U.S. Supreme Court ruled in *Olmstead v. L.C.* that unjustified institutionalization of individuals with disabilities by a public entity is a form of discrimination under the Americans with Disabilities Act of 1990 (ADA, P.L. 101-336). As a result, states are generally required to provide community-based care to such individuals.[1, 2]

Olmstead v. L.C. had implications for Medicaid as the nation's largest payer of long-term services and supports (LTSS). The ruling encouraged states to rebalance delivery of LTSS from institutional care toward greater community integration through home- and community-based services (HCBS). The past twenty years have seen this shift toward HCBS supported by multiple efforts underway at the federal and state levels to serve more beneficiaries in their communities, particularly for certain subpopulations of individuals who use LTSS.

This brief begins by providing historical context. We then describe the implications of *Olmstead v. L.C.* for Medicaid, including federal initiatives that support states in serving individuals in the community and changes in Medicaid spending patterns. The brief concludes by describing ongoing enforcement of *Olmstead v. L.C.*

Historical Context

Deinstitutionalization, that is the shift to serving individuals with LTSS needs in the community rather than in institutions, began in the 1950s due to concerns about the high rates of individuals with severe mental illness living in public mental health facilities, the poor living conditions in such institutions, and the civil rights of institutionalized individuals (Parks and Radke 2014). The development of antipsychotic drugs created more, and often more effective, treatment options that allowed more individuals to reside in the community, which also helped advance deinstitutionalization (Shen 1999).[3] In the 1960s, new funding was provided to increase mental health resources and services in the community, and the movement to deinstitutionalize expanded to include individuals with intellectual or developmental disabilities (ID/DD).[4]

From the early 1970s until the 1990s, statutory changes, court decisions, and advocacy efforts to support community-based care for individuals with mental illness and ID/DD led to the closure of large state mental hospitals and large state facilities for people with ID/DD, reducing the number of individuals receiving care in large institutions (ACL 2017, Bagenstos 2012, PBS 2005).

Enactment of the ADA on July 26, 1990 marked a significant change in civil rights law by prohibiting discrimination against individuals with disabilities in employment and in public accommodations.[5] In addition, under Title II of the ADA, individuals with disabilities could not be excluded from participating in services, programs, or activities provided by state and local governments, including Medicaid. Under U.S. Department of Justice (DOJ) regulations implementing this integration mandate, public entities must administer services, programs, and activities in the most integrated settings appropriate to the needs of qualified individuals with disabilities (28 CFR § 35.130(d)). The regulations also state that public entities must make reasonable modifications in policies, practices, or procedures to avoid discrimination on the basis of disability, unless the modification would fundamentally alter the nature of the services, program, or activity. This reasonable modifications provision (28 CFR § 35.130(b)) would become a key component of *Olmstead v. L.C.* and other litigation in determining whether states were taking reasonable measures to prevent discrimination against individuals with disabilities.

Olmstead v. L.C.

After the passage of the ADA, cases involving institutionalization of individuals with disabilities who could be served in the community became a major area of litigation against states (Butler 2000). One of these cases, *Olmstead v. L.C.,* 119 S. Ct. 2176 (1999) reached the Supreme Court, which ruled in 1999 that the unjustified institutionalization of individuals with disabilities violated the ADA.[6, 7] The ruling was based on two conclusions. First, that institutionalization of individuals with disabilities who are able to live in community settings perpetuates the unwarranted assumption that such persons are not able to live in a community. Second, that "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

Olmstead v. L.C. concluded that states must provide treatment for individuals with disabilities in the most integrated setting possible if the individuals are not opposed, and such placement is appropriate and can be reasonably accommodated by the state. These reasonable accommodations should consider available resources as well as the needs of other people with disabilities, and whether such placement would fundamentally alter the nature of the program, consistent with DOJ's regulations implementing the ADA.

Implementation of *Olmstead v. L.C.*

Under the Supreme Court ruling, a public entity may comply with the ADA's integration mandate and reasonable modifications provision (28 CFR § 35.130(b)) by demonstrating that it has:

- a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings, known as an Olmstead plan, and
- a waiting list that moves at a reasonable pace not controlled by the state's endeavors to keep its institutions fully populated.[8]

The Supreme Court gave states considerable flexibility in designing how, when, and how many individuals were placed in more integrated settings. Thus, states may continue to maintain processes and waiting lists to transition individuals into the community over a period of time.

Implications for Medicaid

As noted above, *Olmstead v. L.C.* did not require rapid deinstitutionalization, nor did it create an immediate right to a community placement in lieu of institutional care. It also did not change federal Medicaid policy requiring state Medicaid programs to cover nursing facility services but not HCBS. In order to be eligible for HCBS, individuals must need a level of care that requires institutionalization in either nursing facilities or—for individuals with intellectual disabilities— in intermediate care facilities.

Nevertheless, all state Medicaid programs cover some HCBS through state plan and waiver authorities (Appendix A).[9] Many states provide HCBS under waivers as these authorities allow them to limit the number of beneficiaries they serve. As a result, Medicaid beneficiaries who could potentially receive care in the community can only get the care they need in institutions.

In 2017, over 707,000 individuals in 40 states were on HCBS waiver waiting lists, with the majority on waiting lists for waivers targeted to individuals with ID/DD (67 percent), and adults who were age 65 or older or physically disabled (28 percent) (Musumeci et al. 2019). It is important to note that in nine states, individuals are placed on waiting lists prior to or during determination of eligibility for HCBS waiver services.

Under *Olmstead v. L.C.*, states may maintain waiting lists for individuals in need of HCBS as long as they are moved into community placements at a “reasonable pace” (Rosenbaum 2016). However, the Supreme Court did not define what a reasonable pace was, leaving it to state discretion. The average waiting period for a community placement across all waivers with waiting lists in 2017 was two-and-one-half years, with variation in waiting times across different populations served under various states’ waivers (Musumeci et al. 2019).[10] The pace at which individuals are moved from waiting lists to receiving HCBS is often a component of litigation alleging violations of the ADA and *Olmstead v. L.C.* (ADA 2019).

Rebalancing Efforts in Medicaid

The federal government has encouraged state efforts to shift LTSS from institutional to home- and community-based settings, referred to as rebalancing, by providing funding and technical assistance through a variety of programs. Some programs provide grants, while others offer an enhanced federal match rate for Medicaid administrative activities to strengthen the HCBS infrastructure. We describe key rebalancing activities below. In addition, states are now working to comply with regulations aimed at ensuring that Medicaid HCBS payments are made only for services provided in settings that provide beneficiaries with adequate control over their daily lives and opportunities to be integrated in the community.

Real Choice Systems Change grant program. From fiscal year (FY) 2001 to FY 2010, the Real Choice Systems Change (RCSC) program provided states with grants to implement HCBS infrastructure changes. States used RCSC grants for activities such as developing consumer-directed programs to give beneficiaries more choice and control over their service providers, and partnerships with housing authorities to increase the availability of affordable and accessible community housing (Shirk 2007). Over the course of the program, the Centers for Medicare & Medicaid Services (CMS) awarded 352 grants to all 50 states and the District of Columbia totaling nearly $289 million (CMS 2019a, Shirk 2007).

Balancing Incentive Program. The Balancing Incentive Program (BIP), created by the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) targeted states that had spent less than half of LTSS dollars on HCBS in FY 2009. States with spending under this threshold could apply for grants to implement:

- standardized functional assessment tools to evaluate beneficiaries' LTSS needs to determine eligibility and plan care;
- conflict-free case management, which separates service authorization and service delivery to prevent potential conflicts of interest when providers determine the services that a beneficiary receives; and
- a streamlined counseling process to inform individuals with disabilities of Medicaid-covered LTSS options; this is referred to as a no wrong door system (CMS 2019b).

The BIP operated from FY 2012 through FY 2015, although some states received extensions into FY 2017 (Karon et al. 2019). Every participating state increased the proportion of its Medicaid LTSS spending for HCBS from approximately 40.1 percent of LTSS spending in FY 2009 to 53.9 percent in FY 2015 (Karon et al. 2019).

Money Follows the Person demonstration program. First authorized by the Deficit Reduction Act of 2005 (DRA; P.L. 109-171), the Money Follows the Person (MFP) demonstration program has provided 44 states and the District of Columbia with flexibility and enhanced funding to support transitioning Medicaid beneficiaries from institutional settings back to the community. MFP participants include individuals with ID/DD, individuals age 65 and older, individuals with physical disabilities, and individuals with psychiatric conditions who have been residents of an institution for at least 90 days.

Beneficiaries in the MFP program typically receive support from transition coordinators who work with the beneficiary to develop a transition plan for the services they will need to successfully live in the community, and to identify a community residence. MFP participants can receive demonstration services beyond HCBS that the state typically covers (Hargan 2017). States receive an enhanced federal medical assistance percentage for HCBS provided to MFP participants, and then invest the enhanced amount into their HCBS infrastructure (Coughlin et al. 2017).

As of December 2016, MFP had helped over 75,000 participants transition back to the community (Coughlin et al. 2017). States had been expected to stop transitioning participants by the end of 2018. However, the Medicaid Extenders Act of 2019 (P.L. 116-3) and the Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16) authorized funding to support new transitions, and pending legislation could extend MFP further if enacted.

Managed long-term services and supports incentives. Twenty-four states have implemented managed long-term services and supports (MLTSS) programs, in which states contract with managed care organizations (MCOs) to deliver LTSS benefits (NASUAD 2019, Lewis et al. 2018). In its guidance to states implementing MLTSS, CMS noted that states must implement MLTSS consistent with the ADA and *Olmstead v L.C.*, including any state Olmstead plan (CMS 2013). CMS further specified that states require MCOs to serve beneficiaries in the most integrated setting possible.

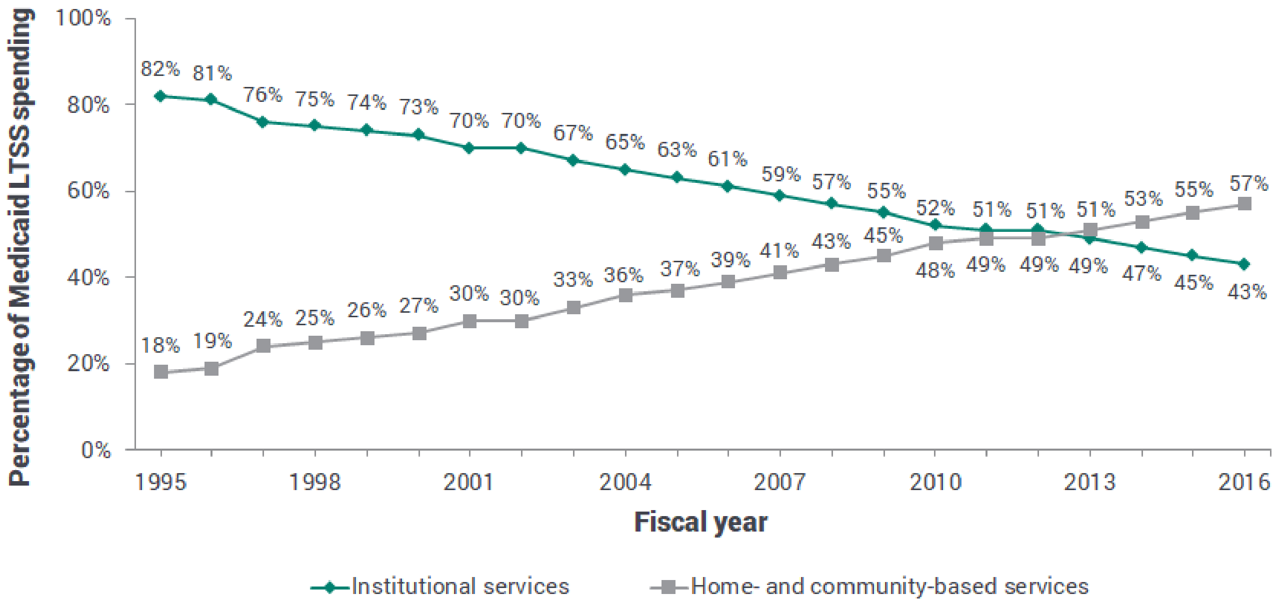
Many states have cited rebalancing as a goal of MLTSS adoption (Dobson et al. 2017). States often structure their capitation rates to achieve this goal by setting a blended payment rate that assumes a certain mixture of institutional care and HCBS. MCOs benefit financially if they serve more individuals through HCBS—which is typically less expensive than institutional services—than was assumed in their capitation rate (Dominiak and Libersky 2016).

HCBS settings rule. CMS finalized a rule in 2014 establishing new requirements for HCBS settings, limiting HCBS payment to settings that do not have institutional characteristics, and providing individuals who receive Medicaid-covered HCBS with the same options for control over their daily lives and interaction with the community as people who do not receive Medicaid HCBS (CMS 2014). For example, under the rule, individuals in provider-controlled residences must have individual leases and a choice of roommates, and all HCBS settings must provide beneficiaries with opportunities for beneficiaries to engage in activities in the community. Providers have until March 17, 2022 to comply with this rule.

Medicaid LTSS Spending Patterns

As a result of these rebalancing efforts, national Medicaid spending on HCBS now exceeds that for institutional services (Figure 1).

FIGURE 1. Percentage of Medicaid Long-Term Services and Supports Spending on Institutional Services and Home- and Community-Based Services, FYs 1995–2016

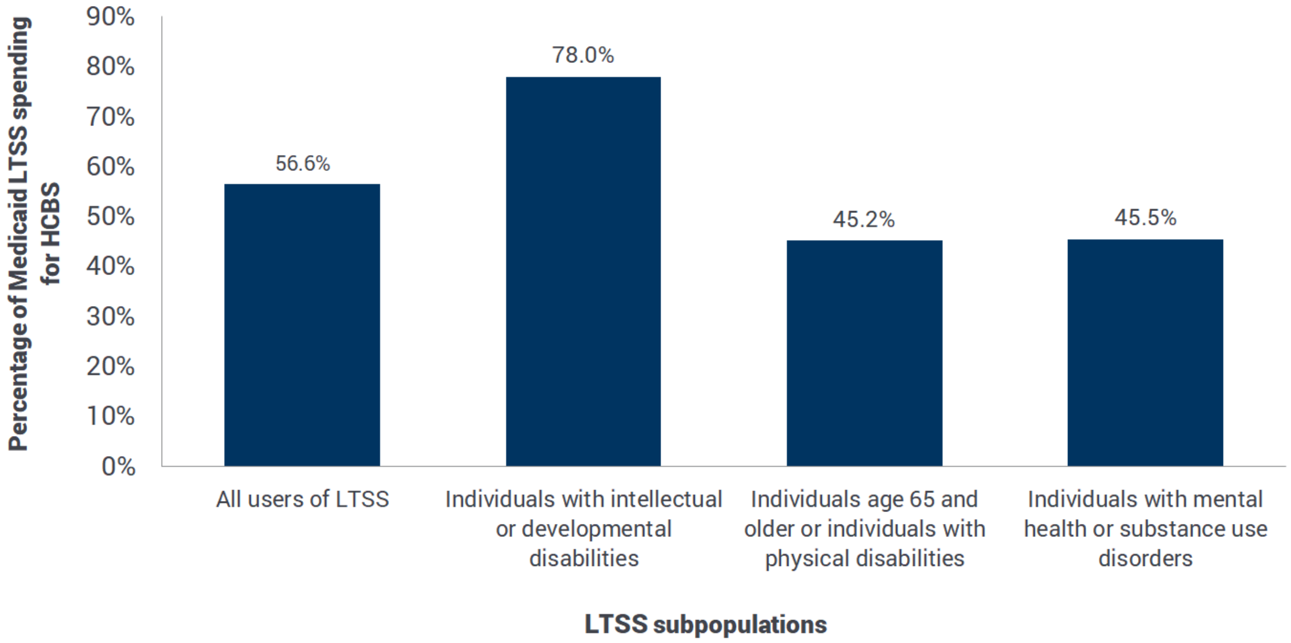


Notes: FY is fiscal year. LTSS is long-term services and supports. Data do not include certain managed care expenditures.

Sources: Eiken et al. 2018, 2017.

Nevertheless, the national data presented in Figure 1 obscure the variation in rebalancing across LTSS subpopulations (Figure 2). For example, individuals with ID/DD are much more likely than individuals age 65 and older or with physical disabilities, or individuals with mental health and substance use disorders to receive services in the community (Eiken et al. 2018).

FIGURE 2. Percentage of Medicaid Long-Term Services and Supports Spending for Home- and Community-Based Services, FY 2016

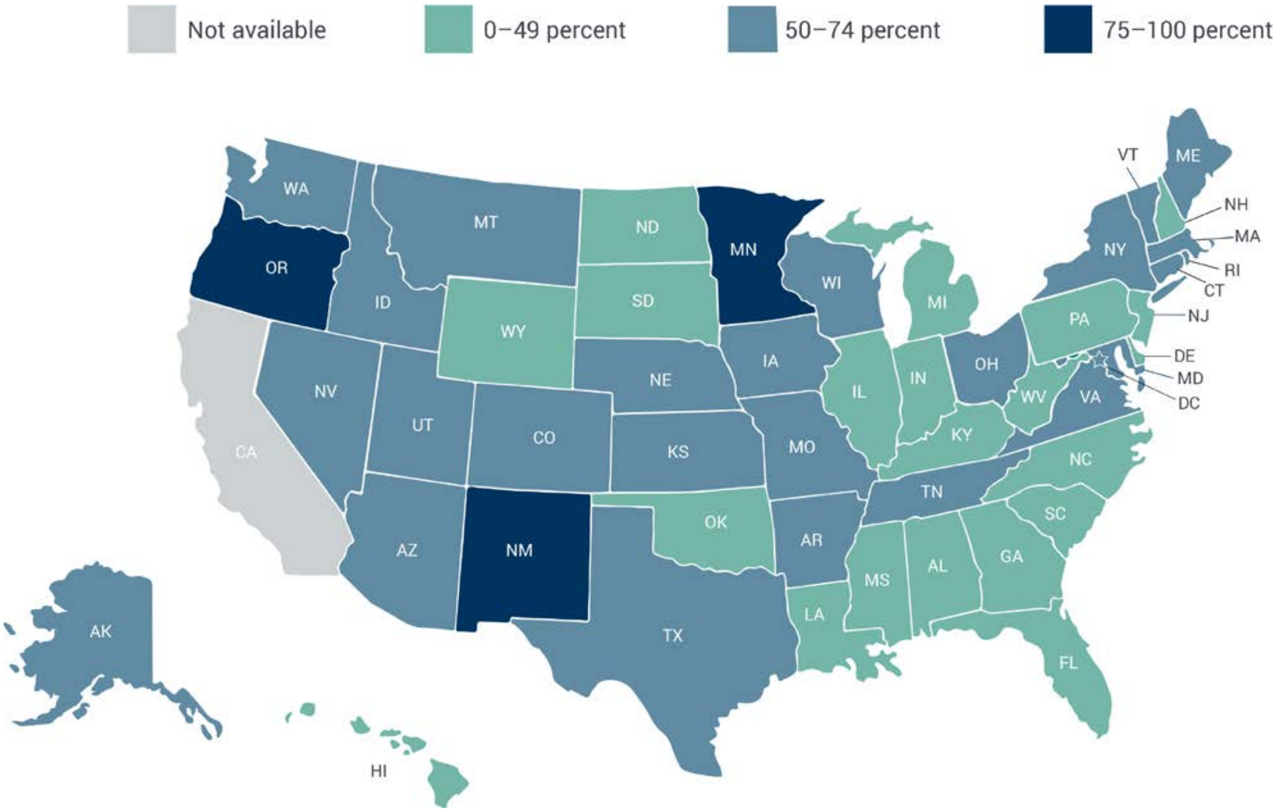


Notes: FY is fiscal year. HCBS is home- and community-based services. LTSS is long-term services and supports.

Source: Eiken et al. 2018.

Similarly, the level of rebalancing varies across states (Figure 3). This is particularly true for certain subpopulations (Appendix B). For individuals with ID/DD, over half of states spent more than 75 percent of their LTSS dollars on HCBS in FY 2016. In comparison, only one state (Oregon) had reached that level of rebalancing for individuals age 65 and older or individuals with physical disabilities, and 11 states had reached that level for people with mental illness or substance use disorders.

FIGURE 3. Percentage of Medicaid Long-Term Services and Supports Spending for Home- and Community-Based Services, by State, Fiscal Year 2016



Source: Eiken et al. 2018.

Enforcement of Olmstead v. L.C.

There have been a number of actions at the federal and state level and in the courts to enforce *Olmstead v. L.C.* and Title II of the ADA. DOJ and the U.S. Department of Health and Human Services' Office of Civil Rights (OCR) both intervene in cases alleging violations of the ADA and *Olmstead v. L.C.*

DOJ has intervened in court cases on behalf of Medicaid beneficiaries with a variety of conditions, including mental illness, ID/DD, and physical disabilities. From 2009 to 2016, DOJ filed briefs in over 50 *Olmstead v. L.C.* integration matters in 26 states and the District of Columbia (ADA 2019). For example:

- In 2013, DOJ and the United States Attorney for the Eastern District of New York entered into a settlement agreement with the state of New York to offer scattered-site supported housing in apartments to at least 2,000 individuals with mental illness who resided in 23 large adult homes in New York City (ADA 2019).[11]
- In 2012, following a complaint by DOJ, Virginia agreed that over a 10-year period the state would create new HCBS waivers for individuals on waiting lists for community services and for those transitioning from institutional settings.[12]

- In 2012, DOJ intervened on behalf of individuals with ID/DD living in Oregon. The plaintiffs alleged that they were unnecessarily segregated in sheltered workshops—settings that only employ people with disabilities—rather than having integrated employment opportunities in the community.[13] The terms of the settlement indicated that over a seven-year period, Oregon would provide over 1,000 working-age adults with ID/DD who were being served in segregated sheltered workshops opportunities to work in more integrated jobs with competitive employment (ADA 2016).

The OCR has intervened, often with DOJ, in over 80 cases of Medicaid beneficiaries in institutional or segregated settings, as well as for persons at-risk for institutionalization or loss of community-based services. For instance, the OCR investigated complaints from multiple advocacy organizations alleging that individuals with mental illness and developmental disabilities in Georgia were not served in the most integrated setting possible.[14] As a result of the investigation and subsequent settlement, the state was required to halt admissions to state-operated institutions, create new opportunities for community living, and transition all individuals into the most integrated setting appropriate to their needs.

In addition, two federal protection and advocacy systems–one for individuals with developmental disabilities and another for individuals with significant psychiatric disabilities–have become instrumental in enforcing *Olmstead v. L.C.*[15] These systems are administered by either state agencies or non-profit organizations that have been designated by the governor of each state (ACL 2019, SAMHSA 2011). They employ attorneys and other advocates who investigate abuse and neglect complaints and provide legal assistance. For example, in 2018, the Kentucky protection and advocacy agency reached a settlement agreement with the State Cabinet for Health and Family Services that ultimately should allow more individuals to transition safely from institutional settings to community housing (CHFS 2018).

Endnotes

[1] *Olmstead v. L.C.,* 119 S. Ct. 2176 (1999)

[2] Unjustified institutionalization refers to cases in which individuals reside in institutions although their treatment team has determined that community placement is appropriate; the individual is not opposed to community-based treatment; and such placement can be reasonably accommodated by the state given their resources and the needs of others with disabilities who are receiving such services from the same public entity. Unjustified institutionalization, and other similar terms (such as unnecessary institutional segregation), are used interchangeably in the Supreme Court decision.

[3] The Mental Health Study Act of 1955 (P.L. 84-182) established the Joint Commission of Mental Illness and Health, which assessed national mental health conditions and resources and made recommendations on federal actions to provide adequate care for individuals with mental illness (Postal 2018, NIH 2017).

[4] The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P.L. 88-164) provided funding for the construction of new mental health centers to serve individuals with mental illness. This law was amended with the passage of the Developmental Disabilities Services and Facilities Construction Amendments of 1970 (P.L. 91-517), which introduced the term developmental disability and expanded the population covered in mental health centers to include individuals with cerebral palsy, epilepsy, and certain other neurological conditions. In 1978, Congress again expanded the definition and switched from a list of conditions to a more general definition of developmental disabilities as an impairment resulting in substantial functional limitations in three of more areas of major life activities (ACL 2017).

[5] Under the ADA, disability is defined as a physical or mental impairment that substantially limits one or more major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.

[6] The case was brought by Lois Curtis and Elaine Wilson, two women with mental health and developmental disabilities residing in state-run psychiatric institutions in Georgia. Although medical professionals determined that these women's needs could be appropriately served in the community, both women remained institutionalized. They sued, asserting that continued institutionalization violated their right under Title II of the ADA to be treated in a community-based program. The state argued that inadequate funding, not discrimination, accounted for continued retention in the hospital setting. The Supreme Court rejected the state's argument, and concluded that unjustified institutionalization constitutes discrimination if the state can reasonably accommodate individuals in a community setting.

[7] While the plaintiffs in *Olmstead v. L.C*. had mental health conditions and developmental disabilities, a letter from CMS to state Medicaid directors clarifies that *Olmstead v. L.C.* applies to all individuals with disabilities protected from discrimination by Title II of the ADA (HCFA 2000).

[8] A state's Olmstead plan provides an assessment of current state efforts to ensure that individuals with disabilities are receiving services in the most integrated setting possible. The plan also provides a framework for changes in policies, practices, and programs and includes the state's timeline for such progress (Moseley 2013, ADA 2011). States and local governments may have alternative strategies not labeled as Olmstead plans that accomplish similar goals (Moseley 2013).

Such plans are not required, but in 2013, 27 states had Olmstead plans, and 18 states had alternative strategies (Postal 2018). DOJ has said that it generally considers these plans as prerequisites for the defense in certain litigation. Public entities accused of violating the ADA and *Olmstead v. L.C.* may find their Olmstead plan useful in providing evidence that they are working towards integration, or to raise a fundamental alteration defense in which the state claims that the changes substantially alter the service system (ADA 2011).

[9] HCBS authorities—with the exception of the Section 1915(i) state plan authority—also require that beneficiaries need an institutional level of care, although they provide beneficiaries with the ability to receive services in the community.

[10] The average wait time varies by waiver from 4 months for people with HIV/AIDS, to 66 months (5½ years) for people with ID/DD. The populations included in the analysis are individuals with ID/DD, individuals age 65 and older with physical disabilities, adults of any age with physical disabilities, medically fragile and technology-dependent children, individuals with HIV/AIDS, individuals with mental health conditions, and individuals with traumatic brain injury and spinal cord injury (Musumeci 2019).

[11] *U.S. v. New York*, 13-CV-4165 (E.D.N.Y. 2013). The settlement presumed that supported housing and associated services (including supported employment and community mental health services such as care coordination, psychiatric rehabilitation, and personal assistance services) provided more opportunities for community integration than found in adult group homes. The settlement has been amended and has had an additional supplement added since 2013 (ADA 2019).

[12] *U.S. v. Virgini*a, 3:12-CV-059 (E.D. Va. 2012).

[13] *Lane v. Brown*, 12-CV-00138 (D. Ct. Or.2012).

[14] *U.S. v. Georgia*, 10-CV-249 (N.D. Ga. 2010).

[15] The Protection and Advocacy for Individuals with Developmental Disabilities program was established by the Developmentally Disabled Assistance and Bill of Rights Act (P.L. 94-103). State-designated agencies are federally mandated

to pursue legal, administrative, and other appropriate remedies to protect and advocate for the rights of individuals with developmental disabilities under applicable federal and state laws. They can access and monitor both facilities and records to ensure that rights are protected. Modeled after the Developmental Disabilities Act, the Protection and Advocacy for Mentally Ill Individuals Act (P.L. 99-319) established a protection and advocacy system for individuals with significant psychiatric disabilities (e.g., major depression or schizophrenia). Initially, agencies were mandated to investigate reports of abuse and neglect in institutions. In 2000, the law was amended to include individuals in need of advocacy that receive community-based care.

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APPENDIX A: Statutory Authorities Used for Medicaid Home- and Community-Based Services

Medicaid-covered home- and community-based services (HCBS) include personal care services delivered both in an individual's private residence and in residential care settings such as assisted living facilities, adult day center services, supported employment services, home-delivered meals, and transportation. States cover HCBS through one or more statutory authorities (Table A-1).

Waiver authorities allow states to forego certain Medicaid requirements. State plan authorities generally provide less flexibility from Medicaid requirements, particularly as they do not allow states to use waiting lists.

TABLE A-1. Statutory Authorities Used for Medicaid Home- and Community-Based Services

Type of authority	Authority	Description
Waiver	Section 1915(c)	Allows states to forego certain Medicaid requirements to target HCBS benefits to specific populations, cap the number of beneficiaries who receive these benefits, or create waiting lists for people who cannot be served under the cap.
	Section 1115	Not specific to HCBS, Section 1115 demonstration waiver authority is a broad authority that allows states to test new delivery models.
State plan	Section 1915(i)	Allows states to offer HCBS under the state plan to people who need less than an institutional level of care, the typical standard for Medicaid coverage of HCBS. States can also establish specific criteria for people to receive services under this authority.
	Section 1915(j)	Gives authority for self-directed PAS, providing beneficiaries with the ability to hire and direct their own PAS attendant. States may also give beneficiaries the authority to manage their own individual service budget.
	Section 1915(k)	The Community First Choice option, established in the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) provides states with a 6 percentage point increase in the federal medical assistance percentage for HCBS attendant services provided under the state plan.

Notes: HCBS is home- and community-based services. PAS is personal assistant services.
Sources: §§ 1115, 1915(c), 1915(i), 1915(j), and 1915(k) of the Social Security Act.

APPENDIX B: Use of Medicaid Home- and Community-Based Services by State and Subpopulation

TABLE B-1. Percentage of Medicaid Long-Term Services and Supports Spending for Home- and Community-Based Services, by State and Subpopulation, Fiscal Year 2016

State	All subpopulations of individuals using LTSS	Percentage for individuals with ID/DD	Percentage for individuals age 65 and older or with physical disabilities	Percentage for individuals with mental health or substance use disorders
Total	**56.6%**	**78.0%**	**45.2%**	**45.5%**
Alabama	42.7	99.4	14.8	68.9
Alaska	64.1	98.5	50.7	0.0
Arizona	70.4	96.5	44.2	31.4
Arkansas	52.1	54.7	33.9	81.3
California	–	87.5	–	1.8
Colorado	66.3	91.2	58.2	84.4
Connecticut	53.1	78.5	39.7	6.3
Delaware	47.8	81.0	35.4	68.8
District of Columbia	56.1	69.1	49.1	27.2
Florida	33.5	73.5	22.5	0.0
Georgia	47.2	92.7	29.1	91.5
Hawaii	41.5	92.0	26.0	100.0
Idaho	55.4	82.3	34.4	0.0
Illinois	49.4	53.0	45.6	46.5
Indiana	31.9	72.2	17.7	21.8
Iowa	50.5	63.9	25.4	79.6
Kansas	56.7	84.9	30.9	88.6
Kentucky	43.3	83.3	12.6	2.1
Louisiana	35.3	54.7	24.0	0.3
Maine	53.8	81.8	28.0	13.7
Maryland	56.2	97.8	28.5	74.7
Massachusetts	70.5	84.6	62.4	81.8
Michigan	40.0	100.0	30.6	12.8
Minnesota	75.7	88.0	69.9	8.1
Mississippi	27.0	23.0	25.5	40.1

State	All subpopulations of individuals using LTSS	Percentage for individuals with ID/DD	Percentage for individuals age 65 and older or with physical disabilities	Percentage for individuals with mental health or substance use disorders
Missouri	58.4	87.7	42.7	60.5
Montana	58.2	91.9	38.2	54.8
Nebraska	52.7	80.4	28.2	0.0
Nevada	56.7	83.5	36.7	71.0
New Hampshire	47.7	98.4	13.9	43.2
New Jersey	38.8	72.7	19.6	3.9
New Mexico	78.5	92.8	73.5	18.2
New York	62.7	82.2	52.9	18.1
North Carolina	45.1	58.8	41.0	5.4
North Dakota	41.8	68.5	15.2	12.8
Ohio	52.7	68.8	36.9	88.3
Oklahoma	47.3	77.7	30.1	26.6
Oregon	81.2	100.0	80.0	78.7
Pennsylvania	48.3	79.8	34.6	0.4
Rhode Island	55.3	95.8	24.4	95.3
South Carolina	49.1	71.2	31.2	64.5
South Dakota	47.6	79.1	18.1	71.2
Tennessee	53.4	78.1	34.5	0.0
Texas	58.2	52.2	55.7	15.8
Utah	52.6	77.3	25.5	55.0
Vermont	70.3	99.4	45.3	99.6
Virginia	57.8	77.2	48.5	0.0
Washington	68.4	73.5	71.2	0.0
West Virginia	44.6	82.5	26.3	49.8
Wisconsin	66.3	89.1	52.5	64.2
Wyoming	49.9	84.6	26.1	0.0

Notes: HCBS is home- and community-based services. LTSS is long-term services and supports. ID/DD is intellectual or developmental disabilities.

– Dash indicates data are missing.

Source: Eiken et al. 2018.