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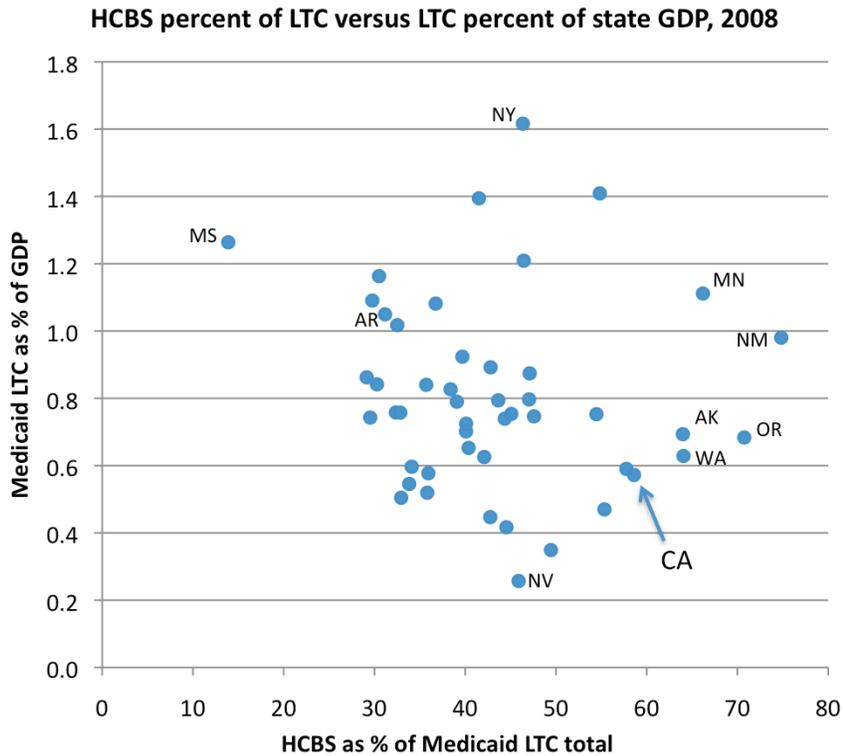
**Testimony prepared for the Little Hoover Commission  
May 27, 2010**

In-Home Supportive Services (IHSS) is the primary source of government-funded Home- and Community-Based (HCBS) long-term care in California, providing services to more than 400,000 elderly and non-elderly people with all types of disabilities and functional limitations. IHSS operates mostly as a Medicaid Personal Care Services (PCS) plan, which is an optional Medicaid benefit, meaning that it is offered at the discretion of each state. As a large, non-Federally mandated program partly funded by the state General Fund, IHSS has been under constant threat of massive budget cuts, and even of complete elimination.

For this testimony, I analyzed state-level Federal data from 2001 through 2008 on both HCBS and institutional long-term care (LTC) programs, supplemented by IHSS data supplied by the California Department of Social Services. The aim was to gain a better understanding of how expenditures on and participation in California's LTC programs compare to those in other states, and how spending patterns over time in California and other states affect the growth of LTC spending. Based on findings from this analysis, I will also offer some conclusions and policy suggestions.

Please note the following:

- (1) All expenditure figures presented reflect the full amount spent by the program; Federal reimbursements have not been subtracted from the totals.
- (2) LTC spending patterns are complex, and can be more easily understood by analyzing programs serving people with intellectual and other developmental disabilities (I/DD) separately from all other LTC programs, which serve mostly elderly and non-elderly people with physical, cognitive, or mental health disabilities. Because the vast majority of IHSS consumers do not have I/DD, I classify IHSS and other PCS programs as non-I/DD programs. Also included as non-I/DD programs are HCBS waivers not specifically targeted to people with I/DD, home health programs, and nursing homes. These programs are the focus of most of this analysis.



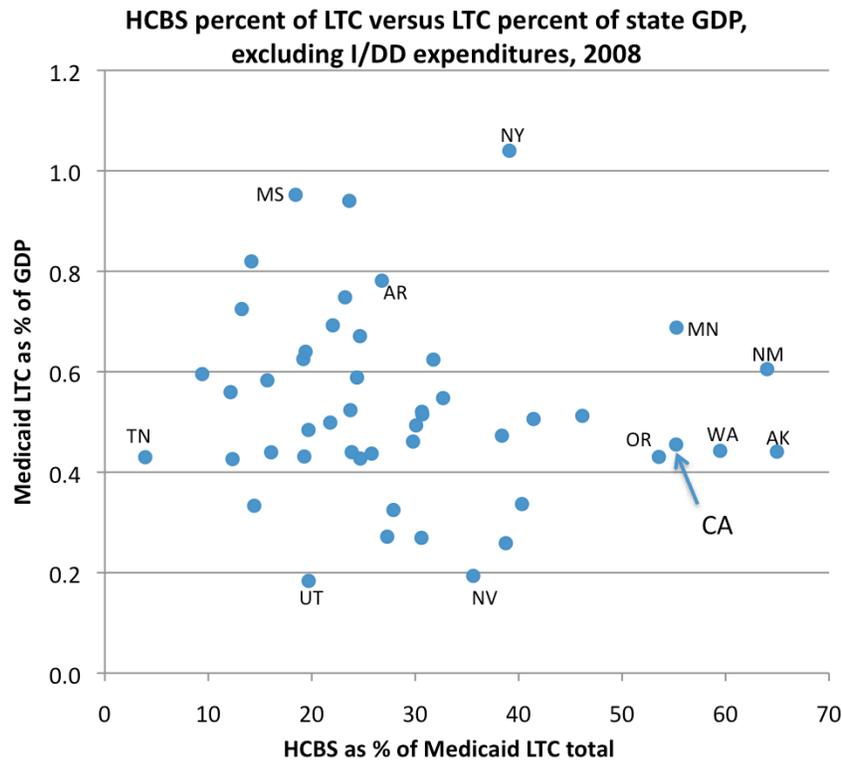
**Long-term care spending: How does California compare to other states?**

The vertical axis on the graph shows the percentage of a state’s gross domestic product (GDP) that was spent on Medicaid long-term care services in 2008. Percentage of GDP is an appropriate way of comparing countries or states that differ in terms of overall wealth. California is in the lowest quartile of states, spending a smaller fraction of its GDP on Medicaid-paid LTC than most other states. Although California (0.57%) spends more than twice as much of its GDP as the lowest state, Nevada (0.26%), its spending relative to GDP is just over one-third as much as that of the highest state, New York (1.62%).

The horizontal axis shows the percent of LTC spending devoted to HCBS. Note that there is no clear relationship between the level of overall spending (vertical axis) and the proportion that is spend on HCBS (horizontal axis). In other words, states that spend a higher proportion on HCBS do not typically spend more on LTC overall.

California (58.6%) is spends a higher fraction of their LTC dollars on HCBS than most states. The highest are Mew Mexico (74.8%), Oregon (70.8%), and Minnesota (66.2%). The state spending by far the lowest fraction on HCBS is Mississippi, at 13.9%. Arkansas, which was recently sued by the Department of Justice for violating Olmstead, spends 31.2% of its Medicaid LTC dollars on HCBS.

Note: Statistics reflect expenditure amounts reported to the Centers for Medicare and Medicaid Services by the states and compiled by Thomson Reuters; California HCBS spending has been updated using DSS figures for IHSS expenditures. Arizona and Vermont are not shown because most of their expenditures are not reported so that institutional and non-institutional spending can be distinguished.



**LTC expenditures, excluding spending on developmental disability programs**

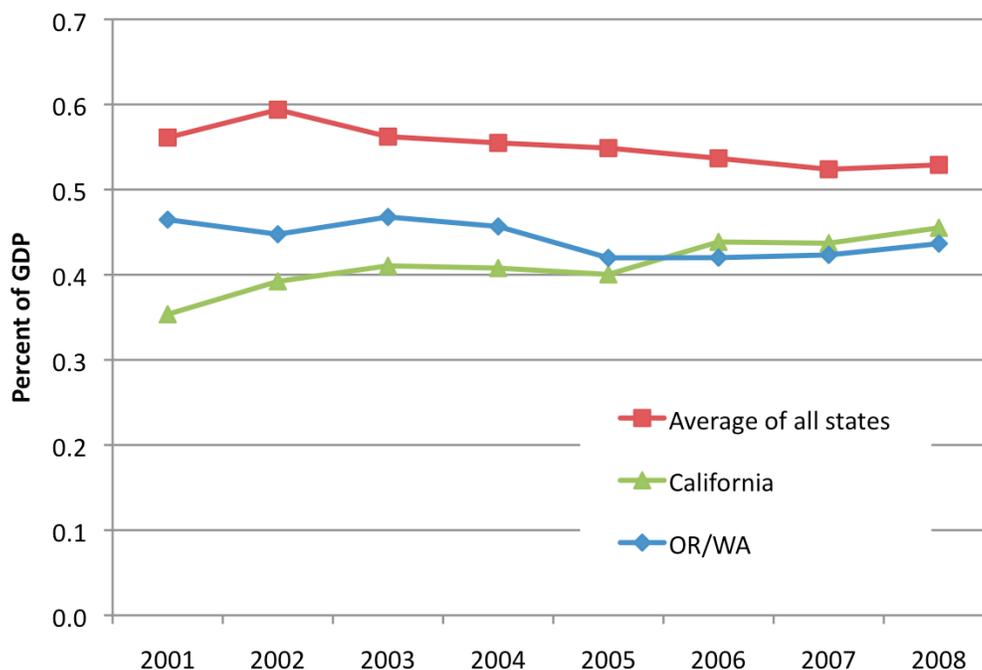
This graph is similar to the previous graph, but it excludes spending on I/DD programs.\* Again, there is no clear relationship between the fraction of expenditures going to HCBS and the level of overall spending.

California is a typical state in terms of total expenditures, at 0.46% of GDP (median for the state is 0.50%). California spends more than twice as much as the lowest states (Utah at 0.18% and Nevada at 0.19%), but less than half as much as the highest state (New York at 1.04% of GDP).

California (55.7%) is one of only 6 states spending more than half of their non-I/DD LTC dollars on HCBS (nearly all of it for IHSS). Alaska is highest at 65.0%, followed by New Mexico at 64.0%. At the other end of the spectrum is Tennessee, which spends only 3.9% of its (non-I/DD) LTC monies on HCBS, and the remaining 96.1% on nursing homes.

\*Excluded expenditures are for Intermediate Care Facilities and HCBS Waivers for people with developmental disabilities.

**LTC expenditures as percent of GDP, excluding I/DD, 2001-08**



**Trends in Medicaid<sup>†</sup> Long-Term Care expenditures**

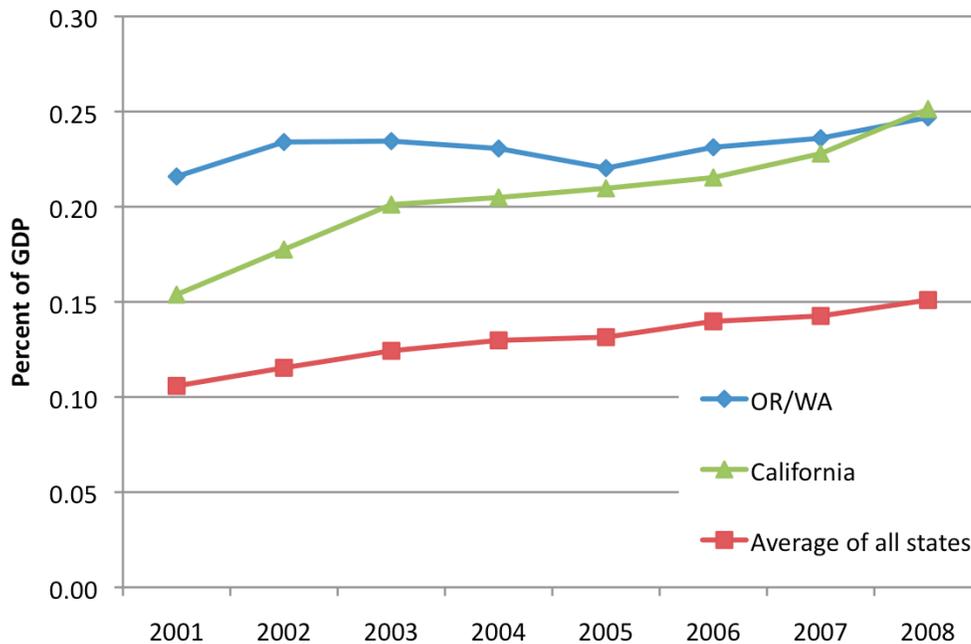
Recent trends in long-term care spending (excluding I/DD expenditures) show a growth in California’s expenditures (up 28.7% over the period relative to GDP) compared to a decline in the average across all states\* (down 5.7%). I use Oregon and Washington (the chart shows the average of their expenditures relative to GDP) as comparison states, partly because of their proximity and partly because I see them as “role model” states in terms of shifting expenditures toward HCBS while also facing budgetary difficulties. Expenditures for those states also declined (down 6.1% relative to GDP) between 2001 and 2008.

Despite the increase, however, California’s overall LTC expenditures remain substantially below the national average, and only slightly above the comparison states.

<sup>†</sup>For purposes of comparison, the entire IHSS program is counted as a “Medicaid” expenditure throughout this analysis, including residual components not reimbursed by CMS.

\*Except Arizona and Vermont.

**HCBS expenditures as percent of GDP, excluding I/DD,  
2001-08**



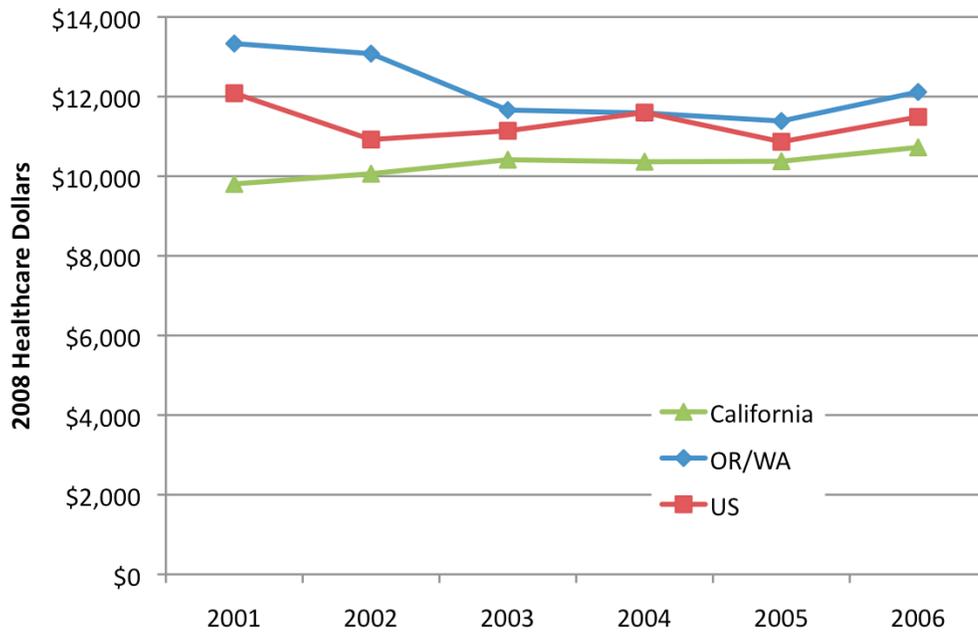
**Trends in home- and community-based services expenditures**

Part of the reason for the increase in California’s overall LTC expenditures is the growth HCBS spending. Between 2001 and 2008, California’s spending on HCBS (excluding I/DD programs) increased by 63.4%, compared to a 42.6% increase in the average expenditure across states.

In contrast, Oregon and Washington, with a spending level relative to GDP similar to that of California, increased by a much smaller 14.4%.

Is the growth in California’s HCBS expenditures a problem? Not necessarily, because expenditures for 2005-08 are similar to those of the comparison states. California was effectively catching up with those states during the prior years.

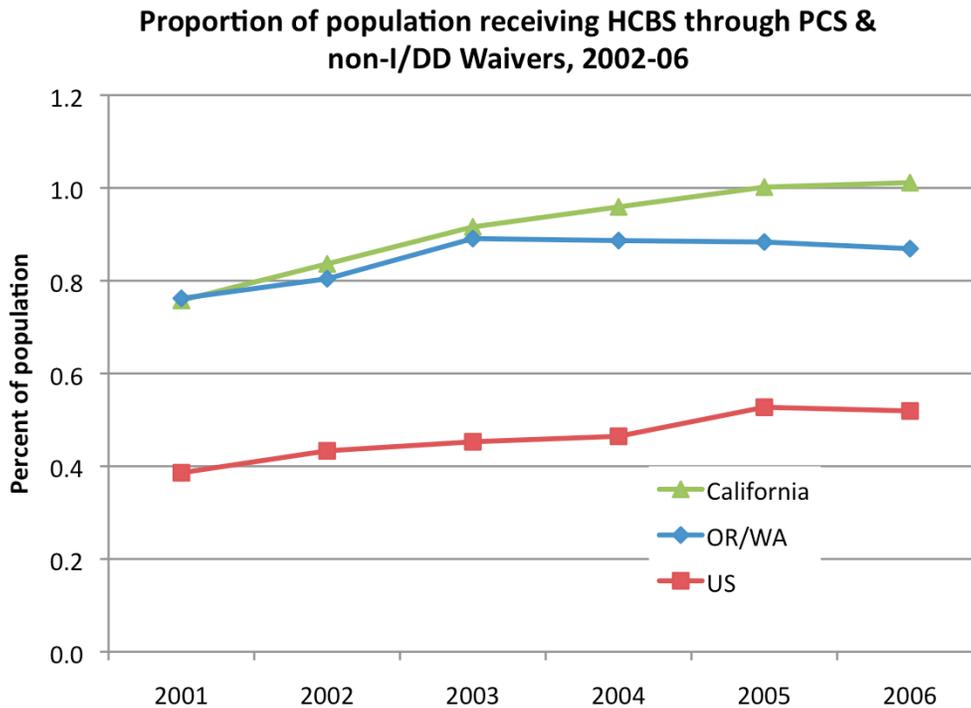
**Per-participant annual expenditure on HCBS through PCS & non-I/DD waivers, 2002-06**



**Why did California’s HCBS expenditures increase? Not because of undue increases in per-recipient costs.**

After adjusting for inflation in healthcare costs, HCBS expenditures per participant\* were relatively stable in California, as they were in other states. California’s average expenditure, between \$10,000 and \$11,000 per recipient per year, is somewhat lower than that of other states, including the comparison states.

\*Limited to personal care services programs, such as IHSS, and HCBS waivers not targeted to the I/DD population. The home health benefit is not included.

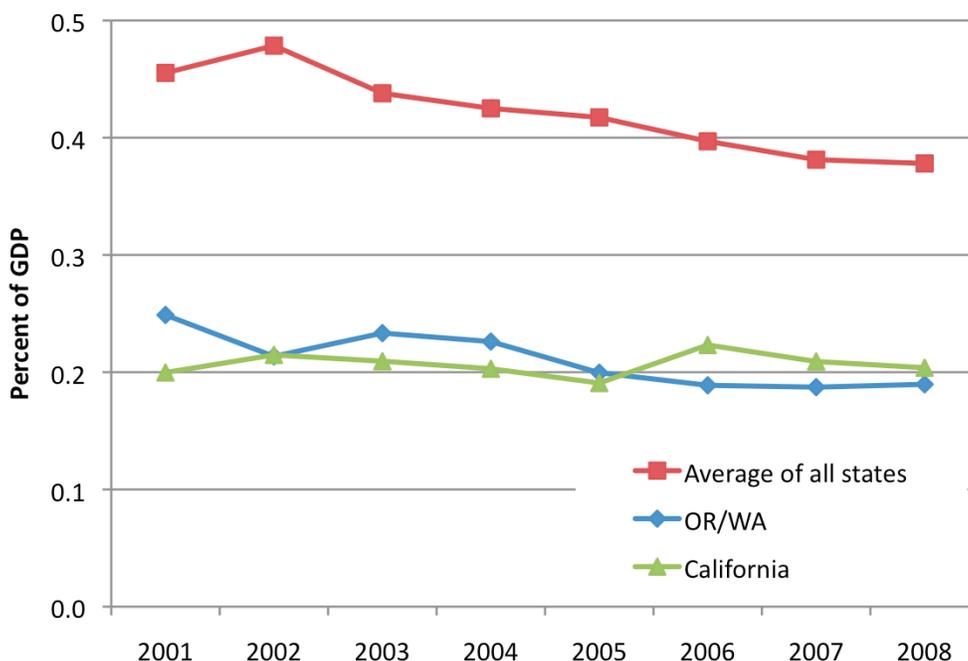


**Why did California’s HCBS expenditures increase? Because of increased participation.**

As in other states, participation in HCBS programs has been increasing. The proportion of California’s population participating in HCBS (33.5% growth in IHSS & non-I/DD waiver participation relative to population size) has been growing at about the same rate as that of other states (34.5% growth). In the comparison states, participation stabilized beginning in 2003, resulting in much lower expenditure growth.

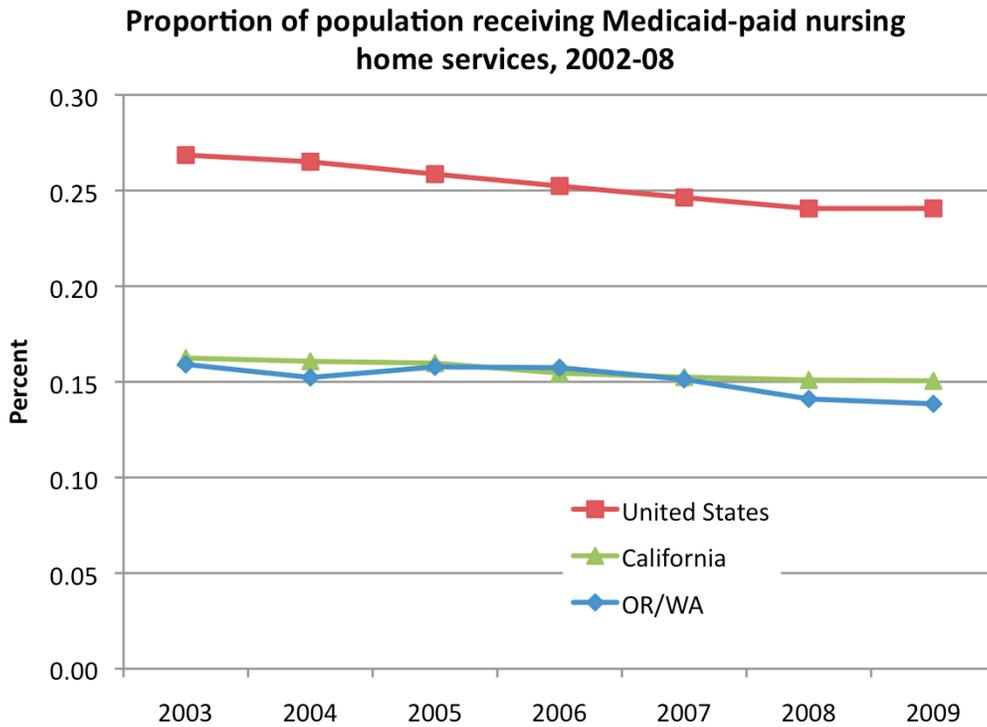
Source: HCBS participant data obtained from Terence Ng and Charlene Harrington, Center for Personal Assistance Services, University of California San Francisco; except for IHSS participant data, which was obtained from the California Department of Social Services.

**Nursing home expenditures as percent of GDP, 2001-08**



### **Trends in nursing home expenditures**

The other component to the growth in California's LTC expenditures is nursing home expenditures. Unlike in other states, nursing home expenditures did not decline in California, but instead grew by 2.0 percent over the period relative to GDP, following a sharp increase in FY 2006. Other states typically spend much more on nursing homes, but their expenditures declined by 17.0%, on average, over the period. The comparison states (Oregon and Washington), which spend about the same amount as California, also saw a substantial decline, of 23.8%.

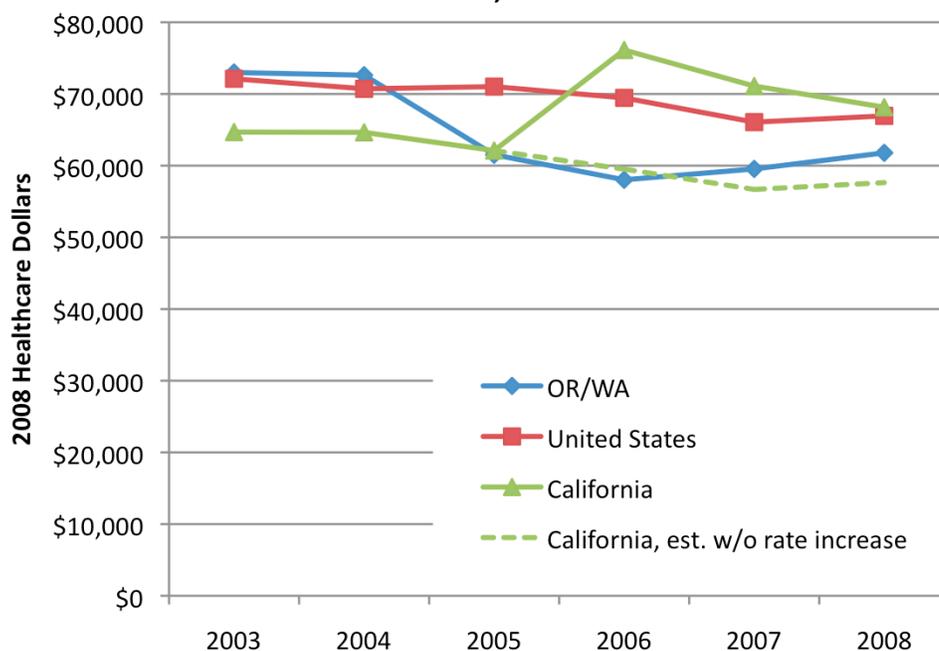


**Why didn't California's nursing home expenditures decline? Utilization dropped, but not as much as elsewhere.**

In both absolute numbers and proportion of the population, utilization of nursing homes has been declining in California and the rest of the country. California saw a 7.1% drop in the proportion of the population living in nursing homes, compared to a 10.4% drop nationally and an 11.4% drop in Oregon and Washington.

Source: Nursing home resident data from Minimal Data Set statistics obtained from the CMS website.

**Per-resident Medicaid nursing home expenditure,  
CA & US, 2002-08**



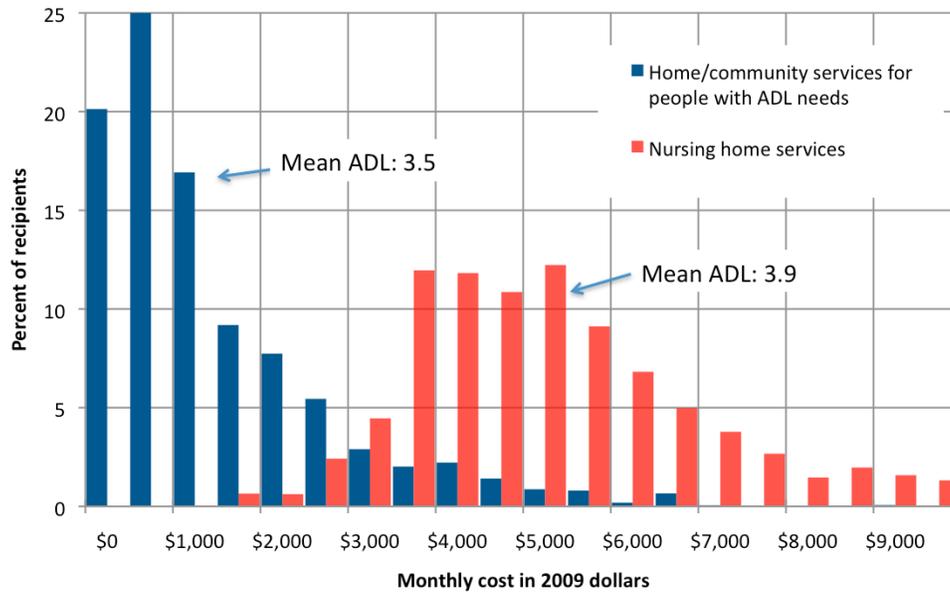
**Why didn't California's nursing home expenditures decline? Because of a rate increase.**

As a result of a rate increase that took effect in 2006, per-resident expenditures *increased* by 5.4% between 2003 and 2008, after adjusting for inflation in healthcare costs, compared to a national *decrease* of 7.1%. I estimate that, without the rate increase, California's inflation-adjusted, per-resident nursing home expenditures would have decreased by 10.9% (dashed line on graph).

Note the scale on the left side of the graph. Nursing homes typically cost between \$60,000 and \$70,000 in Medicaid expenditures, per resident per year in 2008 dollars, roughly 6 times as much as the \$10–11,000 spent in California per recipient per year for HCBS.

Source: Expenditure data from CMS as compiled by Thomson Reuters.

**Distribution of monthly long-term care costs,  
by residential setting, inflation adjusted to 2009.**



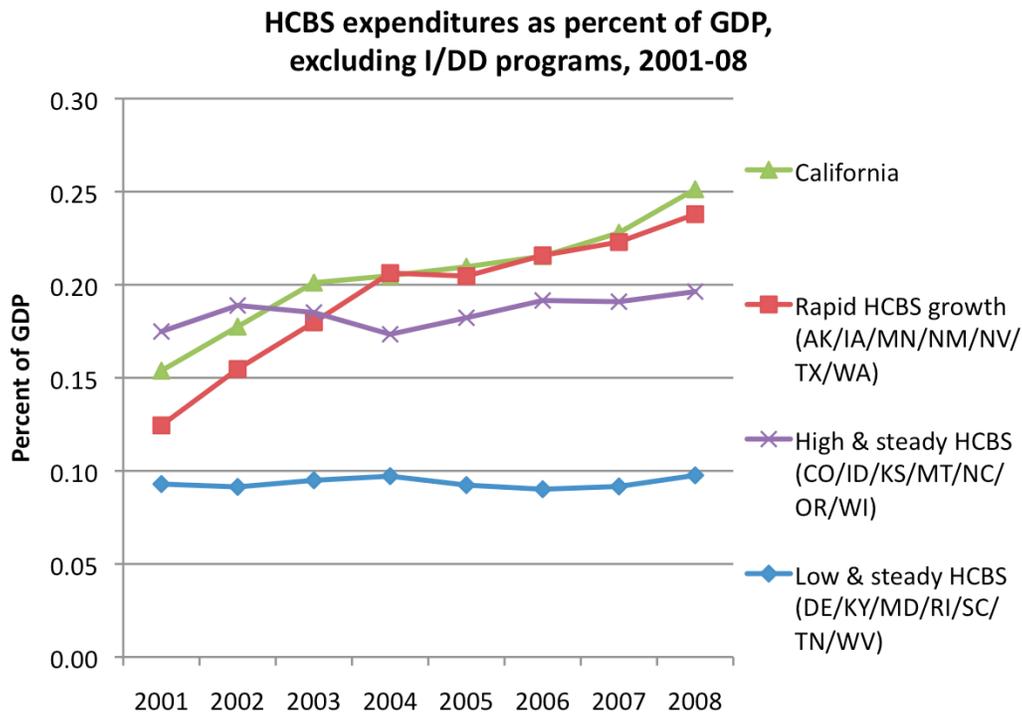
Source: Authors' tabulations from the 2005 and 2006 Medical Expenditure Panel Survey and the 2004 National Nursing Home Survey.

**Nursing home nearly always cost more than HCBS**

This graph is based on national data, and compares monthly expenditures for nursing homes and home- and community-based services. The vast majority (87%) of HCBS expenditures are below \$3,500, with most being below \$1,500. In contrast, nearly all nursing home stays (92%) cost more than \$3,500, with a typical cost of about \$5,000 per month (= \$60,000/year).

The data are limited to people needing help in at least one of the Activities of Daily Living (ADL): bathing, dressing, getting into our out of a bed or chair, using the toilet, eating, and (in this analysis) getting around inside. The extent of a person's disability is often measured by the number of ADL the person needs help with. Although it is very often said that people in nursing homes have much higher levels of need than those living in the community, the difference is much less than people think. People getting HCBS needed help with an average of 3.5 ADL, compared to 3.9 for those in nursing homes. And 37% of HCBS recipients have disabilities severe enough to require help with 5 or 6 of the ADL, compared to 48% in nursing homes.

This chart comes from our January 2010 article in *Health Affairs*:  
 Kaye, H. S., Harrington, C., & LaPlante, M. P. (2010). Long-term care: who gets it, who provides it, who pays, and how much? *Health Affairs*, 29(1), 11-21.



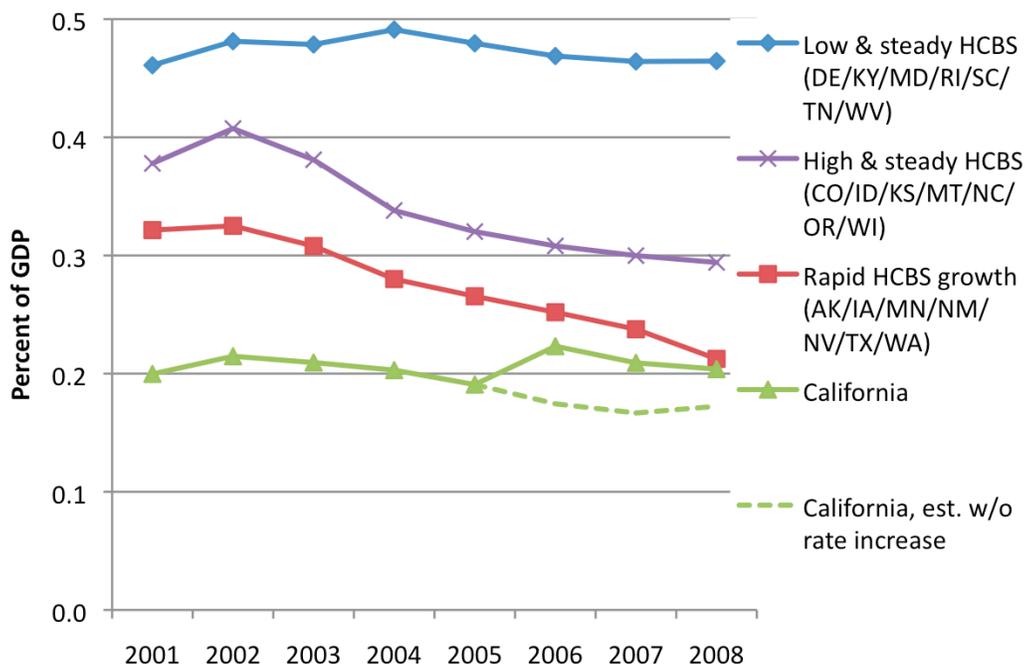
**How to contain LTC expenditures: Three common spending patterns**

This analysis updates\* the previous analysis from our journal article published in 2009 *Health Affairs* (Kaye, H. S., LaPlante, M. P., & Harrington, C. (2009). Do noninstitutional long-term care services reduce Medicaid spending? *Health Affairs*, 28(1), 262-272.).

States vary greatly in the way they allocate their LTC dollars, and the way that allocation changes over time, but we find three common patterns: The *low & steady HCBS states* (bottom line on the graph) spend a small proportion of LTC monies on HCBS and implemented no major expansions in HCBS programs over the period; the *high & steady HCBS states* (middle flat line) spent a relatively large proportion of their LTC expenditures on HCBS and had no major expansions; and the *rapid HCBS growth states* greatly expended their HCBS programs during the period, most notably between 2001 and 2004. California’s expenditures are more similar to those of the rapid growth states than to the high & steady states.

\*I also used somewhat different methods, which I believe are an improvement over the prior analysis: I used GDP-adjusted rather than per capita, inflation-adjusted expenditures; took the average across states rather than pooling states; and selected seven exemplary states in each category rather than assigning every state to a category.

**Nursing home expenditures as percent of GDP, 2001-08**

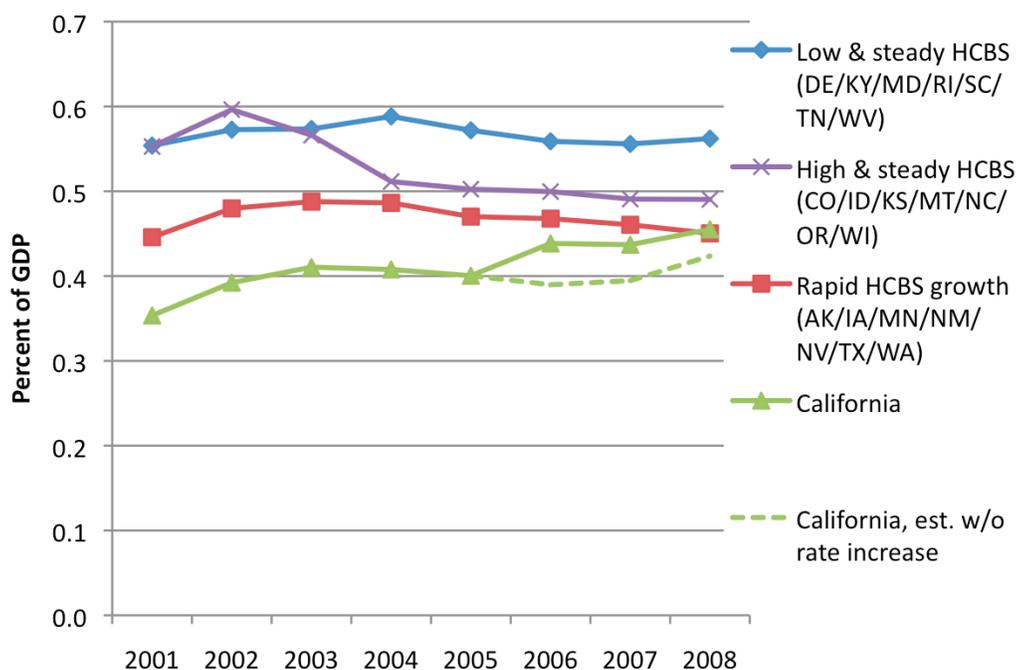


**How to contain LTC expenditures: Relationship between HCBS spending and nursing home spending**

The low & steady states saw essentially no change in nursing home expenditures, relative to GDP (+0.8%), and they spent a great deal more on nursing homes over the entire period than the other types of states. In contrast, the high & steady states and especially the rapid growth states saw large declines in nursing home spending, of 22.2% and 33.9%, respectively.

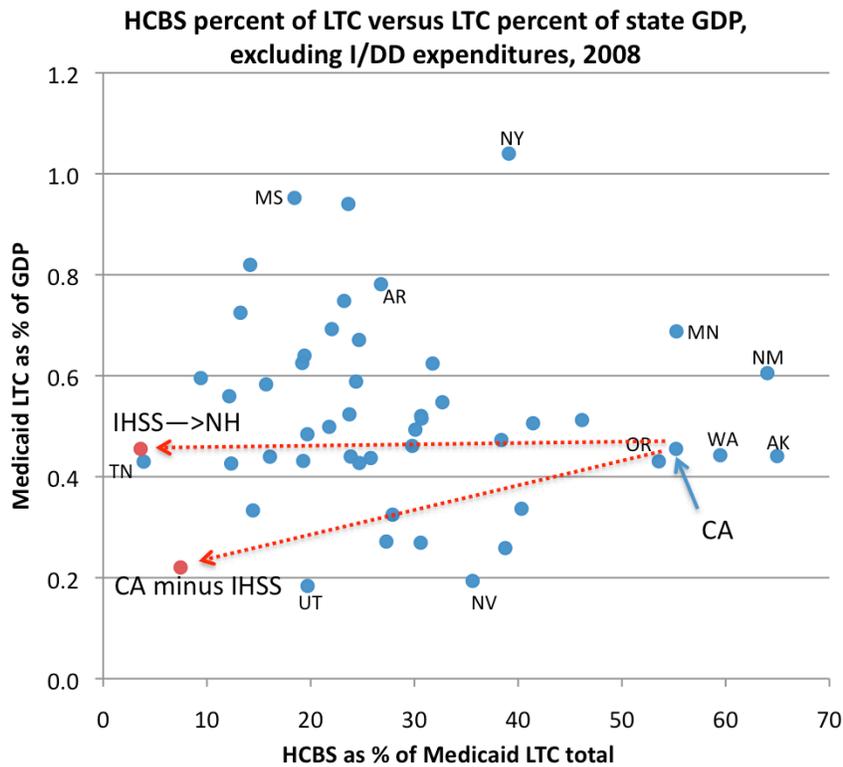
If nursing home rates had not been increased in 2006, California would probably have experienced a relatively modest decline. Nursing home expenditures in California were already far lower than those in all three types of states, however, relative to GDP.

**LTC expenditures as percent of GDP, excluding I/DD, 2001-08**



**How to contain LTC expenditures: Relationship between HCBS spending and total LTC spending**

The high & steady states had the only HCBS spending pattern associated with a reduction in LTC expenditures over the period, relative to GDP. Their expenditures dropped dramatically early in the decade and remained at the lower level, for a decline of 11.3% over the period. The low & steady states spent about as much of their GDP on LTC over the entire period as the high & steady states did before the decline. The rapid growth states saw an increase during the initial period when their HCBS expenditures were increasing fastest, followed by a decline.



### What if IHSS were eliminated or greatly reduced?

If IHSS expenditures were to be eliminated, without any compensatory increase in nursing home expenditures, California would become the third lowest-spending state in the country, in terms of the proportion of its GDP spent on long-term care programs not specifically targeted to people with developmental disabilities. The current spending rate of 0.46% of GDP would drop by more than half, to 0.22%. And California would become the second least progressive state in its LTC policies, spending only 7.5% of its LTC dollars on non-institutional services. A large reduction in IHSS expenditures, short of eliminating the program, would make California appear somewhere along the diagonal line on the graph, no longer an average state in terms of overall expenditures, but instead much below average.

It is very unlikely, however, that large cuts to IHSS would result in no increase in nursing home expenditures. These would almost certainly rise as people who had lost access to non-institutional services demanded services in far more costly institutional settings. Based on data from the low-HCBS states, which spend more of their GDP on LTC than higher-HCBS states, I would suggest that nursing home expenditures would rise to at least equal the current level of IHSS expenditures. If that were the case, California would remain an average state in terms of overall spending, but would win the title from Tennessee (if IHSS were entirely eliminated) as the state with the lowest availability of non-institutional services.

## Conclusions

An analysis of spending on long-term care programs not specifically targeted to people with intellectual and developmental disabilities finds that:

- California is succeeding in reducing reliance on nursing homes, and instead providing needed services to people in their own homes.
- California is a typical state in overall long-term care spending, a little below average, and one that spends a high proportion of long-term care dollars on non-institutional services, approaching that of the most progressive states.
- LTC spending in recent years, adjusted for rising costs, would have remained stable had there not been an increase in nursing home rates beginning in 2006.
- Beyond that change, reductions in LTC spending (adjusted for inflation/GDP) would have been achieved if (1) the annual decline in the nursing home population had equaled that of other states and (2) the number of IHSS participants had stabilized.

Several changes in policy could be made to improve California's long-term care system and probably reduce expenditures:

- **California could do more to reduce usage of nursing homes.** This would not only be very likely to reduce expenditures, because each person not admitted to a nursing home is money saved, but also provide services more likely to allow people to thrive. How to do this? Find out where the unmet need for services is—what forces people into institutions, where they don't want to be?—and adjust policies to fill that need.
- **Nursing home payments could return to pre-2006 levels.** Substantial savings could be achieved, including returning overall, inflation-adjusted LTC spending levels to pre-2006 levels.
- **California could adopt a more flexible approach that would prioritize services to people with higher levels of need.** Cutting services to people already receiving them would have serious, unanticipated economic and human consequences. Without making across-the-board cuts, however, there might be a way to make sure that people most at risk of adverse outcomes—such as hospitalization, institutionalization, isolation, or mortality—are the first people served when the budget is tight, while others might need to wait for services. As a Medicaid PCS plan, IHSS is constrained in its ability to take such an approach, but there may be other avenues.

Vermont has done so with an 1115 Demonstration Waiver obtained from CMS. Participants with more severe disabilities (e.g., a so-called institutional level of need) have immediate access to their choice of intensive HCBS or institutional services, *on an equal footing*. People with lesser needs might get limited HCBS immediately, or they might have to go on a waiting list, depending on budget constraints. The real purpose is not to ration services, but to save enough money by serving people in the community rather than nursing homes so that the program is able to meet the full demand for HCBS.

# Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?

Home and community-based services help people with disabilities stay in their homes while reducing long-term care spending.

by **H. Stephen Kaye, Mitchell P. LaPlante, and Charlene Harrington**

**ABSTRACT:** Medicaid spending on home and community-based services (HCBS) has grown dramatically in recent years, but little is known about what effect these alternatives to institutional services have on overall long-term care costs. An analysis of state spending data from 1995 to 2005 shows that for two distinct population groups receiving long-term care services, spending growth was greater for states offering limited noninstitutional services than for states with large, well-established noninstitutional programs. Expansion of HCBS appears to entail a short-term increase in spending, followed by a reduction in institutional spending and long-term cost savings. [*Health Affairs* 28, no. 1 (2009): 262–272; 10.1377/hlthaff.28.1.262]

ENACTED IN 1965 TO PROVIDE HEALTH COVERAGE for impoverished Americans, the Medicaid program quickly became a major source of payment for long-term care (LTC) services for elderly and nonelderly people with disabilities. During the program's first two decades, these services were offered almost exclusively in institutional settings, such as nursing homes and facilities for people with intellectual disabilities. In the mid-1980s, however, states began to offer LTC services to people living outside of institutions, through what are known as Home and Community-Based Services Waiver programs and Personal Care Services (PCS) Optional Benefit programs. These two programs, plus the smaller Medicaid Home Health Benefit, are collectively referred to as Medicaid home and community-based services (HCBS); all such programs may offer personal assistance that enables people who need help in performing daily activities to continue to live and thrive in the community, instead of being forced to relinquish their independence and move into an institution.

Pressured by advocates for people with disabilities and the elderly, and com-

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pelled by the Supreme Court's 1999 *Olmstead* decision to offer services in "the most integrated setting" appropriate to the person's needs, many states have created or expanded HCBS programs, offering an alternative to institutionalization for millions of poor or near-poor Americans.<sup>1</sup> As a result, HCBS spending has constituted a steadily increasing share of Medicaid LTC costs, rising at a much more rapid rate than spending on institutional services.<sup>2</sup> The estimated \$35.2 billion spent on HCBS in 2005 amounts to 37.2 percent of the \$94.5 billion national Medicaid LTC expenditure, or 11.7 percent of the \$300.3 billion total Medicaid expenditure.<sup>3</sup> A decade earlier, HCBS spending accounted for only 19.2 percent of Medicaid LTC spending and 6.3 percent of all Medicaid spending.<sup>4</sup>

Although states still spend much more on institutional than noninstitutional LTC, the expansion of HCBS programs has nonetheless been blamed for the overall growth in LTC spending. Opponents of further expansion in HCBS have recently used the continued growth in overall LTC spending to argue that noninstitutional LTC services are not cost-effective, in the sense that they increase rather than reduce overall expenditures.<sup>5</sup>

This paper explores the question of whether states that offer extensive HCBS programs experience greater or lesser growth in Medicaid LTC spending than states in which institutional LTC continues to predominate. We are aware of no similar analyses, although one study compared LTC spending in three states that were offering extensive HCBS with projections of spending in the absence of such programs, and concluded that those states had greatly reduced their spending.<sup>6</sup>

The main issue is not the cost of services per person served. A recent study found that the average total public expenditure on a recipient of HCBS waiver services (who must meet the eligibility criteria for institutionalization) was about \$44,000 less per year than for a person receiving institutional services.<sup>7</sup> Indeed, waiver programs are required to demonstrate cost-neutrality, in that the per participant spending under the waiver cannot exceed the state's estimate of the costs for the same people had they entered institutions.

Instead, the concern is with the aggregate cost, which may grow if increasing numbers of eligible people are served. There is a fear that the introduction of HCBS programs would create a "woodwork effect," in which large numbers of people who previously received help from family members and did not seek institutional services might sign up for the more desirable noninstitutional services, thus increasing the overall costs. The impact of HCBS programs on aggregate Medicaid spending has been studied in several demonstration projects, but results have been inconclusive.<sup>8</sup>

## Data Sources And Methods

■ **Sources.** State data on Medicaid LTC spending for fiscal years 1995–2005 were obtained from reports submitted by state Medicaid agencies to the Centers for Medicare and Medicaid Services (CMS). States report both institutional spending,

for services provided in either nursing homes or so-called intermediate care facilities for people with mental retardation (ICF/MR), and noninstitutional spending, for services provided through waiver, personal care, and home health programs. Data on nursing home, ICF/MR, personal care, and home health spending were obtained from CMS 64 reports, as compiled annually by the Medstat Group.<sup>9</sup> Data on HCBS waiver spending, by type of waiver, were obtained from CMS 64 reports on individual waiver programs, occasionally corrected with data obtained from CMS 372 reports.<sup>10</sup>

Because spending patterns, including the proportion devoted to HCBS, differ markedly according to the targeted population, we analyzed spending explicitly directed toward people with mental retardation and other developmental disabilities (MR/DD) separately from those primarily directed toward people with other types of disabilities. ICF/MR spending and MR/DD waiver spending are classified as MR/DD spending, while nursing home, non-MR/DD waiver, personal care, and home health spending is classified as non-MR/DD spending.

■ **Data limitations.** Limitations in these data include occasional incomplete or inaccurate reporting and expenditures reported according to the date of payment rather than the date of service provision, causing year-to-year fluctuations when states delay payment and shift expenditures to the next fiscal year. Furthermore, a limited amount of spending on services provided under capitated managed care programs is not reported; this limitation is mostly an issue for Arizona, which we excluded from the analysis because the bulk of its expenditures are not listed. A few states (most notably Texas) have or had relatively small “frail elderly” programs distinct from the noninstitutional services already mentioned; because data for these programs are available from the Medstat compilations for some years but not others, we omitted these programs from the analysis, too.

In a few cases of missing or incomplete waiver data for particular waivers or states, we interpolated or extrapolated to estimate expenditures. In one case of a suspiciously large expenditure followed by a negative reported expenditure in the subsequent year, we replaced both numbers with their average.

■ **Facilitating comparisons.** To facilitate comparison across states, we obtained per capita (not per recipient) expenditures for each state by dividing the reported spending by the Census Bureau’s population estimate for the state for the given year.<sup>11</sup> To further facilitate comparison across years, we adjusted the per capita spending for inflation in medical care costs, using the Consumer Price Index (CPI) for medical care services; amounts shown are in 1995 medical care dollars.<sup>12</sup>

■ **Classification process.** We then classified states according to their level and pattern of HCBS spending. First, we divided the states into two groups according to the proportion of their total 2005 LTC spending devoted to HCBS. States that spent less than the median proportion on HCBS were classified as low-HCBS states; the remaining states were classified as high-HCBS states. The latter were further divided into two categories according to whether their HCBS spending remained rela-

tively stable or increased markedly during the decade of interest: states whose per capita, inflation-adjusted HCBS spending more than doubled during 1995–2005 were classified as expanding-HCBS states; the remaining states, as established-HCBS states. States that were pioneers in offering extensive noninstitutional services fell into this latter group.

The classification process was done twice, once for non-MR/DD spending and once for MR/DD spending. Thus, two separate groupings of states were obtained (Exhibit 1).

## Study Findings

■ **Non-MR/DD spending.** The high- and low-HCBS states (as differentiated according to their 2005 expenditures) differed markedly in the types and amounts of spending on the non-MR/DD population (Exhibit 1). Low-HCBS states spent only about \$14 per capita on HCBS in 1995, compared to more than \$24 for the high-HCBS states. Both groups of states increased their HCBS spending over the decade much faster than the rate of inflation, with the low-HCBS states increasing by 56.7 percent and the high-HCBS states growing still faster, by 110.0 percent.

HCBS spending data reveal vastly different rates of growth for the established- and expanding-HCBS states (Exhibit 2). Established states increased their HCBS spending relatively modestly during the period (21.2 percent), while expanding states increased their spending by 276.2 percent. Especially rapid HCBS growth is apparent among the expanding states during 2000–2005, mostly because of program growth but also because California shifted a state-only program to a Medicaid personal care plan in 2001.

Nursing home spending grew by 3.4 percent in the low-HCBS states over the period, after adjusting for inflation, but declined by 15.3 percent in the high-HCBS states (Exhibit 3). A pattern of substantial growth is apparent in the low-HCBS states between 1997 and 2002 (followed by a sharp one-year decline, which we hypothesize is attributable to state budget shortfalls), and a steady decline is apparent for the high-HCBS states beginning in 2002.

Total LTC spending on the non-MR/DD population grew by similar amounts in the low- and high-HCBS states (Exhibit 4). But when we compared established and expanding HCBS states, we found that LTC spending actually declined by 7.9 percent in the established-HCBS states, but increased markedly in the expanding-HCBS states (24.2 percent). Spending increased greatly in both the low- and expanding-HCBS states during 1997–2002, when the established-HCBS states were able to hold their LTC spending relatively constant. The established-HCBS states also experienced a large decline in spending between 2003 and 2005, which is not seen in the data from the other states.

■ **MR/DD spending.** Also shown in Exhibit 1 is HCBS and institutional spending targeted to the MR/DD population. The practice of deinstitutionalizing this population, or avoiding institutionalization entirely, is much better established than

**EXHIBIT 1**  
**Mean Per Capita, Inflation-Adjusted Medicaid Long-Term Care (LTC) Spending In States With High And Low Home And Community-Based Services (HCBS), By Type Of Expenditure, And Percentage Change, Fiscal Years 1995 And 2005**

Non-MR/DD spending	Low-HCBS states <sup>a</sup>	High-HCBS states		
		All	Established <sup>b</sup>	Expanding <sup>c</sup>
HCBS spending				
FY 1995	\$13.69	\$24.35	\$39.67	\$14.12
FY 2005 (1995 \$)	\$21.46	\$51.10	\$48.09	\$53.12
Change	56.7%	110.0%	21.2%	276.3%
Institutional spending (nursing homes)				
FY 1995	\$122.64	\$110.83	\$138.54	\$92.35
FY 2005 (1995 \$)	\$126.85	\$93.88	\$116.03	\$79.12
Change	3.4%	-15.3%	-16.3%	-14.3%
Total LTC spending				
FY 1995	\$136.34	\$135.17	\$178.21	\$106.47
FY 2005 (1995 \$)	\$148.31	\$144.99	\$164.12	\$132.24
Change	8.8%	7.3%	-7.9%	24.2%
HCBS proportion of total				
FY 1995	10.0%	18.0%	22.3%	13.3%
FY 2005	14.5	35.2	29.3	40.2

MR/DD spending	Low-HCBS states <sup>d</sup>	High-HCBS states		
		All	Established <sup>e</sup>	Expanding <sup>f</sup>
HCBS spending (MR/DD waivers)				
FY 1995	\$14.21	\$28.89	\$47.82	\$18.24
FY 2005 (1995 \$)	\$36.31	\$59.49	\$71.04	\$52.99
Change	155.6%	105.9%	48.6%	190.4%
Institutional spending (ICF/MR)				
FY 1995	\$42.44	\$24.81	\$26.73	\$23.72
FY 2005 (1995 \$)	\$36.33	\$11.93	\$10.30	\$12.86
Change	-14.4%	-51.9%	-61.5%	-45.8%
Total LTC spending				
FY 1995	\$56.65	\$53.70	\$74.55	\$41.97
FY 2005 (1995 \$)	\$72.64	\$71.42	\$81.34	\$65.84
Change	28.2%	33.0%	9.1%	56.9%
HCBS proportion of total				
FY 1995	25.1%	53.8%	64.1%	43.5%
FY 2005	50.0	83.3	87.3	80.5

**SOURCE:** Authors' calculations based on data from Centers for Medicare and Medicaid Services 64 and 372 reports.

**NOTES:** MR/DD is mental retardation/developmental disability. ICF/MR is intermediate care facility for mental retardation.

<sup>a</sup> AL, CT, DE, FL, GA, HI, IN, IA, KY, LA, MD, MI, MS, NE, NH, NJ, ND, OH, PA, RI, SC, SD, TN, UT.

<sup>b</sup> AR, CO, ME, MA, MT, NY, OR, VA, WV, WI.

<sup>c</sup> AK, CA, ID, IL, KS, MN, MO, NV, NM, NC, OK, TX, VT, WA, WY.

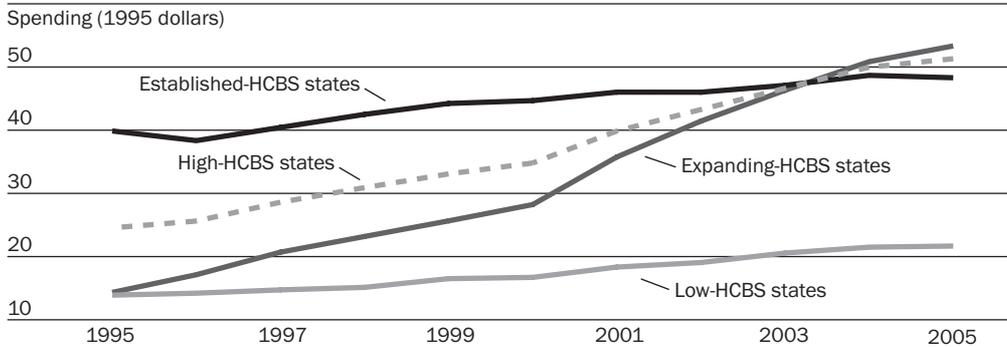
<sup>d</sup> AK, CA, CT, ID, IL, IN, IA, KY, LA, MI, MO, NV, NJ, NY, NC, ND, OH, OK, PA, SC, TN, TX, UT, VA.

<sup>e</sup> CO, MA, NH, OR, RI, SD, VT, WA, WY.

<sup>f</sup> AL, AK, DE, FL, GA, HI, KS, ME, MD, MI, MN, MT, NE, NM, WV, WI.

for people with other types of disabilities, and even the low-HCBS states devoted, on average, half of their 2005 MR/DD LTC spending to noninstitutional services. Both the low- and high-HCBS states more than doubled their HCBS spending over the period; this spending nearly tripled among the expanding-HCBS states. Institu-

**EXHIBIT 2**  
**Mean Per Capita, Inflation-Adjusted Spending On Home And Community-Based Services (HCBS), Excluding Mental Retardation/Developmental Disability (MR/DD) Programs, In States With Low And High HCBS, Fiscal Years 1995–2005**

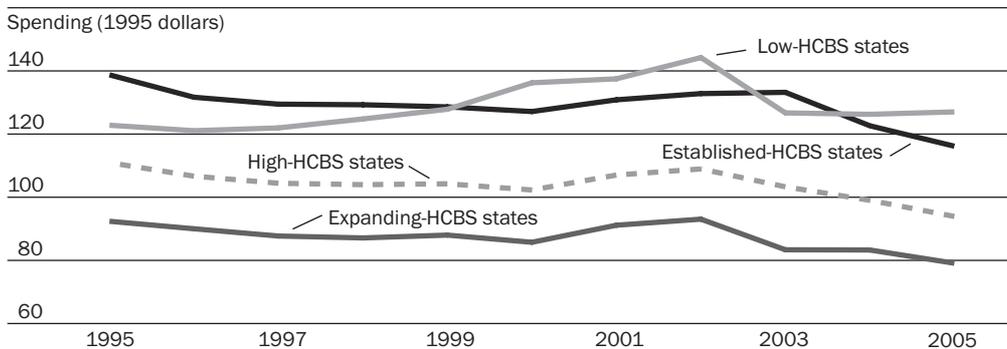


**SOURCE:** Authors' calculations based on data from Centers for Medicare and Medicaid Services (CMS) 64 and 372 reports.  
**NOTE:** For explanation of types of HCBS states, see text.

tional spending dropped for both low- and high-HCBS states, after adjusting for inflation, but the drop was much more dramatic for the high-HCBS states, where ICF/MR spending declined by more than half, compared to a 14.5 percent drop among the low-HCBS states. Particularly impressive is the 61.5 percent drop in ICF/MR spending among established-HCBS states.

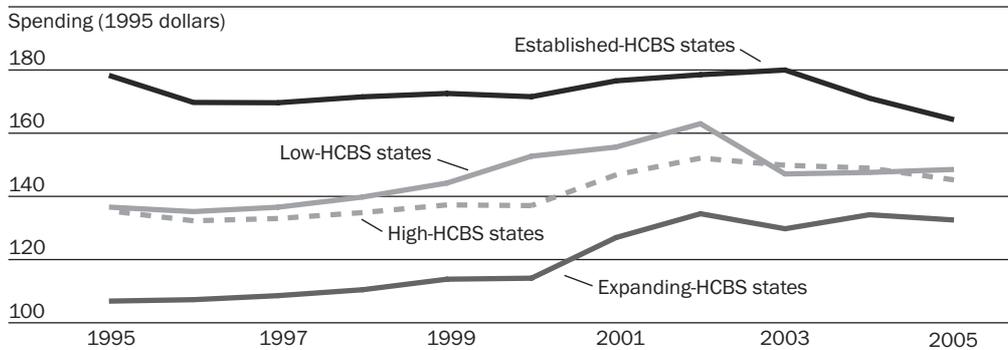
Total LTC spending for the MR/DD population increased for all types of states, with a 28.2 percent increase among low-HCBS states and a 33.0 percent increase among high-HCBS states (Exhibit 5). Established-HCBS states, however, experienced by far the lowest rate of growth (9.1 percent), with hardly any growth in inflation-adjusted spending between 1998 and 2005. Expanding-HCBS states had the highest rate of spending growth, at 56.9 percent.

**EXHIBIT 3**  
**Mean Per Capita, Inflation-Adjusted Nursing Home Spending In States With Low And High Home And Community-Based Services (HCBS), Fiscal Years 1995–2005**



**SOURCE:** Authors' calculations based on data from Centers for Medicare and Medicaid Services (CMS) 64 and 372 reports.  
**NOTE:** For explanation of types of HCBS states, see text.

**EXHIBIT 4**  
**Mean Per Capita, Inflation-Adjusted Long-Term Care (LTC) Spending, Excluding Mental Retardation/Developmental Disability (MR/DD) Programs, in States With Low And High Home And Community-Based Services (HCBS), Fiscal Years 1995–2005**

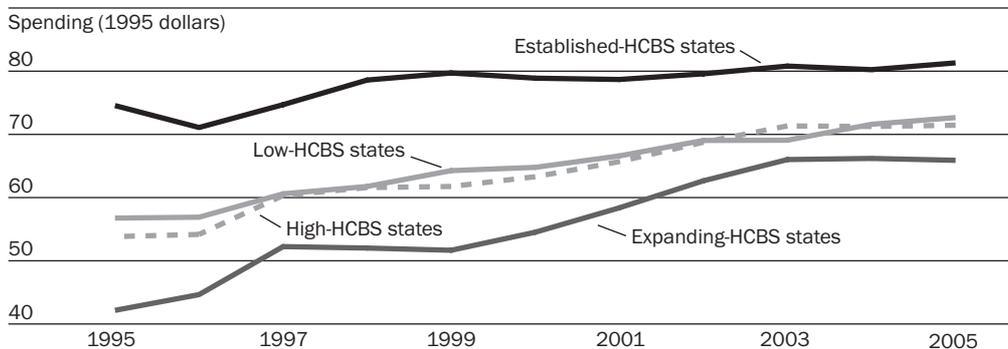


**SOURCE:** Authors' calculations based on data from Centers for Medicare and Medicaid Services (CMS) 64 and 372 reports.  
**NOTE:** For explanation of types of HCBS states, see text.

■ **Expenditures following HCBS expansion.** Having observed that for both non-MR/DD and MR/DD programs, established-HCBS states controlled spending better than low-HCBS states and much better than expanding-HCBS states did, we hypothesized that HCBS programs incur an initial cost and have the eventual, but not immediate, effect of reducing institutional spending and limiting the growth of overall LTC spending. To explore this possibility, we examined LTC spending before, during, and after expansion of HCBS programs in several states.

Nine states rapidly expanded their non-MR/DD HCBS spending during the latter part of the 1990s and then held that (inflation-adjusted) spending relatively steady until at least 2005. One state created a new PCS program and another ex-

**EXHIBIT 5**  
**Mean Per Capita, Inflation-Adjusted Long-Term Care (LTC) Spending On Mental Retardation/Developmental Disability (MR/DD) Programs, in States With Low And High Home And Community-Based Services (HCBS), Fiscal Years 1995–2005**



**SOURCE:** Authors' calculations based on data from Centers for Medicare and Medicaid Services (CMS) 64 and 372 reports.  
**NOTE:** For explanation of types of HCBS states, see text.

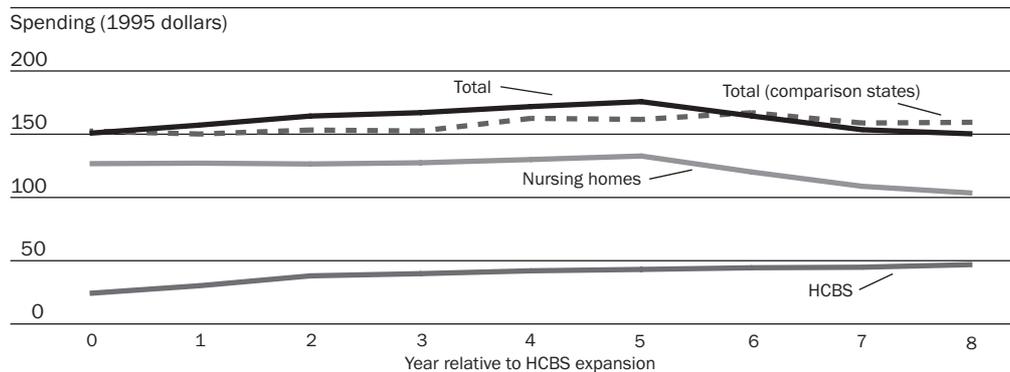
panded an existing program, two states created new waiver programs and four expanded existing waivers, and one state expanded both a PCS and a waiver program. The growth in HCBS spending typically occurred over two years and then leveled off.

Exhibit 6 presents the mean spending on non-MR/DD HCBS, nursing homes, and total non-MR/DD LTC for the nine states; data for the states are combined not according to the fiscal year of expenditure but instead according to the year relative to the expansion. The states had not yet begun to increase spending during Year 0 (1995 for three states, 1996 for two, and 1997 for four); the expansion was essentially complete by Year 2; and HCBS spending remained relatively steady for the six subsequent years (ending in 2003, 2004, or 2005).

For these states, HCBS spending increased on average by 57.3 percent during the two years of rapid growth, and then much more slowly during subsequent years. Nursing home spending remained fairly stable for the three years following full expansion and then declined in each subsequent year. Total non-MR/DD spending rose especially rapidly during the period of HCBS expansion and then rose more slowly for the next three years. During subsequent years, however, total inflation-adjusted spending fell substantially, returning to just below its pre-expansion level in the final year.

For comparison, we identified fifteen states that held their non-MR/DD HCBS spending stable over the entire period (Exhibit 6). With flat HCBS spending and increasing nursing home spending, the comparison states saw a 4.6 percent increase in overall spending over the period. Initial levels were roughly equal in the comparison and expansionary states; following a temporary increase, the expansionary states saw a sharp decline in total spending.

**EXHIBIT 6**  
**Mean Per Capita, Inflation-Adjusted Long-Term Care (LTC) Spending, Excluding Mental Retardation/Developmental Disability (MR/DD) Programs, in Nine States, Before, During, and After Home and Community-Based Services (HCBS) Expansion**



**SOURCE:** Authors' calculations based on data from Centers for Medicare and Medicaid Services (CMS) 64 and 372 reports.

**NOTES:** Expansion states are CO, CT, KS, MN, NC, NE, TX, WA, WI. Comparison states are AL, AR, DE, FL, GA, IN, KY, MI, NJ, NY, ND, RI, TN, VA, WV.

sionary states were able to reduce their overall non-MR/DD LTC spending to approximate that of the comparison states in Year 6, and then further reduce it in subsequent years to below the comparison levels.

A similar analysis of states that expanded their MR/DD spending in the late 1990s (not shown) also suggests a lag between an increase in HCBS spending and a reduction in institutional spending, but the lag period appears to be shorter than for the non-MR/DD population.

## Discussion

An analysis of state-by-state Medicaid LTC spending for 1995–2005 reveals that states offering extensive noninstitutional services experienced growth in overall spending comparable to that in states offering lower levels of such services. This finding holds true for spending on services both for people with nondevelopmental physical or cognitive disabilities, on the one hand, and for people with intellectual and other developmental disabilities, on the other.

For both types of spending, states with extensive, well-established noninstitutional programs saw much less spending growth than states with minimal noninstitutional services. In the case of non-MR/DD spending, states with well-established noninstitutional programs actually reduced their overall, inflation-adjusted LTC spending, in contrast with growing expenditures among states with minimal noninstitutional services. States that greatly expanded their HCBS programs during the period, however, saw greater increases in overall spending than other states did; the bulk of this expansion occurred after 2000, and its long-term effects are not yet observable.

■ **Negligible impact of other factors.** In comparing LTC spending patterns across states, it is worth exploring whether economic or population factors might account for the observed differences. Published models of state variations in total LTC spending have identified the most important predictors as average income and proportion of the population likely to need LTC, based either on a disability measure or on the proportion of residents who are very elderly.<sup>13</sup> We obtained state-by-state data from the 2000 census on median household income and on the proportion of residents with self-care difficulties; we found no significant correlation between either of these variables and the proportional change in LTC spending. It is therefore unlikely that such factors could explain the different spending trends observed among the states.

■ **Lag between HCBS expansion and lower LTC spending.** An examination of a group of states that expanded HCBS programs in the late 1990s suggests that there is a lag between the expansion of noninstitutional services and a subsequent, compensatory reduction in institutional spending, resulting after several years in lower total LTC spending than in states that did not expand HCBS programs. Because HCBS programs tend to serve people at risk of needing institutional services, with the goal of deferring or obviating their eventual institutionalization, and not merely

people gradually moving out of institutions, a lag between the introduction of an HCBS program and a reduction in the institutional population might be expected. Furthermore, real savings in institutional costs occur only when the number of Medicaid-financed nursing home residents is reduced, a process that can take years.

It seems apparent that states offering noninstitutional LTC services as an alternative to institutionalization are not only complying with the *Olmstead* decision and meeting the demands of their citizens with disabilities, but are also potentially saving money. One caveat, however, is that an initial outlay is required to launch a new HCBS program, followed several years later by a reduction in institutional spending and the possibility of overall cost savings. Additionally, our results do not necessarily imply that institutional savings occur automatically, but instead may result from parallel policy initiatives such as certificate-of-need programs or moratoria on new nursing home beds.<sup>14</sup>

It is clear, in any case, that states offering noninstitutional alternatives do not generally suffer any long-term financial penalty as a result. Such states have been able to contain and even reduce costs, largely avoiding a feared “woodwork effect” in which the demand for services was predicted to grow tremendously once HCBS programs became available.

■ **Pending legislation and its costs.** Legislation pending before Congress would require states not already doing so to offer noninstitutional alternatives to anyone eligible for institutional services. The Community Choice Act, successor to the Medicaid Community-Based Attendant Services and Supports Act (MiCASSA), was once estimated by the Congressional Budget Office to require additional Medicaid expenditures of \$10–\$20 billion or more annually, but a recent study calculates that the cost would be much lower, \$1.4–\$3.7 billion.<sup>15</sup> Neither analysis attempted to estimate cost savings through a commensurate reduction in institutional spending, however. Our study suggests that if experience is any guide, such legislation would likely entail no additional long-term spending and might in fact save money over the long run by providing less costly services to people who could then avoid or defer entering a nursing home or an ICF/MR.

**F**RAIL ELDERLY PEOPLE, and especially nonelderly people with various types of disabilities, need services that allow them to remain in their homes and retain their independence, and avoid entering an institution, possibly to remain there for the rest of their lives. In some states, those who cannot afford to purchase their own services have no alternatives to institutionalization. Justifications based on financial constraints can no longer be credibly offered as reasons for forcing such people into nursing homes and other institutions. HCBS programs may be one instance in which offering people greater choice also helps reduce costs.

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