Cost-Effectiveness of Home and Community Based Services

March 25, 2011
Friday Morning Collaborative

With support from The SCAN Foundation, NCOA leads a coalition of national aging and disability organizations working to protect and strengthen Home and Community-Based Services.

For more information about The SCAN Foundation visit: www.TheSCANFoundation.org
Friday Morning Collaborative

- AARP
- Alliance for Retired Americans
- American Network of Community Options and Resources
- Association of University Centers on Disabilities
- Alzheimer’s Association
- Balezon Center for Mental Health Law
- Easter Seals
- Families USA
- Jewish Federations of North America
- Leading Age
- Lutheran Services in America
- National Alliance for Caregiving
- National Association of Area Agencies on Aging
- National Association for Home Care and Hospice
- National Committee to Preserve Social Security and Medicare
- National Council on Aging
- National Council on Independent Living
- National Consumer Voice for Quality Long-Term Care
- National Disability Rights Network
- National Senior Citizens Law Center
- Paralyzed Veterans of America
- Paraprofessional Healthcare Institute
- Service Employees International Union
- The Arc/United Cerebral Palsy
- United Spinal Association
- Volunteers of America
Webinar Overview

▪ Introduction
  • Joe Caldwell, National Council on Aging

▪ Speakers
  • Steve Kaye, University of California San Francisco
  • Lisa Alecxih, The Lewin Group
  • Charlie Lakin, University of Minnesota
  • Dee Mahan, Families USA

▪ Questions and Answers
  • 15 - 20 minutes

▪ Closing Remarks
All Lines Will Be Muted During the Call
To Ask A Question Use the Chat Feature
Slides and Materials Will Be Available

Everyone who registered for the webinar will receive a follow up e-mail with:

- Link to archived recording
- Link to power point
Are Home- and Community-Based Services “Cost-Effective”?  

Steve Kaye  
University of California San Francisco  
NCOA Webinar 3/25/11
National per capita Medicaid HCBS expenditures, by type, adjusted for inflation in medical care costs, 1995–2005

- MR/DD Waivers
- Non-MR/DD Waivers
- Personal Care Services
- Home Health
National per capita Medicaid LTC expenditures, by type, adjusted for inflation in medical care costs, 1988–2005

1995 Dollars

- Total LTC
- Institutional
- HCBS
What does ‘cost-effective’ mean?

• Individual basis:
  – For a given individual to achieve a given outcome, HCBS are equally or less costly than institutional services.

• Program basis:
  – In aggregate, total LTSS program costs are equal or less when HCBS are offered than when only institutional services are available.
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.
“Woodwork effect”

• Offering HCBS increases participation
  – Favoring nursing homes = rationing by offering services nobody wants
  – But many more people served for same $
  – Isn’t it a govt. program *supposed* to serve everyone eligible who needs services?

• Alternative “woodwork” definition:
  – Program costs increase because more people enroll
  – E.g., HCBS not “cost-effective” on a program basis
Methods

• Examine annual state Medicaid expenditures for nursing homes, ICF/MR, home health, personal care plan, and HCBS waivers
  – Source: CMS 64 & 372 reports from Burwell et al.
• Separate costs for people with intellectual & developmental disabilities from other disabilities
• Combine states with similar spending patterns and examine trends over a decade
• Analysis details:
<table>
<thead>
<tr>
<th>Residential Setting</th>
<th>Population Served</th>
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<tbody>
<tr>
<td>Non-institutional</td>
<td>Non-MR/DD</td>
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</table>
Percent of Non-MR/DD LTC expenditures spent on HCBS, 2005
Mean per capita, inflation-adjusted non-MR/DD HCBS expenditures, in low- and high-HCBS states,

- Low-HCBS states
- High-HCBS states
Classifying the states

• Low HCBS states: Less than median proportion of spending on HCBS in 2005

• High HCBS states
  – Expanding HCBS states: Inflation-adjusted HCBS spending more than doubled from 1995 to 2005
  – Established HCBS states
Mean per capita, inflation-adjusted non-MR/DD HCBS expenditures, in low- and high-HCBS states,
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Percent of MR/DD LTC expenditures spent on HCBS, 2005
Mean per capita inflation-adjusted LTC expenditures targeted to the MR/DD population, in low- and high-HCBS states, 1995–2005
Mean per capita inflation-adjusted MR/DD Waiver expenditures, in low- and high-HCBS states, 1995–2005
Mean per capita inflation-adjusted ICF/MR expenditures, in low- and high-HCBS states, 1995–2005

- Low-HCBS states
- Established HCBS states
- Expanding HCBS states
Mean per capita inflation-adjusted LTC expenditures targeted to the MR/DD population, in low- and high-HCBS states, 1995–2005

- Low-HCBS states
- Established HCBS states
- Expanding HCBS states

What happens when states rapidly expand HCBS?

• Expanding states have faster spending growth; established states contain spending

• Examine states that introduced new or greatly expanded HCBS programs in late 1990s & follow subsequent LTC spending
  
  • Non-MR/DD: 9 such states
    – 15 comparison states w/o big increases
  
  • MR/DD: 11 states
Mean per capita non-MR/DD HCBS expenditures in 9 states before, during, and after HCBS expansion.

Year relative to HCBS expansion:
- Before growth
- Initial growth
- Full growth
- +1 year
- +2 years
- +3 years
- +4 years
- +5 years
- +6 years

1995 Dollars:
- $0
- $20
- $40
- $60
- $80
- $100
- $120
- $140
- $160
- $180
- $200
Mean per capita non-MR/DD LTC expenditures in 9 states before, during, and after HCBS expansion

- Nursing homes (red squares)
- HCBS (light blue diamonds)

1995 Dollars:
- Before
- Initial growth
- Full growth
- +1 year
- +2 years
- +3 years
- +4 years
- +5 years
- +6 years

Year relative to HCBS expansion
Mean per capita non-MR/DD LTC expenditures in 9 states before, during, and after HCBS expansion

- **Total**
- **Total (comparison states)**
- **Nursing homes**
- **HCBS**

Year relative to HCBS expansion:
- Before
- Initial growth
- Full growth
- +1 year
- +2 years
- +3 years
- +4 years
- +5 years
- +6 years

1995 Dollars:
- $0
- $20
- $40
- $60
- $80
- $100
- $120
- $140
- $160
- $180
- $200
Mean per capita MR/DD HCBS expenditures in 11 states, before, during, and after major HCBS expansion.
Mean per capita MR/DD LTC expenditures in 11 states, before, during, and after major HCBS expansion

1995 Dollars

Year relative to HCBS expansion

Before growth
Initial growth
Full growth
+1 year
+2 years
+3 years
+4 years
+5 years
+6 years

MR/DD Waivers
ICF/MR
Mean per capita MR/DD LTC expenditures in 11 states, before, during, and after major HCBS expansion
Conclusions

• HCBS programs do not break the budget
  – Nearly identical spending for low- and high-HCBS states confirms cost neutrality
• States with well-established HCBS programs contained costs better than states with low HCBS
  – Institutional savings probably not automatic
• HCBS expansion increases short-term spending but may cut long-term spending
• Serve more people at equal or lower cost
Estimating the Cost Impact of State Efforts to Shift Medicaid to HCBS

March 2011
Overview

- Alternative Measures of Cost Impact
- Measuring Success
Alternative Measures of Cost Impact

- Randomized Control Experimental Design
- Past Caseload Trends
- Use Rates
Randomized Control Design

- Participants randomly assigned to a treatment group that experiences the intervention and a control group that does not experience the intervention.

- In theory, as a result of the random assignment, the only difference between the two groups and the outcomes measured should be the result of the intervention.

- Grabowski (2006) notes that few cost-effectiveness of noninstitutional long-term care services studies relied on a randomized study design or an appropriate statistical technique, such as instrumental variables, to address the issue of selection bias across the treatment and comparison groups.

Channeling Demonstration: (10 sites, 1982-1984)

- Did NOT examine the impact of HCBS versus no HCBS
  - Added comprehensive case management and expanded community services to a system that already provided a substantial amount of community care.

- Supported “woodwork effect” concerns
  - Found HCBS/CM could cost more public money because did not sufficiently reduce nursing facility utilization to offset a “woodwork effect” of more people seeking services.

- Found targeting of services critical
  - Subsequent analysis suggests more rigorous targeting of the right mix of services can achieve much greater reductions in the use of nursing facilities.
Randomized Control Design

- Expensive and, depending on outcomes measured, can require many years to conduct
- Sometimes not feasible, particularly with statewide and systemic changes
- Can not be conducted after the fact
Past Trends

- Relies on counterfactual of continued past NF user trend & compare to actual number of users

- **Washington State estimate**
  - Assumes 3% annual change in Medicaid nursing home clients from 1992-2006
    - Based on best guess
  - Actually experienced -2.7% change

- **UMBC alternative estimates**
    - National average of 0.8% annual change based on 1992-2006
    - Maryland average of -0.93% annual change based on 1992-2006
    - Use national 2006 average of 23% HCBS times Washington total spending to estimate expected HCBS $s if NF did not decline
    - Conclude no savings because estimated HCBS spending offset NF decline savings
Past Trends

- Simple to calculate and explain
- Relies on counterfactual of continued past NF user trend & compare to actual number of users

What is the “right” comparison?

- Recommend trend in states that had little Medicaid HCBS expansion
- -0.38% annual change for bottom 10 states compared to -0.78% national average (1995-2005)
- -3.3% annual change in Washington

- Fails to account for any differences in demographics between the past trend period and the estimated period
Use Rates -- 1996 AARP Report

- Colorado, Oregon and Washington;
  - Examined early 1980s to 1994
- Estimated the counterfactual
  - What if NF use had not declined?
  - Projected versus actual Medicaid LTC spending
  - Did not address causality
- Accounted for:
  - Age 75+ population growth, national NF trends, level of impairment, Medicaid home health and supplemental income payments
- Found all three states at least broke even
  - Savings between 9-23% with impairment and national use trend
  - Washington with all factors breaks even
More Recent Analysis of Washington

- Analysis from 1984 through 2005
  - Similar methodology to AARP analysis, but updated
- Serving 14% more people than expected
  - +49% in community
  - -88% in nursing facility
- Spending 15% less Medicaid LTC than expected
  - +96% in community
  - -47% in nursing facility
How Do We Know What Works?

- Identify successful states
- Need to establish measures of success
- Need consistent data across all states
Three Measures of Progress

- **Proportion of Medicaid HCBS spending of the total Medicaid long term care spending**
  - Subset of states with 25%+ in 2005 (16 states)
  - National average 23.7%

- **Change in institutional placements**
  - Decline in per 65+ Medicaid NF use of 25%+ from 1995-2005
  - National average -15.2%

- **Change in per capita rate of Medicaid long term care spending**
  - Less than or equal to 5.2% annual increase from 1995-2005
  - National average 5.2% annually
# States Meet All 3 Medicaid LTC Measures

<table>
<thead>
<tr>
<th></th>
<th>Minn.</th>
<th>Mont.</th>
<th>Wash.</th>
<th>Wisc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995 % HCBS</td>
<td>4.1%</td>
<td>16.8%</td>
<td>18.1%</td>
<td>11.5%</td>
</tr>
<tr>
<td>2005 % HCBS</td>
<td>37.5%</td>
<td>25.2%</td>
<td>50.1%</td>
<td>34.3%</td>
</tr>
<tr>
<td>% pt difference</td>
<td>33.4%</td>
<td>8.4%</td>
<td>32.0%</td>
<td>22.8%</td>
</tr>
<tr>
<td>1995 NF/1,000 65+</td>
<td>45.2</td>
<td>34.4</td>
<td>26.7</td>
<td>42.9</td>
</tr>
<tr>
<td>2005 NF/1,000 65+</td>
<td>31.9</td>
<td>24.5</td>
<td>16.8</td>
<td>30.6</td>
</tr>
<tr>
<td>% difference</td>
<td>-29.3%</td>
<td>-28.8%</td>
<td>-37.0%</td>
<td>-28.8%</td>
</tr>
<tr>
<td>Annual change $/65+</td>
<td>2.0%</td>
<td>2.7%</td>
<td>5.0%</td>
<td>4.6%</td>
</tr>
</tbody>
</table>
## States Exceeding 25% Medicaid HCBS Only

<table>
<thead>
<tr>
<th>State</th>
<th>2005 % HCBS</th>
<th>% difference NF/1,000 65+</th>
<th>Annual change $/65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>52.3%</td>
<td>-12.7%</td>
<td>9.9%</td>
</tr>
<tr>
<td>Idaho</td>
<td>37.9%</td>
<td>-18.5%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Kansas</td>
<td>29.9%</td>
<td>-15.7%</td>
<td>6.8%</td>
</tr>
<tr>
<td>Missouri</td>
<td>27.9%</td>
<td>-12.5%</td>
<td>6.6%</td>
</tr>
<tr>
<td>New Mexico</td>
<td>51.5%</td>
<td>-22.6%</td>
<td>9.9%</td>
</tr>
<tr>
<td>North Carolina</td>
<td>37.9%</td>
<td>-13.4%</td>
<td>6.6%</td>
</tr>
<tr>
<td>Vermont</td>
<td>31.5%</td>
<td>-23.0%</td>
<td>5.6%</td>
</tr>
</tbody>
</table>
What do the Successful States Use? Financing Strategies

- Global Budgets
- Money Follows the Person
- Nursing Home Bed Buy Backs
- Expansion of Home and Community-based Alternatives
- Capitated Managed Long Term Care
- Long Term Care Insurance Partnership Program
What do the Successful States Use?
System Strategies

- **Knowledge for Informed Choices**
  - Easily accessible and understandable
  - Options counseling

- **Interventions in Critical Pathways to Institutionalization**
  - Outreach to hospital discharge planners, physicians...
  - Pre-admission screening for institutions

- **Accelerated Eligibility Determination**
  - Fast track
  - Presumptive eligibility

- **Consumer Direction**

- **Transitions out of Nursing Facilities**
Strong ADRC Implementation Associated with Greater Medicaid NF Use Decline

ADRC Fully Functioning and Decline in Medicaid NF Residents Excluding Statewide Managed Care & <50% Pop. Coverage

n=24

2005-2009 Annual Change in Medicaid NF Residents per 1,000 Age 65+

2008 ADRC Fully Functioning Score

Correlation = -0.429
What Do the Successful States Do Differently?

- Articulate a Government-wide Vision
  - Cross department and sometimes cross-disability
  - Engage all stakeholders in setting the Vision

- Plan to that Vision
  - All policy and funding decisions checked against Vision
  - Determine whether new initiatives/flavor of the month also within the Vision (or whether Vision needs to be modified)

- Execute the Plan
  - Develop a work plan and strategy to fulfill the Vision

- Monitor the Execution with Data
  - Develop measures & reports that indicate progress toward the Vision

- Regularly Reassess the Vision
Lisa Alecxih
Senior Vice President
Center for Long Term Care
The Lewin Group
3130 Fairview Park Drive
Suite 800
Falls Church, VA 22042
(703) 269-5542
www.lewin.com
Cost-Effectiveness in Medicaid Long-Term Services and Supports for Persons with Developmental Disabilities

Charlie Lakin
lakin001@umn.edu

Research and Training Center on Community Living

University of Minnesota
Driven to Discover℠
There is Substantial Evidence that Institutional Services Are Not Effective (e.g., Studies of Changes in Adaptive Behavior)

![Bar Chart]

- Positive Effects with Leaving: 22
- No Effects: 9
- Negative Effects with Leaving: 3
- No Effects: 2

**Effects**
- +/: Statistically Significant Difference
- +/−: Tendency Not Reaching Statistical Significance
- No Difference
There Has Been Progress in Reducing People Living in Public and Private Institutions of 16+ Residents
The Slowest Moving States Have Become the Primary Factor in Reduced Rates of Public Institution Depopulation

- **1990:**
  - 10 Slowest: 28,403
  - All Others: 55,836
  - 33.7% vs. 66.3%

- **1999:**
  - 10 Slowest: 21,481
  - All Others: 28,613
  - 42.9% vs. 57.1%

- **2009:**
  - 10 Slowest: 16,923
  - All Others: 15,986
  - 51.4% vs. 48.6%
States Have Shifted from Medicaid ICFs/MR to Home and Community Services (and Greatly Increased HCBS)
We’ve Found That Medicaid Expenditures Are Much Lower on Average for Adults in Family-Based Settings

Source: MSIS (KY, AL, WY, OK) data from 4 states
We’ve Supported A Rapidly Growing Number and Proportion of HCBS Recipients Who Are Living with Family Members
We’ve Found That Expenditures in HCBS Better Reflect Need: Average Annual Medicaid Expenditures for Adult HCBS and ICF/MR Recipients by Level of ID in Four States

Sources: MSIS (KY, AL, WY, OK)
By Shifting from ICF/MR to HCBS, Average Real Dollar Per Person Annual Expenditures for Medicaid Long-Term Services and Supports Decreased by 21% between 1993 and 2009.
The Types of Residences of Medicaid LTSS Recipients with ID/DD Changed Substantially Between 1992 and 2009

<table>
<thead>
<tr>
<th>Year</th>
<th>Agency-Operated ICF/MR</th>
<th>Agency-Operated HCBS</th>
<th>With Family</th>
<th>Host Family</th>
<th>Own Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>36,828</td>
<td>146,200</td>
<td>13,348</td>
<td>5,088</td>
<td>7,199</td>
</tr>
<tr>
<td>2000</td>
<td>224,608</td>
<td>116,441</td>
<td>107,682</td>
<td>26,385</td>
<td>29,963</td>
</tr>
<tr>
<td>2009</td>
<td>251,489</td>
<td>273,998</td>
<td>90,348</td>
<td>161,141</td>
<td>90,412</td>
</tr>
</tbody>
</table>
These Increased Beneficiaries (Not Average Cost) Have Driven Medicaid LTSS Expenditures for People with ID/DD

- Medicaid LTSS expenditures for persons with DD—Grown a bit faster than overall Medicaid
- Considerably faster than overall Medicaid LTSS
We’ve Learned That Trends Toward Smaller Service Settings is Consistent with People’s Well-Being

% Lonely Sometimes or Often

<table>
<thead>
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<th>Residence Size</th>
<th>% of Sample</th>
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<tbody>
<tr>
<td>1</td>
<td>44</td>
</tr>
<tr>
<td>2</td>
<td>42</td>
</tr>
<tr>
<td>3 to 6</td>
<td>53</td>
</tr>
<tr>
<td>7+</td>
<td>57</td>
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</tbody>
</table>

% Like Home? No or In-Between

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<tr>
<th>Residence Size</th>
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<tbody>
<tr>
<td>1</td>
<td>10</td>
</tr>
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</tr>
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<td>3 to 6</td>
<td>16</td>
</tr>
<tr>
<td>7+</td>
<td>18</td>
</tr>
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Source: National Core Indicators
We’ve Seen That Adults Report Good Quality of Life Outcomes While Living with Family

- No difference on:
  - Feeling afraid in your neighborhood

- Better results for those NOT living with family on:
  - Home staff nice & polite

- Better results for those living with family on:
  - Loneliness
  - Feeling afraid at home
  - Feeling happy
  - Liking home

Source: National Core Indicators
Taking Stock About How Well Do We Reflect Basic Qualities of Sustainability?

Sustainable Systems:

• Are economically viable for the long term.
• Carry out functions valued in the society.
• Have active and mobilized constituencies.
• Avoid demanding greater shares of public resources by being efficient and effective.
• Have built-in capacities to gather, analyze, report and use data to improve performance.
• Are flexible and change to new demands.
• Accommodate shifting priorities
• Effectively develop future generations.
Advocating for Home- and Community-Based Services: Cost Effectiveness and Beyond

Dee Mahan, Families USA
March 25, 2011
Cost-effectiveness arguments are critical to fight cuts and support HCBS expansion, but there are additional arguments that can help
Medicaid is under attack on several fronts

EDITORIAL: Medicaid cuts will hurt down the road

Brown Proposes Deep Cuts to Health Care Programs

Illinois Budget Cuts Will Cost Seniors and Disabled

Republican Governors Seek More Flexibility in Medicaid

Shaping GOP entitlement reform plans
There’s a need to reach multiple audiences

• Key decision makers: Governors, state legislators

• Administrators: New Medicaid Directors and their staff members

• The public: Seniors, people with disabilities, caregivers, people with aging parents
Additional arguments to build the case for HCBS

• Economic arguments
  – Role of Medicaid in state economies
  – Economic cost of informal caregiving
  – Business impact of caregiving

• Additional arguments
  – Need to build the long-term services infrastructure and workforce
  – Consumer preferences
  – Cuts may violate Olmstead
Medicaid supports jobs, economic growth in communities, states

- Economic impact of new money into a state exceeds the amount of dollars alone
- Medicaid funding has a “multiplier” effect—new jobs, economic growth
- Medicaid cuts mean losses in business activity, jobs, wages
Enhanced Medicaid match in new options is an added selling point

- Stimulates economic growth through “multiplier” effect
- Balancing Incentive Program – can help some states fund changes underway
- Community First Choice – Increased match does not sunset
Supporting caregivers has an economic benefit.

- Medicaid HCBS provide critical support to unpaid caregivers.
- A typical family caregiver can lose $110 in wages and benefits/day, reduces household spending, delays medical care.
- Lost wages, reduced spending have an economic impact.
And can help businesses

- 60% of employed caregivers make work-related adjustments
- Cost to businesses: reduced hours, absenteeism, replacement costs
- Full-time employed caregivers cost to businesses: Estimated over $33 billion nationally
Investing in HCBS can help build the long-term care workforce

- Demographic imperative in all states
- Inadequate long-term services workforce
- From 2006 to 2016, 35% increase in demand for direct-care workers—over 1.3 million new openings
- Investing in HCBS can help build the workforce
Expanding HCBS is consistent with consumer preferences

- 80% of people needing long-term services would prefer to live in the community
- Expanding HCBS polls well among seniors
- Polls show Americans oppose Medicaid cuts that would affect seniors
Cuts might constitute an *Olmstead* violation

- States must have a plan for placing individuals in the least restrictive setting
- Obama administration is enforcing *Olmstead*
- Reductions in HCBS, or failure to provide adequate HCBS, may violate *Olmstead*, the Americans with Disabilities Act
Generating support among legislators and the public

- Remind people: Medicaid pays for things Medicare doesn’t
- Use state specific data as possible
- Build an economic and human argument
- Use personal stories
- Develop relationships with reporters
Take advantage of opportunities

• Develop broad coalitions; “strange bedfellows” can help
• New legislators, Medicaid Directors and staff need to get up to speed on programs
• Fighting cuts and promoting new options together

Keep pushing
Some resources

• AARP Public Policy Institute, *Valuing the Invaluable: The Economic Value of Family Caregiving, 2008 Update,* online at http://assets.aarp.org/rgcenter/il/i13_caregiving.pdf

• Families USA:
  – Medicaid calculator to estimate economic impact of Medicaid cuts or increased funding in your state. Note: Calculator is based on 2008 spending and will be updated shortly. Calculations are also based on the 2008 Medicaid match so impact of increased FMAP in some of the HCBS options in the Affordable Care Act is not reflected. Go to http://www.familiesusa.org/issues/medicaid/other/medicaid-calculator/medicaid-calculator-states-map.html
  – State specific advocacy pieces on expanding HCBS. Go to http://www.familiesusa.org/issues/long-term-services/states/


To Ask A Question Please Use the Chat Function
Continue the Conversation Online

Join to discuss what you learned today!

www.NCOACrossroads.org/HCBS

- New online community!
- Join advocates nationwide to protect HCBS
- Easily share ideas and resources

Learn more at our free training:
- Wednesday, April 6th
- 1:00 - 2:00 p.m. Eastern
- Register on www.NCOACrossroads.org/HCBS
Thank You

- You will receive a follow up e-mail with a link to a recording of this webinar and additional resources discussed today.

- Please share with other advocates in your state.

- As you exit the webinar please take a minute to answer a few questions to help us plan future webinars.