

COSTS AND BENEFITS OF IN-HOME SUPPORTIVE SERVICES FOR THE ELDERLY AND PERSONS WITH DISABILITIES : A CALIFORNIA CASE STUDY

(Responding to the California Legislative Analyst's Report of 1/21/10)ⁱ

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Executive summary

California's Medicaid (called Medi-Cal in California) long-term care program currently places it among the top 5 states in terms of coverage, balance between nursing home and home- and community-based care, and cost effectiveness. Yet, Governor Schwarzenegger, in his proposed Budget for 2010-2011, has recommended cutting the In-Home Supportive Services (IHSS) program for 444,000 people, leaving IHSS recipients with two options: to rely on unpaid family care or to enter a nursing facility.

In a January 2010 report, the California Legislative Analyst's Office (LAO) argued that IHSS is just barely cost effective to the state (by keeping people out of more expensive nursing homes) and that the state could increase the fiscal benefits of IHSS if it implemented a 3-tiered targeting proposal in which only the most impaired IHSS recipients would receive IHSS services while services for the other two thirds would be reduced or eliminated altogether.

This Briefing Paper summarizes the conclusions of the LAO report, and shows that some of the LAO's assumptions are unrealistic. It presents a more realistic set of assumptions and then re-estimates the relative benefits of the IHSS program. Finally, it considers the savings to the state if, instead of cutting all or part of the IHSS program, the state transitioned one-third of nursing home residents back into the community.

This Briefing concludes that:

- **If IHSS is eliminated** – or even down-sized – and if more than 22 percent of current and future IHSS recipients enter nursing homes, **the state will spend more money providing additional long term care in nursing homes to fewer people than it currently does in nursing homes and IHSS combined.**
- **If California replaces the IHSS program with the LAO's 3-tiered targeting proposal**, the ranking of its long-term care program would fall below the **mean for all states.**
- **If California simply transitioned one-third of nursing facility residents back into the community it could save almost \$300 million per year in general fund expenditures on Medicaid long term care services for the elderly and persons with disabilities.**

California is not the only state looking for ways to reduce the cost of its Medicaid programs in the face of huge budget deficits. This briefing suggests that **if states cut their home- and community-based services it would weaken their long term care programs and cost them more in the long run.**

Introduction

California's Medicaid (Medi-Cal) long-term care program currently places it among the top 5 states in terms of coverage, balance between nursing home and home- and community-based care, and cost effectiveness. While its coverage (the number of participants per 1,000 in population) is higher than the national average, its per participant costs are only three-quarters of the national average, and its per capita costs (cost divided by state population) are about 5 percent below the national average (see Table 1 at end of this briefing). Per participant and per capita costs are kept low, relative to the national average, because most of California's long term care is delivered through its In-Home Supportive Services (IHSS) program, which provides, as an alternative to nursing home services, personal care assistance with activities of daily living such as feeding, toileting and transfer, to 444,000 people in their homes.

Despite California's reputation for running an efficient long-term care program, **the governor has proposed eliminating IHSS, as part of his strategy to cut the \$20 billion deficit..** In doing so, **California will end up spending more money on increased nursing home services than it currently does on nursing homes and IHSS, combined. If California eliminated, or even downsized, its IHSS program, the ranking of its long term care program would drop into the bottom tier of states,** all of which have below average coverage, poor balance, and per participant costs that are higher than California's current costs. When below average per capita costs are achieved in these other states, it is because they are providing low-quality services.

Medicaid Long-Term Care

Medicaid, a means-tested non-contributory program, which is jointly funded and administered by the federal government and states, provides comprehensive health and

long-term care for more than 60 million low-income individuals nation-wide.

Under the Medicaid statutes, states are required to provide institutional long-term care services as an entitlement to the very low-income Medicaid enrollees who need an institutional level of care. Beginning in 1981, the federal government also paid matching funds for lower cost home- and community-based alternatives to institution-based long-term care. Especially since the 1999 Supreme Court ruling in *Olmstead v. L.C.* confirmed that persons with disabilities should receive Medicaid long-term care services in the least restrictive setting, most states have expanded their lower-cost, high quality home- and community-based services.ⁱⁱ Still, 75 percent of all Medicaid funds are spent on providing long-term care for elderly persons and persons with disabilities who comprise 25 percent of all Medicaid recipients, and 57 percent of Medicaid long-term care spending goes to institutional services.ⁱⁱⁱ

Long-term care and state budgets

IHSS is the fastest-growing major social service in California, due to the combined effects of increasing per case cost and an increasing IHSS caseload.^{iv} This is not unique to California, nor is California the only state trying to balance its budget by reducing the size, or limiting the growth, of Medicaid long-term care spending.^v Since its inception in 1965, Medicaid's average share of state budgets has grown to 21 percent, rivaling spending on primary and secondary education and making it a highly visible target for deficit reduction.

But, options for controlling the cost of the Medicaid PCS Option in California's Medicaid Plan (which is the source of funding for most of the IHSS program in California) are limited. Under Medicaid rules any service included in a state's Medicaid plan must be offered to all

qualifying Medicaid enrollees. Like other states, California can tighten long-term care eligibility requirements for all Medicaid consumers, within certain guidelines set by Medicaid regulations, but it cannot target services to specific high-need groups. So if it focuses only on IHSS, California's cost-cutting options are limited to cutting wages and benefits for IHSS workers, dropping the personal care option from its Medicaid plan altogether, and/or re-designing its long-term care program using Medicaid Waivers. Medicaid Waivers allow states to waive certain Medicaid rules and target some services to specific populations and geographic areas.^{vi}

Poorly understood during the state fiscal panic of the last few years, however, is how truly cost effective California's reasonably well-balanced, and highly leveraged long-term care program is. The federal government normally pays for at least 50 percent of the cost of nursing homes and IHSS. The state pays the remainder for nursing homes and shares the costs with counties for the IHSS program.^{vii} Federal support for at least half the cost of programs that were once entirely supported by state and local budgets has made it possible for states to

offer low income families an alternative to unpaid family care. Paid services have been particularly effective in supplementing unpaid family care in California because rising IHSS wages have made it easier for families to find reliable workers or to quit other jobs and do the work themselves.^{viii}

Also obscured by the burden of a \$20 billion state deficit is that, even if cutting the IHSS program (or IHSS workers wages and benefits) did lead to direct savings in the state's long term care budget, it is one of the worst possible strategies the state could use to cut its deficit. Money spent on the IHSS program has huge multiplier effects since 85 percent of the spending goes directly to pay for the wages of IHSS workers. Low income residents, like IHSS workers, spend a greater share of their income locally, and create more jobs, than do high income residents. One billion dollars spent by the state on the IHSS program generates 216,000 full time equivalent jobs and contributes \$360 million in state income tax revenue compared to 6,400 jobs and \$70 million in tax revenue generated from a \$1 billion tax cut to upper income households.^{ix}

The LAO Report – Assumptions and Results

Against that background, the California Legislative Analyst’s Office, which provides non-partisan fiscal and policy analysis, released a report in January, 2010, examining the fiscal impact of the IHSS program on the state and counties. The LAO report bolstered the Governor’s case for cutting the IHSS program when it concluded that IHSS in its present form was probably just marginally cost effective for the state alone, but was not cost effective for the state and counties combined. Savings from the IHSS program, the LAO argued, (in the form of avoided

nursing home costs) are probably more than offset by the costs of providing IHSS and related services to those program

participants who are unlikely to go into nursing homes if the IHSS program was cut.

The LAO constructed a model to estimate the fiscal impact of completely eliminating the IHSS program. Using various assumptions it measured the baseline cost of the program in seven years (starting from 2008). It then used the model to compare the estimated increase in costs of nursing home services to the cost of keeping IHSS.

The model was built on assumptions about the cost per nursing home resident relative to IHSS participant. Further assumptions were made about: a) how long individuals who moved from

IHSS would stay in nursing facilities, and b) the cost to the state of Supplemental Security Income/State Supplemental Payment (SSI/SSP) and other benefits that are paid to IHSS consumers but not to nursing home residents. The LAO assumed in its model that only caseload growth would increase IHSS costs over the 7-year period. Finally, the LAO made an assumption about how many persons could reasonably be expected to go into nursing homes if IHSS was shut down.

Table 2

LAO Model for Different Scenarios

(General Fund (state) and county funds, in millions)

	Percent shifted to SNF		
	38%	56%	78%
Total SNF and Developmental Disability Costs with no IHSS	\$3,134	\$3,843	\$4,700
Baseline Costs of IHSS	\$3,843	\$3,843	\$3,843
Savings (+)/Costs(-) from dropping IHSS	\$709	\$0	-\$857

The LAO explicitly omitted the following costs: a) impact on quality of life of recipients; b) potential costs of other programs for IHSS recipients living in the community, which are probably small;^x c) the effect of a temporary increase in the federal matching rate (the LAO does this because the enhanced federal matching rate is due to expire on December 31, 2010 and its concern is with the long-run costs of the program); and d) the effect of recent cost-cutting changes to program.

Table 3

LAO Model for Different Scenarios*(General Fund (state), in millions)*

	Percent shifted to SNF		
	16%	32%	48%
Total SNF and Developmental Disability Costs with no IHSS	\$1,968	\$2,595	\$3,221
Baseline Costs of IHSS	\$2,770	\$2,770	\$2,770
Savings (+)/Costs(-) from dropping IHSS	\$801	\$175	-\$451

Replicating the LAO model

Using all of the LAO's stated assumptions, and estimating its unstated assumptions, I was able to exactly replicate the LAO's result that IHSS (including SSP) would cost the state and counties a combined \$3.8 billion after seven years. I was also able to closely replicate the LAO's \$2.5 billion estimate of the cost to the state alone.^{xi} (Tables 2 and 3 show the LAO results.) I also got estimates similar to the LAO's for the percentage of IHSS consumers who would have to enter nursing facilities before shutting IHSS began to cost more money than it saved (the break even point). For the state and counties *combined*, I estimated the breakeven point would occur when 58 percent of IHSS recipients entered nursing homes, identical to the LAO results. For the state alone, I estimated that IHSS was cost effective as long as no more than 34 percent entered nursing homes. The LAO estimated a break-even point for the state of 32 percent.

LAO Conclusion:

The LAO suggests, rather than completely eliminating the program, the state could achieve greater cost effectiveness by targeting services to groups most likely to enter a nursing facility.

The LAO proposes the following options:

- Raise the minimum functional impairment ranking to qualify for IHSS service (this approach is currently being challenged in court);
- Eliminate IHSS and target waivers only to recipients who are authorized to receive above a high minimum number of hours of service;
- Make SNF certification (which requires a higher level of impairment than IHSS certification) a condition for receiving IHSS services;
- 3-tier targeting: Target different levels of services to three tiers: **Tier 1**, the severely Impaired (SI), who are currently authorized to receive 195 or more hours per month, would continue to receive IHSS; **Tier 2**, the not severely impaired (NSI), who are authorized 80 – 194 hours per month, would be given cash vouchers to purchase services and assistive devices combined with assistance from a case worker;^{xii} and **Tier 3** - NSI receiving 1 – 79 hours, would get neither IHSS nor cash services, but would get increased case management to monitor whether they needed to be moved to Tier 2 or 1.^{xiii}

What is wrong with the LAO Assumptions?

There are a couple of major problems with the LAO assumptions. The first concerns the rate at which the LAO discounts nursing home costs based on the relative length of time consumers remain in a nursing home compared to IHSS, and the second is the assumption about how many IHSS consumers will enter nursing homes in the absence of IHSS. A third problem, which I will not address here, is that when the LAO does not factor in the impact on quality of life, it is essentially ignoring the high probability of, and significant cost associated with, Olmstead litigation. Together, these two assumptions lead the LAO to conclude that IHSS is only marginally cost effective to the state.

The average stay in a nursing home

The first assumption, that former IHSS recipients, who currently average 4.5 years in the IHSS program, **would spend only 1.75 years in a nursing facility**, has the effect of discounting the true cost of a stay in a nursing home. The LAO was able to make this assumption only because it ignored important differences in the two populations.^{xiv}

With this assumption, the relative cost of a nursing home stay is only 50 percent higher, instead of 5 times higher than the cost of getting the services from IHSS.^{xv} The LAO's only gesture to the possibility that having IHSS as an option might shorten the length of time people spend in nursing homes, is to test the sensitivity of its results to the assumption that an influx of IHSS consumers would increase the average length of a nursing home residency by 10 percent. The LAO finds little impact on the relative cost effectiveness of IHSS.

Why is the average length of stay shorter in nursing homes? Two factors can explain the shorter average length of stay in nursing homes. First is the difference in the health

characteristics of the two populations. In California, 32 percent of the nursing home population is made up of short-stay residents who are getting rehabilitation following an injury or surgery or a hospital stay. Short-stay residents generally stay a maximum of 100 days.^{xvi} On the other hand, when a Medicaid recipient is authorized to receive long term care services in a nursing home or community-setting, a social worker has already determined that her condition is expected to last at least a year. Obviously, any shift in the mix of short and long-stay residents is going to change the average length of stay in nursing homes. Shutting down IHSS would certainly increase the proportion of long-stays and the average length of stay in nursing homes would rise.

Estimating the average length-of-stay. Although short-stay residents currently make up only 32 percent of all residents at a point in time, because their beds turn over a minimum of every 100 days, they account for 58 percent of all residents during the year. Accounting for turnover, the weighted average length of stay for all residents would be 2.03 years, which is very close to the average length-of-stay assumption used by the LAO. **If the IHSS program is cancelled and at least 35 percent of IHSS recipients, or 155,000, move into nursing homes, I estimate that the average length of stay would rise to 3.2 years.**

There are also probably too many long-term residents in California nursing facilities. California's residents are more disabled than the national average, suggesting there are too many persons with physical disabilities in nursing facilities who could be living in the community with good support systems.^{xvii xviii} By any measures, California has at least 30 percent more persons with disabilities per capita in SNFs than does Oregon and at least 10

percent more than Washington.^{xix} In contrast, California has numbers of persons per 1,000 with cognitive impairments in nursing facilities which are similar to those for Oregon and Washington.)

How many move to nursing homes?

“The key question”, as the LAO states, “is whether the IHSS program prevents 58 percent (or 32 percent from the perspective of the state alone) of the recipients who are not developmentally disabled from entering nursing homes.”^{xx}

While it acknowledges the difficulty involved in predicting how many IHSS consumers would go into nursing homes, the LAO nonetheless settles on a low measure of 32 percent. To test how realistic this assumption might be, the LAO looked at which groups of IHSS consumers currently had a greater propensity to enter nursing homes and concluded that these groups could be expected to enter SNFs in high enough numbers to reach the state’s break-even point of 32 percent. While that analysis can tell us who might need a higher level of care than they can get in IHSS, it does not tell us who will need a higher level of care than they can get in the community without IHSS.

A better evidence-based approach. If instead, we look at how many residents there are in nursing homes in states that have little or no community-based long-term care programs, but which are providing long term care services at a scale comparable to the national average of 10.8 per 1,000 in the population, that can provide a baseline estimate of the minimum socially and politically acceptable level of coverage. For California to achieve the national average level of coverage without IHSS, about 300,000 IHSS consumers, 66 percent of the current IHSS population, would have to go to nursing homes. California, which is already has

a capacity utilization rate of 85 percent, would have to quadruple its current capacity.

Only Arkansas, Connecticut, New York, and Rhode Island, which have the highest-cost long-term care systems in the country, have maintained the capacity to house as many as 10 persons per 1,000 in nursing homes. The latter three spend between 50 and 150 percent more per capita than California does for long term care. Only 2 states have anything close to a long-term care system that relies almost entirely on nursing homes – Tennessee and Indiana. Even if California’s goal was to achieve only Indiana’s below average coverage rate of 8.3 per 1,000, almost 37 percent of the current IHSS population would have to go into nursing homes.

If and when California’s long term care system does start to resemble Indiana’s, its standing with respect to coverage, balance and generosity of its long term care programs would fall into the bottom tier of states. In short, unless California expects to take care of its aged residents and persons with disabilities at a rate that is far below that of the national average, **300,000, rather than the LAO’s predicted 144,000 persons, will have to move to nursing homes.**^{xxi}

Correcting the assumptions

Summing up, the LAO has undoubtedly underestimated the length of time that people transferring from IHSS would stay in nursing homes. The LAO has also not considered that there may already be too many long-stay residents with disabilities in nursing homes who with adequate support could function in the community at lower cost to the state. Finally, the LAO does not challenge the politically and morally reprehensible notion that

average length of stay in institutions would increase from 1.75 to 3.2 years. I then re-estimated what percent of IHSS consumers would have to go into nursing homes before the

Table 4

Corrected Fiscal impact to state & counties of ending IHSS program

(General Fund (state) and county funds, in millions)

	Percent shifted to SNF		
	22%	34%	66%
Total SNF and Developmental Disability Costs with no IHSS in 2015	\$3,079	\$3,843	\$5,944
Baseline Costs of IHSS	\$3,843	\$3,843	\$3,843
Savings (+)/Costs(-) from dropping IHSS	\$764	\$0	-\$2,101

Table 5

Corrected Fiscal impact to state alone of ending IHSS program

(General Fund (state), in millions)

	Percent shifted to SNF		
	12%	22%	66%
Total SNF and Developmental Disability Costs with no IHSS in 2015	\$2,123	\$2,770	\$5,640
Baseline Costs of IHSS in 2015	\$2,770	\$2,770	\$2,770
Savings (+)/Costs(-) from dropping IHSS	\$646	\$0	-\$2,870

program stopped being cost effective.

I found that the breakeven point for the state and counties combined is reached **when 34 percent of IHSS recipients move to nursing homes**, compared to the 58 percent estimated by the LAO (Table

California could actually reduce the number of people receiving Medicaid long term care below the national average and deny them their rights under the ADA, as affirmed in the Olmstead decision, to receive services in the most integrated setting that is reasonable.

4). The breakeven point for the state alone is reached when only 22 percent of IHSS residents go into nursing facilities (Table 5).

Starting with the LAO model, I used the assumption that if as many as 35 percent of IHSS recipients moved to nursing homes, that

Earlier, I showed that the evidence from other states suggests as many as **66 percent** of IHSS consumers could be looking for places in nursing facilities. If 66 percent of terminated IHSS recipients did enter nursing homes, it

would add **\$2.1 billion to the annual combined state and county costs** (Table 4) and **\$2.87 billion to state costs** (Table 5).

While this is, by no means, the definitive analysis of the cost effectiveness of IHSS it

certainly demonstrates how vulnerable the LAO analysis is to the impact of questionable assumptions about the length of stay and the number of IHSS consumers who would move to nursing homes.

The cost impact of other proposals

The LAO’s 3-tier proposal

California currently provides more LTC than most states at less than the national average cost, in large part because it is better balanced in favor of HCBS than all but about 5 states.^{xxii}

At a time when national policy initiatives are providing incentives to states to rebalance their LTC systems by redirecting and relocating Medicaid LTC recipients to HCBS services, it seems improbable that California would actually adopt policies that would increase the number of nursing home residents. California seems more likely to follow the LAO’s alternative 3-Tier strategy described above.

The 3-tier proposal would save the state and counties \$747 million and about \$1.5 billion for the state alone due to the reduction in IHSS services. (See column 1 in Tables 6 and 7.) Under this plan, long term care coverage in California for the aged and persons with disabilities would drop from 13.8 persons per 1,000 to 9.9, which is below the national

average. California would become less balanced in a time when other states are striving for greater balance. Per participant expenditures would rise while per capita costs would fall, but only because 155,000 persons had lost their IHSS services.

Transition SNF residents to community

As discussed earlier, California probably has too many persons with physical disabilities in nursing homes. The state’s range of alternative settings is limited relative to Oregon. If the state offered expanded options for long-term care comparable to Oregon’s across a range of settings such as assisted-living, residential care facilities and adult foster care it could probably move as many as 30 percent of full time equivalent residents with disabilities to home and community sites. The second columns in Tables 6 and 7 show that if the state moved 30 percent of the nursing home population into IHSS, combined with eliminating IHSS services

Table 6

Fiscal impact of 3-tier and transitioning proposals for state and counties

(General Fund (state) and county funds, in millions)

% of IHSS and SNF clients still receiving services	3-tier		Transition back to community	
Total IHSS and SNF costs in 2015		\$4,294	\$4,250	\$4,799
Baseline Costs of LTC in 2015		\$5,040	\$5,040	\$5,040
Savings (+)/Costs(-) from proposals		\$747	\$791	\$242

for 25 percent of the current IHSS caseload, other than case management, it could achieve the same level of savings as the LAO 3-tier proposal and cut services for fewer people. Under the LAO 3-tier proposal, 150,000 would lose IHSS coverage, while under the first transitioning proposal, 100,000 would lose services. Savings to the state alone would again be lower than for the state and counties combined.

reduce projected costs for the state and counties by over \$242 million. (See the last column of Table 6) The state’s savings in nursing facility costs of \$395 million would be partially offset by \$154 million in higher costs for IHSS and SSP. Savings for the state alone would be slightly higher at \$285 million because it gets all of the non-federal savings due to moving people out of nursing homes (Table 7).

However, if the state did nothing but move 25,000 nursing home residents into IHSS, it could cover the same number of consumers and

Table 7

Fiscal impact of 3-tier and transitioning proposals for state

(General Fund (state), in millions)

<i>% of IHSS and SNF clients still receiving services</i>	<i>Transition back to community</i>		
	<i>3-tier</i>	<i>75%</i>	<i>100%</i>
Total IHSS and SNF costs in 2015	\$3,482	\$3,326	\$3,682
Baseline Costs of LTC in 2015	\$3,967	\$3,967	\$3,967
Savings (+)/Costs(-) from proposals	\$485	\$641	\$285

Conclusion

One of my purposes in writing this brief was to show, using California as a case study, that states should use caution when they target Medicaid services to relieve their fiscal distress. The goal of balancing state budgets in a severe recession must be weighed against the longer term goals of providing adequate and cost-effective long-term care services to low income residents. Most states have made progress toward balancing their long term care systems so that more people who need services can be housed in home and community settings.

Elderly persons and persons with disabilities cannot be successfully diverted into the community without building up the institutions, and workforces that are needed to care for people in less restrictive settings. Medicaid statutes currently create perverse incentives for states to cast off their home- and community-based services in order to slow growth in Medicaid expenditures because states are required to provide institutional care, but not home- and community-based care to Medicaid enrollees.

Limiting long-term care to institutional settings is a proven strategy for slowing the growth of the number of recipients since most persons needing long-term care services avoid nursing homes until it is the absolute last resort. But this is hardly a humane or socially responsible approach. Cutting wage rates for homecare workers can also reduce costs in the short-run but in the longer term, as turnover increases and consumers have more trouble finding providers, costs associated with more nursing home admissions and elevated use of hospitals and emergency rooms begin to accumulate.

But if federal statutes required states to provide home- and community based services as a condition of receiving any federal matching funds, states like California would be forced to

consider solutions to the joint problem of building acceptable long-term care programs while simultaneously achieving balanced budgets that are both humane and fiscally responsible. States would also have to acknowledge that it is hard to maintain sufficient community services if they do not pay the workers adequate wages.

Governor Schwarzenegger's proposal to terminate the In-Home Supportive Services (IHSS) program for 444,000 current recipients would force many people who want to live in their community to move into nursing facilities which would in the end cost the state more money than it expects to save. Furthermore, the burden that the proposal places on families to provide unpaid care is an utterly unacceptable reversal of the trend toward the paid care which has made it possible for more women to join the workforce, or, in some cases, to substitute working as a paid family caregiver for the other paid jobs.

Table 1. State Medicaid Long-Term Care Coverage for Aging & Disabled 2006 (2008 share of spending)^{xxiii xxiv}

	Coverage			Generosity			Balance		Cost
	No. of recipients 2006			Spending per recipient			% of HCBS in LTC		LTC \$
	LTC	HCBS	NH	LTC	HCBS	NH	Recipient s 2006	Spending 2008	per capita
	HCBS Above Average			Average & Above			Above Average		
Alaska	13.1	11.2	1.9	\$28,718	\$17,245	\$97,044	86%	63%	\$293
California	13.8	9.6	4.2	\$15,242	\$10,802	\$25,297	69%	51%	\$210
Minnesota	14.4	8.3	6.0	\$19,177	\$13,217	\$27,404	58%	51%	\$313
New Mexico	10.4	6.7	3.7	\$20,907	\$17,548	\$26,882	64%	64%	\$242
North Carolina	12.5	7.6	4.8	\$16,537	\$10,570	\$25,986	61%	41%	\$201
Oregon	11.4	8.7	2.7	\$14,316	\$9,973	\$28,390	76%	53%	\$184
Washington	12.1	8.7	3.4	\$15,577	\$11,666	\$25,490	72%	59%	\$213
	HCBS Average			Average & Above			Average & Below		
Kansas	11.7	5.6	6.1	\$15,123	\$10,630	\$19,228	48%	36%	\$200
Montana	10.6	5.3	5.4	\$19,495	\$9,953	\$28,808	49%	28%	\$220
New York	16.1	5.4	10.7	\$30,399	\$23,880	\$33,705	34%	29%	\$525
Washington DC	13.0	5.8	7.2	\$29,419	\$14,815	\$41,052	44%	40%	\$513
West Virginia	11.8	5.5	6.3	\$23,188	\$9,289	\$35,394	47%	19%	\$302
Wisconsin	12.4	6.2	6.3	\$18,985	\$10,112	\$27,709	50%	28%	\$218
	Average & Above			Below Average			Average & Above		
Arkansas	18.9	8.8	10.1	\$12,286	\$5,289	\$18,352	46%	21%	\$250
Idaho	11.6	8.2	3.4	\$12,999	\$7,072	\$27,147	70%	39%	\$169
Illinois	9.8	4.1	5.7	\$14,058	\$6,866	\$19,199	42%	24%	\$151
Maine	14.1	7.4	6.7	\$17,565	\$7,968	\$28,266	53%	24%	\$249
Michigan	11.8	6.5	5.3	\$14,562	\$4,281	\$27,248	55%	19%	\$183
Missouri	18.8	12.1	6.6	\$9,838	\$4,493	\$19,635	65%	30%	\$205
Oklahoma	12.7	6.6	6.0	\$13,407	\$6,413	\$21,058	52%	29%	\$205
Texas	11.6	7.4	4.2	\$10,361	\$5,661	\$18,568	64%	33%	\$118
Vermont	15.5	6.4	9.1	\$14,070	\$8,465	\$18,047	41%	32%	\$268

	Coverage			Generosity			Balance		Cost
	No. of recipients 2006			Spending per recipient			% of HCBS in LTC		LTC \$
	LTC	HCBS	NH	LTC	HCBS	NH	Recipients 2006	Spending 2008	per capita
	HCBS Below Average			Average & Above			Below Average		
Connecticut	15.0	3.7	11.2	\$25,640	\$8,556	\$31,342	25%	9%	\$392
Massachusetts	12.3	3.6	8.7	\$26,977	\$20,594	\$29,578	29%	21%	\$314
Nebraska	10.2	3.8	6.5	\$22,982	\$10,060	\$30,522	37%	19%	\$231
Ohio	11.9	3.4	8.5	\$23,240	\$13,490	\$27,131	29%	18%	\$269
Rhode Island	13.0	2.8	10.2	\$24,193	\$11,854	\$27,597	22%	13%	\$323
	Below Average			Above Average			Below Average		
Delaware	5.8	1.6	4.3	\$35,467	\$12,516	\$43,861	27%	9%	\$221
Georgia	5.9	1.6	4.3	\$24,784	\$10,531	\$29,927	27%	19%	\$170
Hawaii	5.6	1.8	3.9	\$33,321	\$17,569	\$40,497	31%	19%	\$212
Maryland	6.1	1.5	4.6	\$30,970	\$14,736	\$36,074	24%	12%	\$201
New Hampshire	7.7	2.2	5.5	\$32,777	\$13,497	\$40,314	28%	15%	\$268
New Jersey	8.7	3.3	5.4	\$30,164	\$15,204	\$39,211	38%	20%	\$267
Pennsylvania	8.8	2.1	6.7	\$39,988	\$17,213	\$46,926	23%	11%	\$349
Virginia	5.4	1.7	3.7	\$21,985	\$15,546	\$25,025	32%	30%	\$136
	HCBS Below Average			Below Average			Below Average		
Iowa	10.5	3.5	7.0	\$16,376	\$6,170	\$21,534	34%	16%	\$186
Kentucky	9.5	2.8	6.7	\$19,874	\$5,217	\$25,994	29%	8%	\$205
Louisiana	10.3	2.8	7.4	\$16,902	\$8,061	\$20,296	28%	27%	\$222
Mississippi	11.9	4.0	7.9	\$18,945	\$314	\$28,400	34%	1%	\$244
North Dakota	12.5	3.5	9.0	\$21,968	\$3,813	\$29,064	28%	9%	\$287
South Dakota	9.7	2.5	7.2	\$18,585	\$4,631	\$23,405	26%	8%	\$187

	Coverage			Generosity			Balance		Cost
	No. of recipients 2006			Spending per recipient			% of HCBS in LTC		LTC \$
	LTC	HCBS	NH	LTC	HCBS	NH	Recipients 2006	Spending 2008	per capita
	Below Average			Below Average			Ave & Below		
Alabama	7.7	2.0	5.7	\$25,355	\$6,607	\$31,842	26%	11%	\$201
Colorado	7.0	3.4	3.6	\$17,577	\$7,177	\$27,339	48%	23%	\$132
Florida	8.7	2.3	6.4	\$16,426	\$4,539	\$20,760	27%	12%	\$149
Indiana	8.3	0.6	7.6	\$19,719	\$7,760	\$20,730	8%	5%	\$206
Nevada	5.4	3.4	2.0	\$16,277	\$8,110	\$30,527	64%	35%	\$96
South Carolina	6.7	3.0	3.7	\$19,522	\$8,122	\$28,564	44%	23%	\$145
Tennessee	5.8	0.3	5.6	\$30,028	\$6,131	\$31,185	5%	4%	\$174
Utah	3.3	1.0	2.3	\$17,521	\$2,487	\$23,867	30%	12%	\$68
Wyoming	8.5	3.1	5.5	\$16,724	\$6,083	\$22,745	36%	16%	\$155
United States	10.8	5.0	5.8	\$19,598	\$10,295	\$27,698			\$220

KEY

For all except the last column, green indicates that the state's performance is at least 20 percent above the national average, red indicates that the state is at least 20 percent below the national average and states within plus or minus 20 percent of the national average are colored yellow. In the last column (Cost), green indicates that per capita spending is at least 20 percent *below* average and red indicates that spending is 20 percent *above* average, in keeping with the principle that green indicates better than average performance while red is less than average performance. The states are listed in alphabetical order within each performance group. Except for expenditure data used to measure HCBS spending as a share of total LTC spending, which is from 2008, all data are from 2006, the most recent year for which both usage and expenditure data are available, so the numbers may have improved since then, but the ranking of the states remains accurate. Arizona is excluded from the table because comparable data is not available.

ⁱ Taylor, Mac. 2010. "Considering the State Costs and Benefits: In-Home Supportive Services," California Legislative Analyst's Office, January 21. http://www.lao.ca.gov/reports/2010/ssrv/ihss/ihss_012110.pdf ; Roughly 85 percent of program costs are paid directly as wages and benefits to about 360,000 IHSS providers. Since 1995, hourly wage rates for all IHSS workers have more than doubled, tracking the 88 percent increase in the state minimum wage. In some counties, where IHSS workers are represented by unions, wages have been pushed above the minimum wage and health insurance has been added to workers compensation. The average number of hours authorized for each consumer has also grown by 6 percent and the case load has grown 105 percent, in the last 10 years.

ⁱⁱ In *Olmstead v. L.C.*, the Supreme Court ruled that under Title II of the Americans with Disabilities Act (ADA) of 1990, the plaintiffs in the case – two women with developmental disabilities who had continued to be institutionalized against their will -- had the right to receive care in the most integrated (i.e., community) setting appropriate and that their unnecessary institutionalization was discriminatory and violated the ADA (<http://www.law.cornell.edu/supct/html/98-536.ZS.html>). The court indicated that states should make reasonable accommodations to their long-term care systems, which intent could be demonstrated by comprehensive, effectively working plans to increase community-based services and reduce institutionalization.

ⁱⁱⁱ Burwell, Brian, Kate Sredl, and Eiken, Steve. 2009. Medicaid Long Term Care Expenditures FY 2008. Thomson Reuters, October accessed at <http://www.hcbs.org/moreinfo.php/doc/2374>, January 2010.

^{iv} Taylor, op. cit.

^v Evidence that Medicaid long-term care costs are a major concern for many states is provided by a recent report from UnitedHealth Group estimates that states could realize savings of \$60 billion between 2011 and 2019, \$5 billion of which would accrue to California alone, by "modernizing" their Medicaid long-term care programs, including diverting significant numbers of current and projected nursing facility residents into home- and community-based services (UnitedHealth, Center for Health Reform and Modernization. 2010. Coverage for Consumers, Savings for States: Options for Modernizing Medicaid, Working Paper No. 3, April. Accessed April 21, 2010 at

http://www.unitedhealthgroup.com/hrm/UNH_WorkingPaper3.pdf.)

^{vi} States that adopt Medicaid Personal Care Services as an option in their state Medicaid plan must provide the service statewide and to all Medicaid eligible individuals who meet the eligibility criterion for long term care as well. In contrast, if a state provides home- and community-based services through a Waiver, they do not have to conform to these rules and can instead target specific populations of Medicaid recipients. Waivers are one strategy that states use to control costs of long term care. Currently, for example, 7 percent of the IHSS consumer population is covered by the IHSS Plus Waiver which waives the Medicaid rule prohibiting spouses and parents from being paid to provide long-term care services.

^{vii} Note that the federal match has temporarily been increased to 61.59 percent under the American Recovery and Reinvestment Act of 2009 (ARRA), leaving the remaining non-federal share of 38 percent to the state. The state pays 65 percent of the non-federal share of IHSS wages and benefits up to \$12.10 per hour, and counties pay the remaining 35 percent of up to \$12.10 per hour; beyond \$12.10 per hour, counties pay the entire non-federal share. The state proposed cutting the maximum wages and benefits that it would match to 10.10 per hour beginning in fiscal year 2010, however, a federal judge issued an injunction to stop the decrease in state participation.

^{viii} Howes has shown that the wage increase in San Francisco between 1997 and 2002 cut the turnover rate for new entrants to the workforce in half. More recently, in a series of declarations in the case of *Martinez v Schwarzenegger*, she has shown that proposed cuts in the state match for IHSS wages and benefits would increase turnover and ultimately cost more to the state in the long-run. (Howes, Candace. 2005 "Living Wages and Retention of Homecare Workers in San Francisco," *Industrial Relations*, Vol. 44, No. 1, 139-163; Howes, Candace. 2008. "For Love, Money or Flexibility: Why people choose to work in consumer-directed homecare," *The Gerontologist*, 48, Special Issue 1:46-59; Howes, Candace. 2009. "Declaration of Candace Howes in the case of *Martinez v Schwarzenegger*, Case No. C 09-02306 CW, June.)

^{ix} Jacobs, Ken, T. William Lester and Laurel Tan. 2010. "Budget Solutions and Jobs," Center for Labor Research and Education, University of California, Berkeley, March. Accessed at April 21, 2010 at

http://laborcenter.berkeley.edu/californiabudget/budget_solutions_jobs10.pdf.)

^x The average additional costs per IHSS recipient are likely to be small inasmuch as the number of cases in each of other programs MSSP, Alzheimer's Day Care Resource Center and Adult Day Health is miniscule compared to the IHSS caseload.

^{xi} I estimated that the cost to the state alone would be \$2.7 billion, slightly higher than the LAO estimate.

^{xii} This is similar to the Cash & Counseling program which is a Medicaid Demonstration Waiver granted to several states. The Waiver enables the state to experiment with giving long-term care eligible Medicaid recipients a cash allowance which can be used to hire a home care provider and case management services, instead of the state directly paying agencies or independent home care providers.

^{xiii} This three tier proposal is similar to Vermont's 1115 Waiver – Choices for Care – except that Vermont's program is a capitated managed care program in which the second tier gets homecare services, as long as funds are available and tier 3 gets homemaker services, but only if there is money available.

^{xiv} The LAO does not report the average years in IHSS or in SNF; rather, it provides average length of stay by age group; I have estimated a weighted average for length of stay in SNFs and IHSS from Figure 9 of the LAO study.

^{xv} If the typical aged, blind or disabled IHSS recipient, who expects to receive \$9,900 of IHSS services annually (plus \$6,800 in SSI/SSP payments) for 4.5 years, at a total cost of \$75,300, transfers to a nursing facility that costs \$50,100 per year but stays only 1.75 years, the total long-term cost of the nursing home – which is shared by the state and the federal government would be \$87,675, 16 percent higher than the total cost of IHSS.

^{xvi} Harrington C., H. Carrillo, and B. Blank. 2009. "Nursing, Facilities, Staffing, Residents, and Facility Deficiencies, 2001 Through 2008," Department of Social and Behavioral Sciences, University of California, San Francisco, accessed November 2009 at <http://www.pascenter.org>.

^{xvii} California's nursing home population is more disabled than the national average. By two acuity indices, California has among the most disabled residents in its facilities; only 3 states – Hawaii, Maryland and South Carolina - and the

District of Columbia have higher average scores measuring the "resource use for assistance with activities of daily living (ADLs)". The average summary score "acuity index" for California was 108.07, compared to the national average of 99.91; again, only a few states had higher acuity scores than California. The averages for Oregon (97.38) and Washington (95.74), which have fewer disabled nursing facility residents per population, were much lower. The management minute acuity index is another measure of physical disability, this one measuring the relative number of nursing minutes required per resident. (Harrington, et al., *ibid*).

^{xviii} In California 25.1 percentage of the nursing home population is less than 65 years of age which is much higher than the national average (18.1%) or than Oregon or Washington (20.4 and 19.8 percent). (CMS. 2009. Nursing Home Data Compendium. Accessed at http://www.cms.gov/CertificationandCompliance/Downloads/nursinghomedatacompendium_508.pdf on April 14, 2010.)

^{xix} Using the CMS measure of "unique eligibles" from the MSIS State Quarterly Summary Data, California had 40 percent more SNF eligibles per 1,000 and 60 percent more disabled eligibles than did Oregon. Compared to Washington State, California had 10 percent fewer eligibles, but 8 percent more disabled eligibles per 1,000 in the population. (Author's analysis using <http://msis.cms.hhs.gov/> MSIS State Summary DataMart).

^{xx} Taylor, *op.cit*.

^{xxi} Some would argue that these coverage numbers should be age adjusted, but since a large proportion of the population covered by long term care services is disabled, rather than elderly, age adjustment could skew the results.

^{xxii} Currently California covers more people in HCBS (9.6 per 1,000) than the national average of 5.0 and at 4.2 per 1,000, fewer in nursing homes than the national average of 5.8, making it one of the more "balanced states" in the country. However, several other states have higher total coverage and others, such as Oregon and Washington, are more balanced. These two, considered model states, cover 8.7 per 1,000 in HCBS, and both have significantly fewer persons per 1,000 in nursing homes – 2.7 and 3.4 (based on CMS measure of "beneficiaries.") compared to California's 4.2.

^{xxiii} Table sources: Harrington, Charlene; Ng, Terence; O'Malley Watts, Molly. 2009. "Medicaid Home and

Community-Based Service Programs: Data Update,” Issue Brief for Kaiser Commission on Medicaid and the Uninsured, Publication #7720-02, March. Downloaded November 9, 2009 from <http://www.kff.org/medicaid/upload/7720-03.pdf> and data online at <http://www.statehealthfacts.org/compare.jsp> ; Burwell, et al., op. cit.

^{xxiv} Arizona, which provides LTC and acute care services through a single managed care program, is not included because data does not permit comparison with other states.