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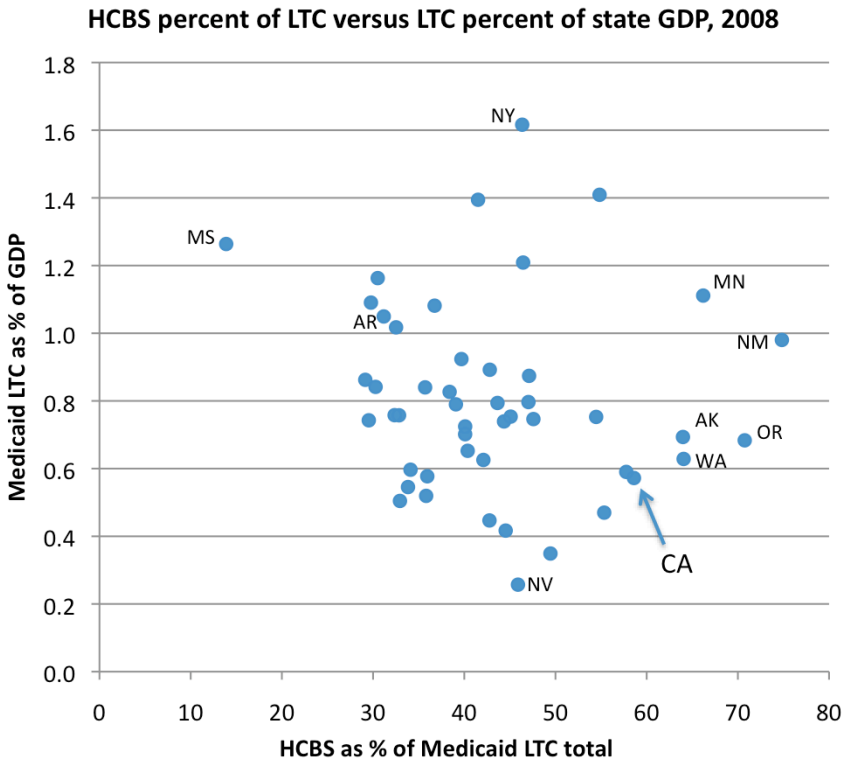
In-Home Supportive Services (IHSS) is the primary source of government-funded Home- and Community-Based (HCBS) long-term care in California, providing services to more than 400,000 elderly and non-elderly people with all types of disabilities and functional limitations. IHSS operates mostly as a Medicaid 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.



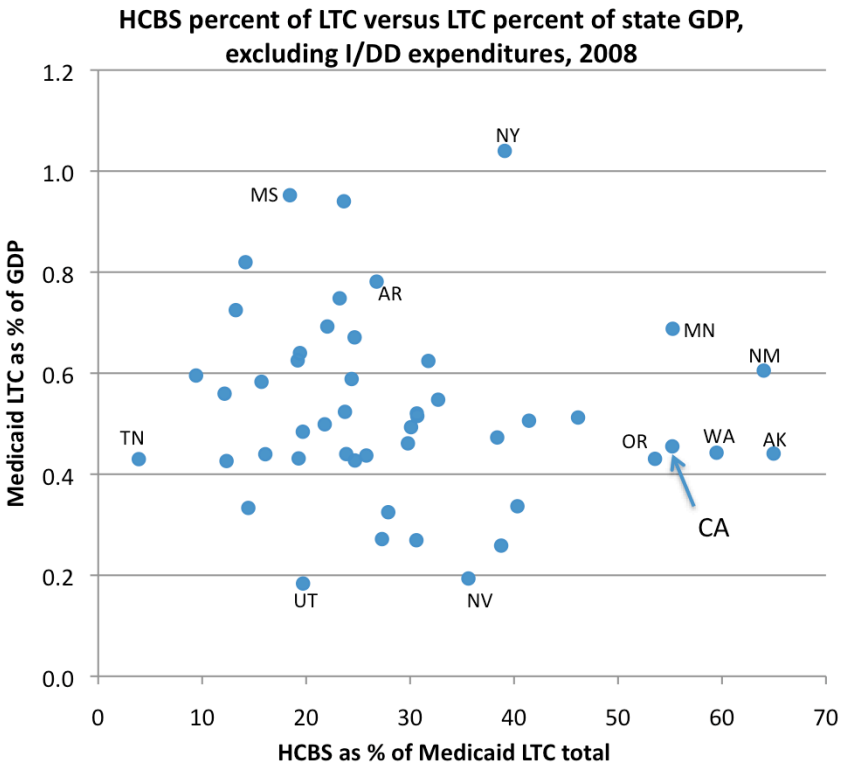
Long-term care spending: How does California compare to other states?

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.



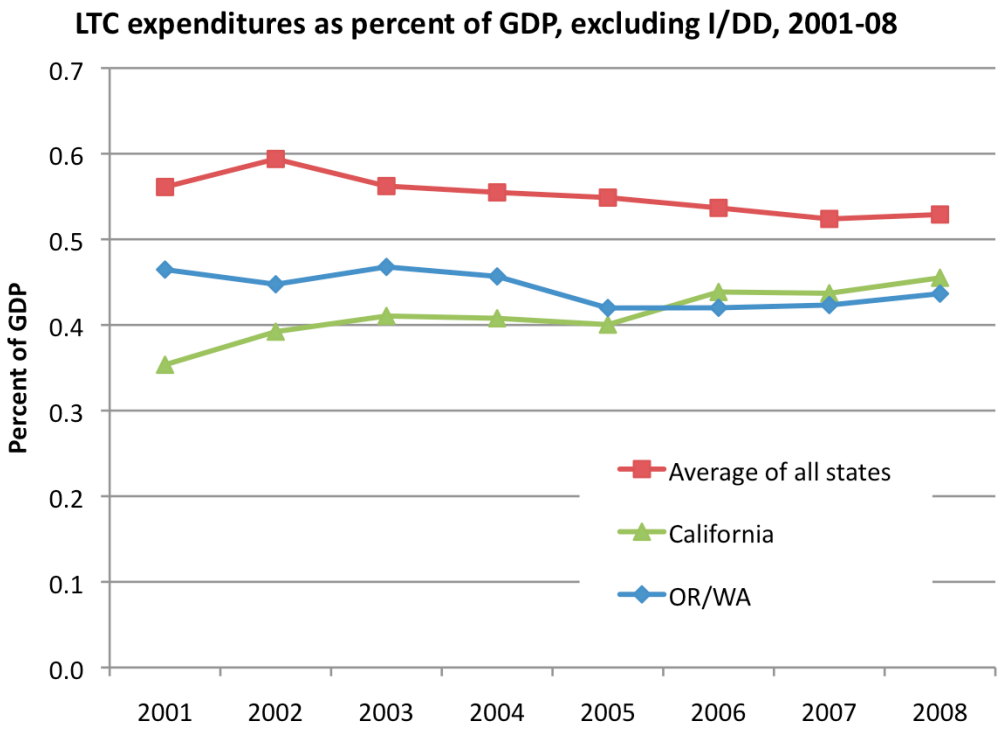
LTC expenditures, excluding spending on developmental disability programs

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.

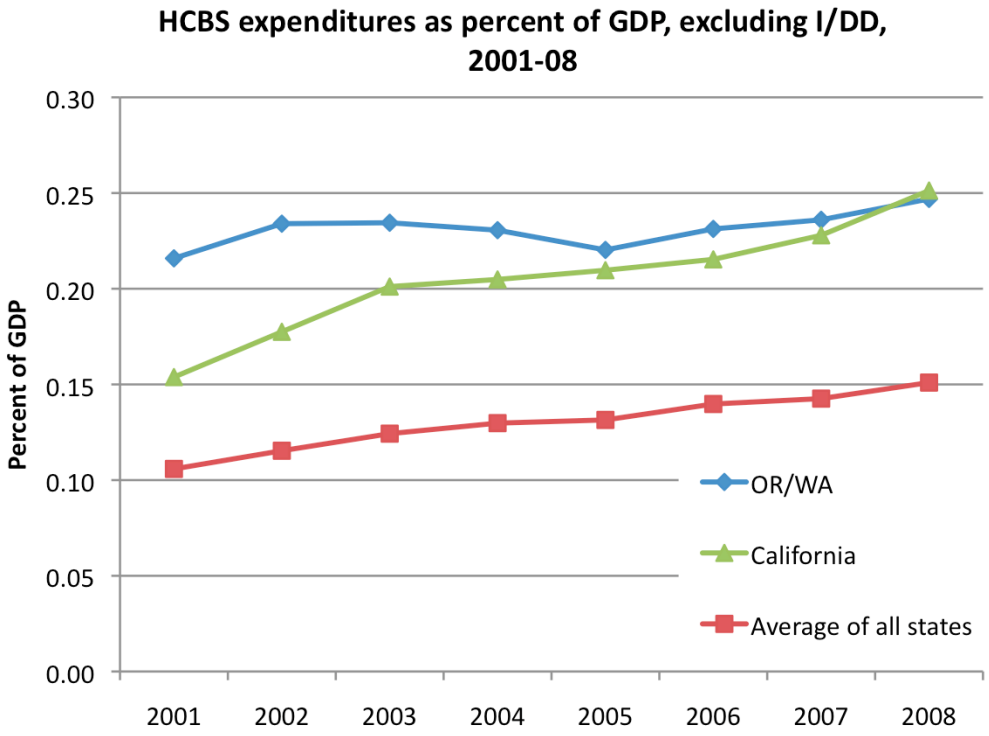


Trends in Medicaid† Long-Term Care expenditures

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.

†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.

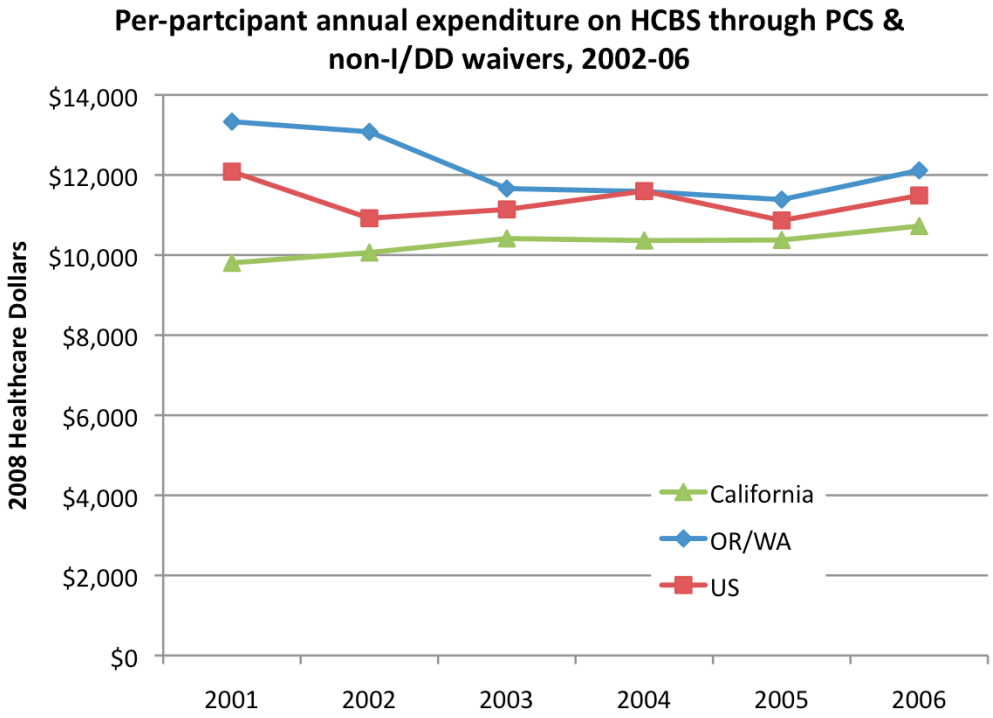


Trends in home- and community-based services expenditures

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%.

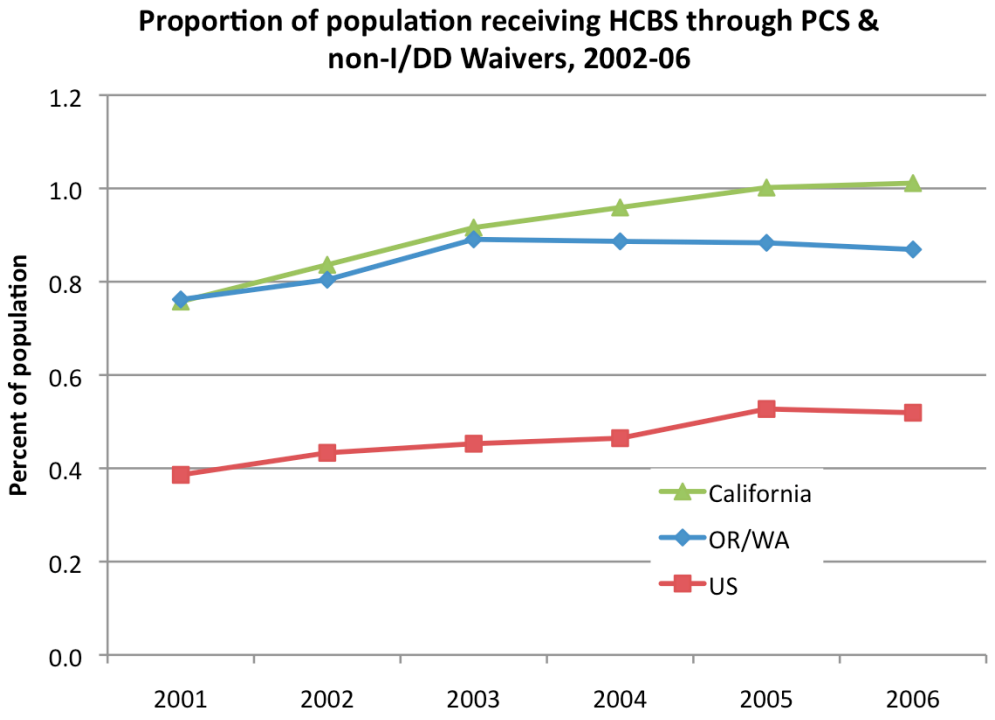
Is the growth in California's HCBS expenditures a problem? Not necessarily, because expenditures for 2005-08 are similar to those of the comparison states. California was effectively catching up with those states during the prior years.



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.

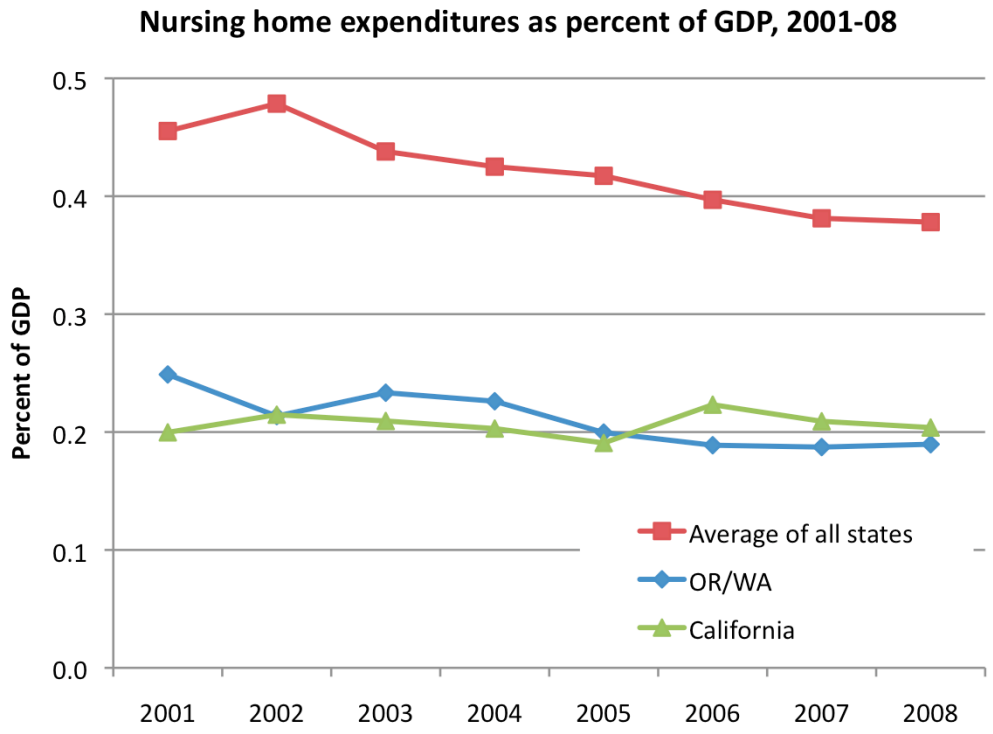
*Limited to personal care services programs, such as IHSS, and HCBS waivers not targeted to the I/DD population. The home health benefit is not included.



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

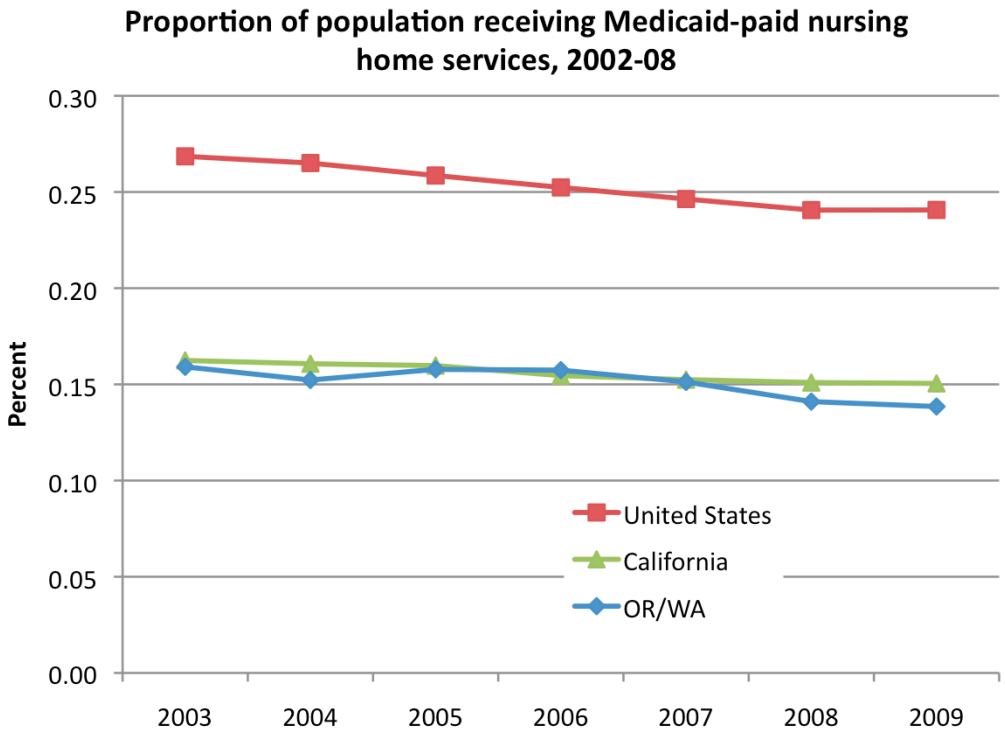
As in other states, participation in HCBS programs has been increasing. The proportion of California's population participating in HCBS (33.5% growth in IHSS & non-I/DD waiver participation relative to population size) has been growing at about the same rate as that of other states (34.5% growth). In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



Trends in nursing home expenditures

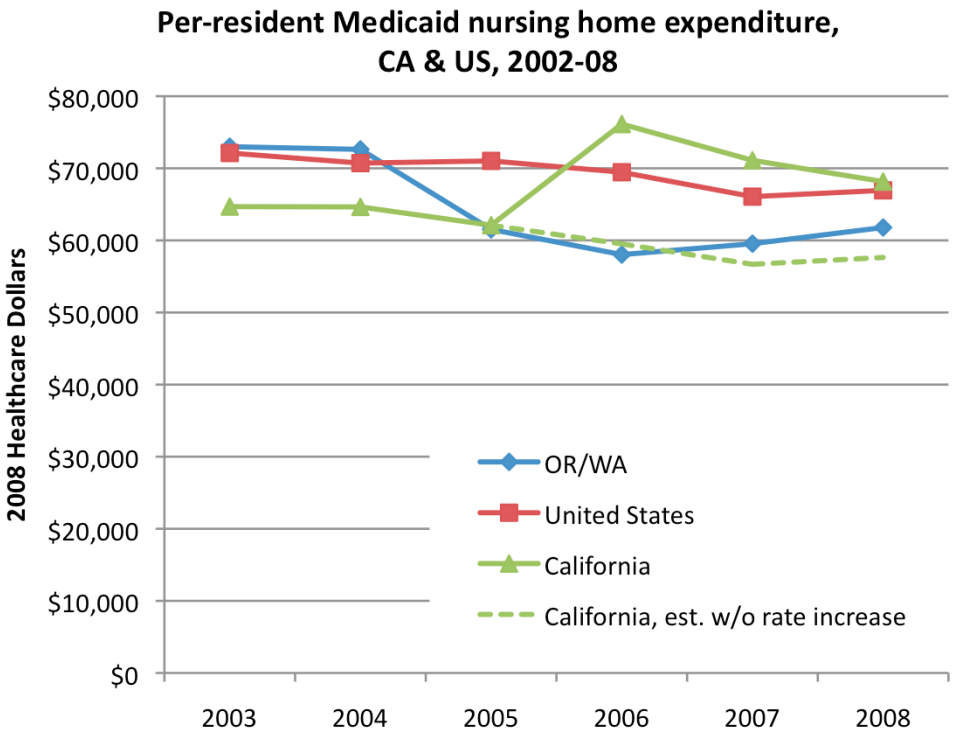
The other component to the growth in California's LTC expenditures is nursing home expenditures. Unlike in other states, nursing home expenditures did not decline in California, but instead grew by 2.0 percent over the period relative to GDP, following a sharp increase in FY 2006. Other states typically 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.

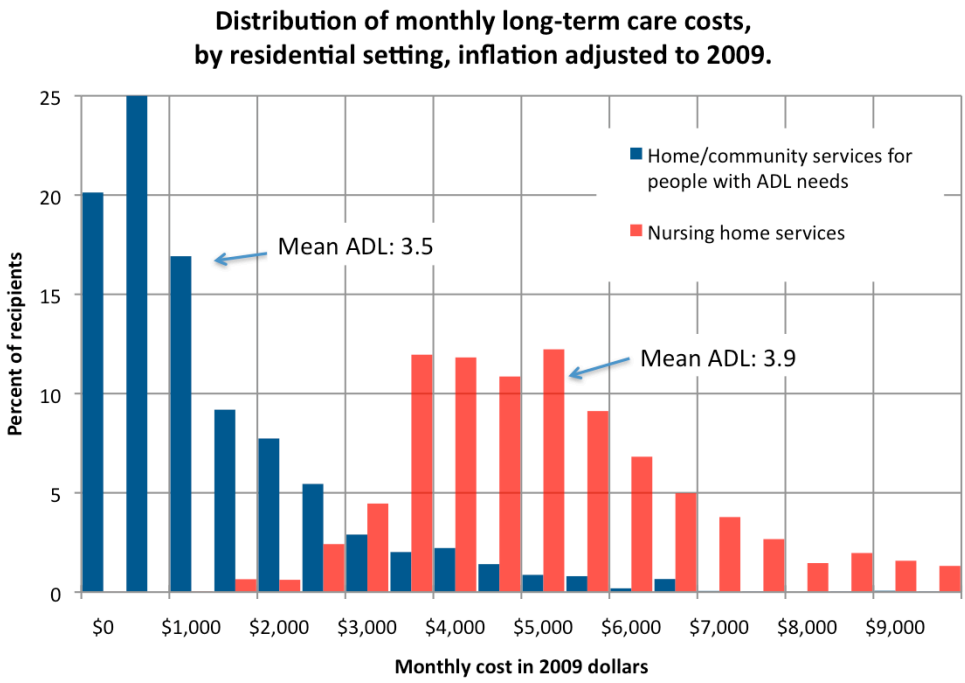


Why didn't California's nursing home expenditures decline? Because of a rate increase.

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.



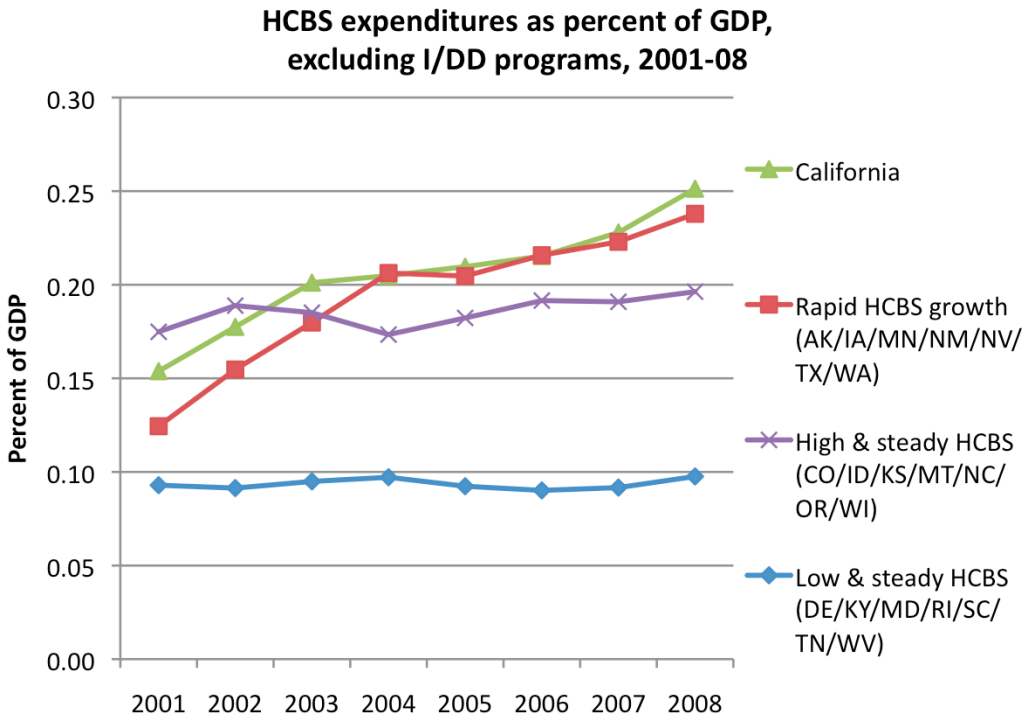
Source: Authors' tabulations from the 2005 and 2006 Medical Expenditure Panel Survey and the 2004 National Nursing Home Survey.

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.

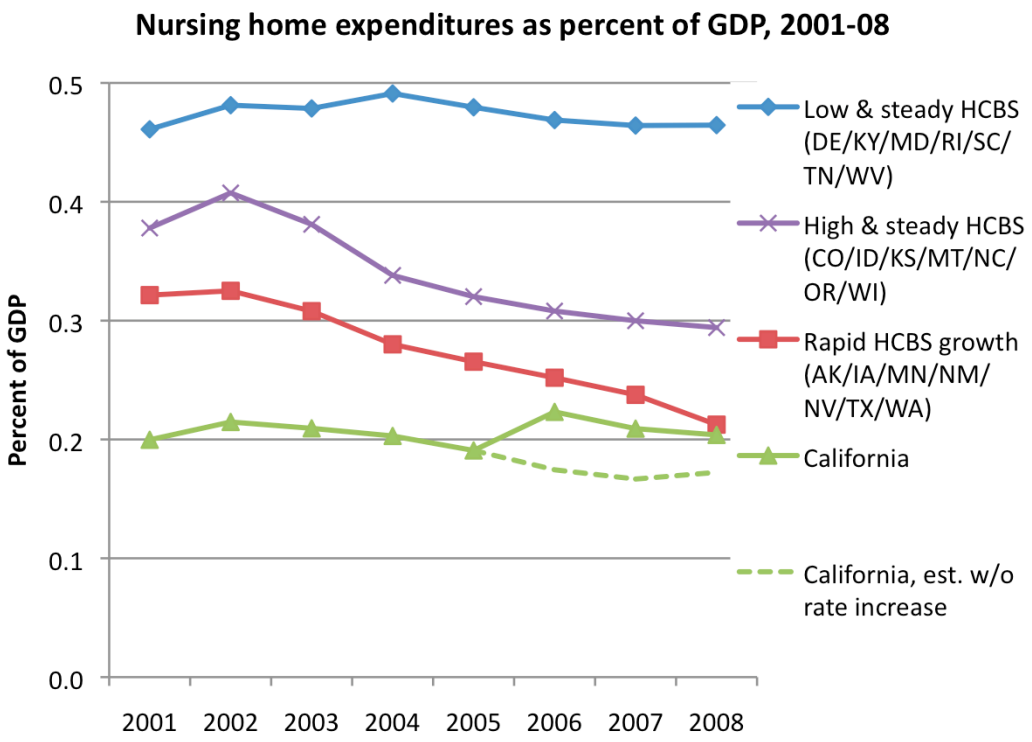


How to contain LTC expenditures: Three common spending patterns

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.

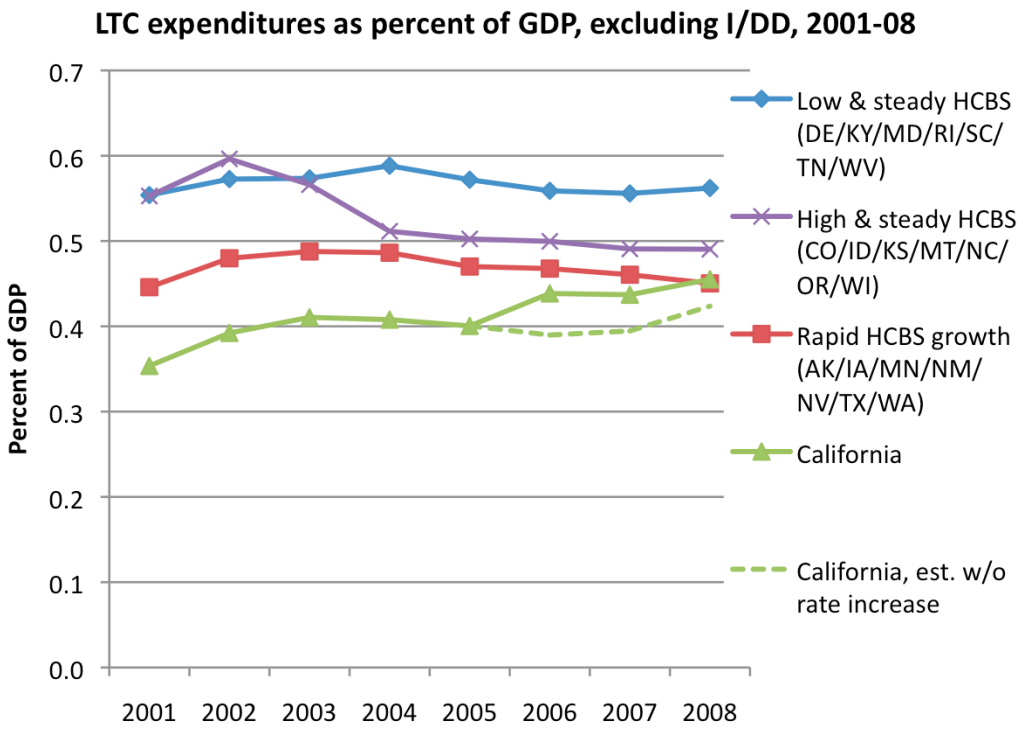
*I also used somewhat different methods, which I believe are an improvement over the prior analysis: I used GDP-adjusted rather than per capita, inflation-adjusted expenditures; took the average across states rather than pooling states; and selected seven exemplary states in each category rather than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



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

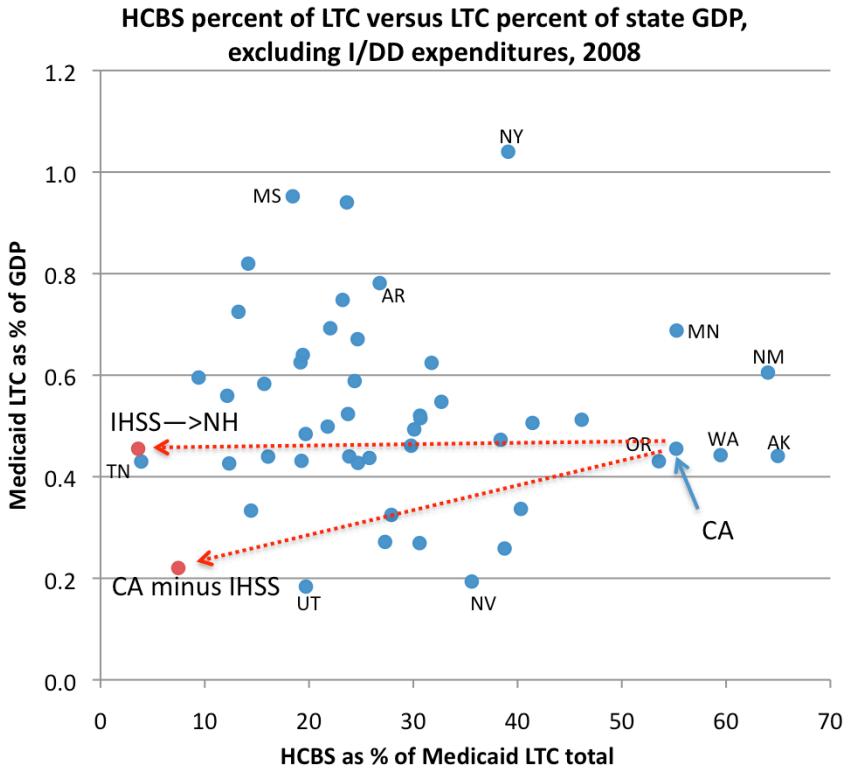
The low & steady states saw essentially no change in nursing home expenditures, relative to GDP (+0.8%), and they spent a great deal more on nursing homes over the entire period than the other types of states. In contrast, the high & steady states and especially the rapid growth states saw large declines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



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 their 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 that nursing homes so that the program is able to meet the full demand for HCBS.