

# **The State of the States in Developmental Disabilities 2005**

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**Preliminary Report**

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# THE STATE OF THE STATES IN DEVELOPMENTAL DISABILITIES: 2005

## I. INTRODUCTION

This monograph presents the results of the eighth nationwide study of the “state of the states in developmental disabilities.” The current study was designed to evaluate trends in the states during 2002-04 in the growth and development of services and funding for persons with mental retardation and closely related developmental disabilities (MR/DD). This study, in a sense, is a benchmarking analysis of the states’ implementation of the U.S. Supreme Court’s *Olmstead* decision promoting community living (*Olmstead v. L.C.*, 1999).

Part I of the monograph summarizes the methodology of the study and reviews general trends in MR/DD spending during 2002-04 in the states and nationally. This section presents a national overview of trends in community services and supports, in out-of-home residential placements, costs, staff wages, and revenue sources. National trends in supported living, supported employment, and family support are described. Part I also reviews trends in public and private institutional services in the states including nursing home care, and identifies factors influencing demand for MR/DD services and supports. These factors include aging caregivers, growing waiting lists, and widespread litigation in the states. Part II of the monograph presents statistical profiles for each of the 50 states and the District of Columbia.

Our first study was initiated almost 25 years ago as the U.S. economy was experiencing the soaring inflation that had begun during the Carter administration, reaching double-digit levels in 1980-81 (U.S. Bureau of Economic Analysis, 2005a). The Reagan administration had implemented its “Program for Economic Recovery,” largely through the Omnibus Budget Reconciliation Act (OBRA) of 1981 (Pub. L. 97-

35). OBRA-1981 reduced previously legislated federal authorization levels for many domestic programs. During 1981-84, federal spending for special education, vocational rehabilitation, social services, and Developmental Disabilities Act services grew little or not at all in inflation-adjusted terms (Braddock, 1987).

A major recession had impacted states in 1982-83. In our study completed two years ago, we noted that many state MR/DD programs were entering a period of significant fiscal retrenchment (Rizzolo, Hemp, Braddock, & Pomeranz-Essley, 2004). Emerging fiscal conditions in state governments appeared to be nearly as bad in 2003-04 as they were in 1982-83. Given that 15 states had reduced MR/DD spending in 1983, we hypothesized that a similar number of states might reduce spending in 2003 and/or 2004. The recent slide in state economic conditions actually began in the first quarter of 2001 (National Conference of State Legislatures, 2002).

The impact of the 1982-83 recession, and subsequent impact of the challenging fiscal conditions in 2003-04, are reflected in **Figure 1** which shows the percentage change in states’ inflation-adjusted general fund expenditures from 1979-2006 (National Association of State Budget Officers, 2005). Note the dramatic decline in these expenditures in 1983 (6.3%). General funds are appropriated by the state legislature from “own-source” non-federal revenues. A state’s “own-source” revenues are especially important in developmental disabilities because they are used extensively to match federal Medicaid reimbursement for MR/DD services, including the Intermediate Care Facility/Mental Retardation (ICF/MR) program and the Home and Community Based Services (HCBS) Waiver.

However, the 1982-83 reduction in general fund expenditures was temporary as these expenditures grew faster than the rate of inflation

every year between 1984 and 2001. State general funds declined 1.4% in 2002 and 2.4% in 2003, the first such declines since 1983. State general fund expenditures grew by 0.3% in 2004, 3.3% in 2005, and 0.5% in 2006.

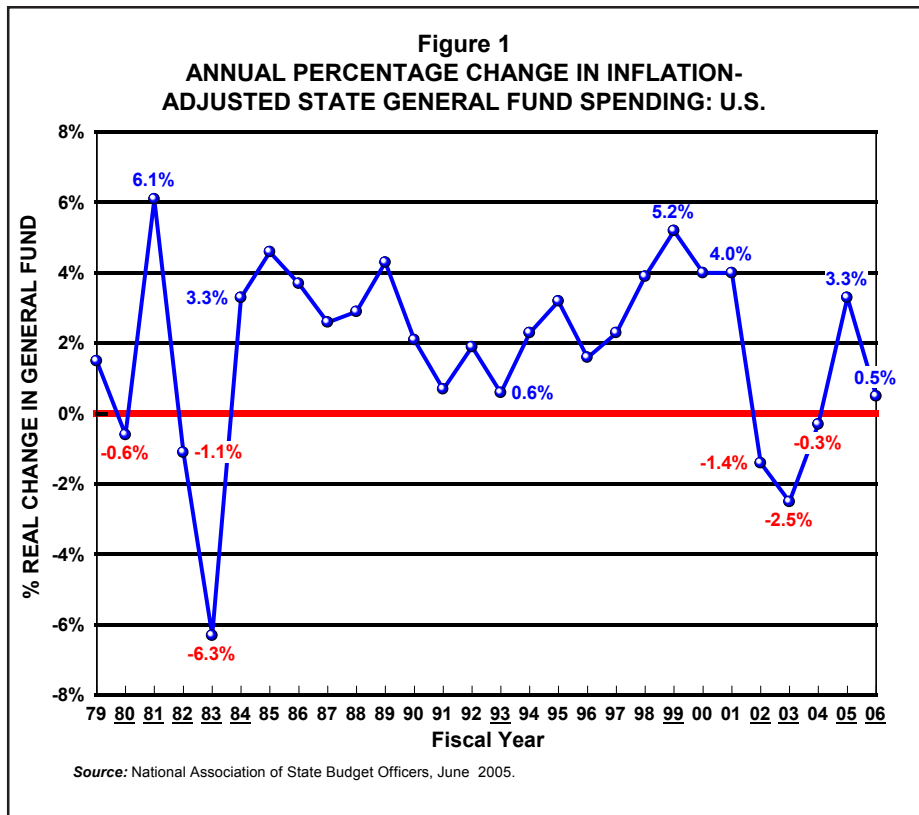
**Growing Demand for Services**

While budget difficulties have been preoccupying most state governments in recent years, powerful demographic and legal forces continue to stimulate demand for MR/DD residential and community services. The number of persons over age 65 is increasing and will double over the next 30 years (U.S. Census Bureau, 2001). The aging of our society will increase demand for services for people with developmental disabilities who currently reside with aging family caregivers (Braddock, 1999). In 2004, for example, approximately 2.8 million of the 4.6 million persons with MR/DD in the United States were receiving residential support from family caregivers, and an estimated 710 thousand of these persons (25%) were residing with caregivers age 60+. (See discussion on page 56).

Increased longevity of persons with developmental disabilities is a second demand stimulus for services and supports. The mean age at death for persons with mental retardation in the United States was 66 years in 1993, up from 59 years in the 1970s. Janicki (1996) has noted that with continued improvement in their health status, individuals with mental retardation,

particularly those without the most severe impairments, are expected to have a lifespan equal to that of the general population. This increased life expectancy of persons has accounted for an estimated 10-20% increase in demand for residential services in the past three decades alone (Braddock, 2002a).

Litigation also remains a powerful force shaping the funding and development of service delivery systems for persons with MR/DD in many states. In the 1990s, three types of class-action litigation lawsuits were filed to compel states (a) to expand services to people on waiting lists; (b) to meet the requirements of the community integration mandate in the *Olmstead* U.S. Supreme Court decision; and (c) to provide Medicaid services for individuals who were eligible but were not receiving those services. In May 2005, 22 waiting list lawsuits, 9 *Olmstead* lawsuits, and 15 Medicaid-access lawsuits were active in the states (Smith, 2005). Such cases historically have often led to the appropriation of



additional funding for residential and community services (Braddock & Fujiura, 1991).

As a consequence of demographic dynamics, increasing longevity, and legal rights initiatives, the states and the federal government are being encouraged to expand services and supports for people with developmental disabilities and their families. At the same time, increasing demands are being placed on the states and the federal government to expand home and community-based long-term care services and supports for the long-neglected populations of persons with physical disabilities and with severe, persistent mental illness (Braddock, 2002b). Confronting this rapidly growing broad-based demand for aging and disability-related long-term care services in the current uncertain fiscal environment presents formidable challenges for the states, for the federal government, and certainly for the field of developmental disabilities.

## II. APPROACH

In this study, MR/DD financial and programmatic data from the states were collected and analyzed for fiscal years (FYs<sup>1</sup>) 2003 and 2004. Data collection procedures included: 1) the acquisition and analysis of budget and program documents from each state; 2) development of 51 specialized state survey instruments reflecting the fiscal and programmatic idiosyncrasies of each state and the District of Columbia (DC); 3) implementation of these surveys in all states and the District; and 4) extensive personal interviews and related contact with state agency officials to obtain, interpret, and verify the MR/DD financial and programmatic data collected.

The key federal, state and local financial support categories employed in our analysis are outlined in *Table 1*. This framework is the basis both for the survey instruments that are constructed for each state, and for comparative state-by-state statistical summaries. In addition

to the federal, state, and local revenue and expenditure categories specified in *Table 1*, we collected spending, revenue and participant data for *family support*, *supported living*, and *supported employment* in each state, and revenue and participant data for *day and work programs*. A minimum data set for participants in *residential services* settings was also collected to generate cost of care statistics specifically tied to the financial data we collected (*Table 2*).

### Methodological Challenges

Numerous methodological problems are encountered in any nationwide study of public spending. In this study, four empirical problems were confronted in regard to state budget procedures used in the states (Braddock, Hemp, & Fujiura, 1986): 1) the wide variety of budgeting systems (e.g., *program budgets* vs. *line-item budgets*); 2) several types of capital, equipment, and debt service budgeting methods and varied budgeting practices for *fringe benefit costs*; 3) the varied *reliability* of the spending figures reported in official state budget documents (i.e., whether the budget reports “actual,” “revised appropriations,” “governor’s recommendation” or “legislative request” data); and, 4) the difficulty of *disaggregating* state, federal, and local funds reported in states’ executive budget documents.

Fiscal data available in *program budgets* are frequently unavailable or available only in part in *line-item budgets*, and vice versa. Comparative nationwide financial studies are thus constrained by the lowest common denominator; that is, by the amount of detail in the least detailed state budget. As noted, extensive interpretive contact is required with state agency officials to supplement budget document analysis. Access to detailed state

<sup>1</sup> Unless otherwise noted, all years refer to states’ fiscal years, which typically run July 1 - June 30.

**Table 1**  
**PROGRAM/BUDGET CATEGORIES**  
**UTILIZED FOR DATA COLLECTION**

**I. INSTITUTIONAL SERVICES FUNDS**

A. PUBLIC INSTITUTIONS FOR 16+ PERSONS

1. STATE FUNDS
  - a. General Funds
  - b. ICF/MR Medicaid Match
  - c. Other State Funds
  - d. Local Funds
2. FEDERAL FUNDS
  - a. Federal ICF/MR
  - b. Title XX/Social Services Block Grant
  - c. Other Federal Funds

B. PRIVATE INSTITUTIONS FOR 16+ PERSONS

1. STATE FUNDS
  - a. General Funds
  - b. ICF/MR Medicaid Match
  - c. Other State Funds
  - d. Local Funds
2. FEDERAL FUNDS
  - a. Federal ICF/MR
  - b. Other Federal Funds

**II. COMMUNITY SERVICES FUNDS**

A. COMMUNITY SERVICES FOR <16 PERSONS

1. STATE FUNDS
  - a. General Funds
  - b. Medicaid Match
  - c. Other State Funds
  - d. Local Funds
  - e. SSI State Supplement Funds
2. FEDERAL FUNDS
  - a. Public ICF/MR (< 16 persons)
  - b. Private ICF/MR (< 16 persons)
  - c. HCBS Waiver
  - d. Other Medicaid Services
    1. Rehabilitative Services
    2. Clinic Services
    3. Targeted Case Management
    4. Personal Care Services
    5. Administrative, Other Services
  - e. Title XX/Social Services Block Grant
  - f. Other Federal Funds
    1. Temporary Assistance for Needy Families (TANF)
    2. Other Federal Funds
  - g. SSI and Adult Disabled Child (ADC) benefits for HCBS Waiver Participants

**Source:** Braddock (1981; 2002a).

agency administrative records is typically necessary.

Several types of *capital*, equipment, and debt service budgeting methods are used in the 50 states and the District of Columbia. A number

of states integrate these expenditures into their regular operating budgets, and these amounts have to be carefully extracted from operating expenditures to ensure comparability across states. Also, *fringe benefit costs* for state employees are often reported separately from MR/DD agency budgets. These nontrivial sums (which can exceed 20% of agencies personnel budgets) must be obtained directly from other state agencies (usually personnel management agencies) and aggregated with developmental disabilities operating expenditures.

A third methodological problem stems from the different levels of *reliability* in the spending figures reported in official state budget documents. The stability of a reported spending figure depends upon the stage of the budget process in which it is captured. Gubernatorial “recommended” or “requested” figures are subject to substantial change because they are subsequently reviewed and often modified by legislative appropriations committees; “actual expenditures” are not subject to change and represent fixed values after the official closing of the books. “Actual expenditures” are generally available within two years of the initial appropriation. Intermediate stage spending data include “revised appropriations” and “obligations,” the latter reflecting legally binding financial commitments incurred by an agency. Revised appropriations figures are adjusted periodically during and after the fiscal year in which the funds were originally appropriated. Data used for the analysis of trends in MR/DD state spending should be based on actual expenditures, obligations, or, at a minimum, revised appropriations. As different iterations of this study have been completed over the years, we have worked with the states to continuously revise and improve the reliability of prior years’ data.

State executive budget documents typically provide three years of data. Most governors’ executive budgets for FY 2005 were

published in early calendar year 2004. They typically presented actual expenditure data for FY 2003, revised appropriations for FY 2004, and the “governor’s recommendation” or “legislative request” for FY 2005. We rely on state budget documents for general background information on MR/DD-related budget priorities in the states. In some states, the budgets also provide some detail on MR/DD institutional and community services spending and related performance measures such as participant data. However, useful budget detail in gubernatorial executive budgets is the exception, not the rule. We must also obtain fiscal and programmatic data via state-specific survey instruments and in repeated communication with state MR/DD, Medicaid, and social services agency officials.

Many states also fail to *disaggregate* state, federal and local funds in their official executive budget documents. Resolving this problem also requires supplementing budget document analysis with extensive correspondence and telephone interviews with state officials including access to state agency administrative records. Altogether, the methodological problems noted above pose significant challenges, as Caiden (1978) warned, in terms of the time and labor it takes to complete a nationwide study of public spending in the states.

### State Data Sources

Initial contact with a given state is preceded by inspection of the state’s published executive budget documents, and review of acquired programmatic documents including material from our data collection efforts in previous years. Interviews with state MR/DD agency personnel help guide development of a uniform fiscal classification system that is sensitive to each state’s budgeting terminology.

The project’s survey instruments include electronic spreadsheets that are

## Table 2 SUMMARY OF KEY PROGRAM/ PARTICIPANT CATEGORIES FOR DATA COLLECTION

- I. PUBLIC & PRIVATE INSTITUTIONAL SETTINGS (16+ PERSONS)
  - A. State-Operated Institutions
  - B. Private ICFs/MR
  - C. Other Private Residential Facilities
  - D. Nursing Facility Residents with MR/DD
- II. COMMUNITY RESIDENTIAL SETTINGS (7-15 PERSONS)
  - A. Public ICFs/MR
  - B. Private ICFs/MR
  - C. Other Residential Facilities for 7-15 Persons
- III. COMMUNITY RESIDENTIAL SETTINGS (1-6 PERSONS)
  - A. Public ICFs/MR
  - B. Private ICFs/MR
  - C. Supported Living
  - D. Personal Assistance
  - E. Other Residential Settings  
(Group Homes, Apartments, Foster Care)
- IV. DAY/WORK PROGRAM PARTICIPANTS
  - A. Sheltered Employment/Work Activity
  - B. Day Habilitation (“Day Training”)
  - C. Supported/Competitive Employment
- V. HCBS WAIVER PARTICIPANTS

Source: Braddock (1981, 2002a).

sufficiently detailed to reflect each state’s budget structure, and are also consistent with the study’s classification categories (*Table 1*). Reliability of the classification of developmental disabilities revenue and spending data into the various classification categories by our project’s research analysts has been demonstrated to be high (Braddock & Fujiura, 1991). Winer’s (1971) unbiased intraclass correlation coefficients were determined to be between .88 and 1.00 for the classification process.

At the outset of each data collection cycle, each state is sent a guide containing definitions and instructions along with three data collection instruments. One is for revenue and expenditure data and is structured according to the classification categories outlined in *Table 1*; a second is for data on the numbers of participants in residential and day programs, as outlined in *Table 2*; and a third is for spending, revenue, and participant data for family support, supported living, and supported

employment activities. The data we collect on family support, supported living, and supported employment are a subset of community services spending and participant data.

Each new study update we complete involves extensive communication and data exchanges with state agency officials. Moreover, to obtain data not directly available from the principal state MR/DD agency, which is frequently the case, personnel must be contacted from other agencies such as Medicaid, social services, rehabilitation, health, and public welfare. However, data obtained from these “outside” state agencies must then be evaluated carefully in consultation with our state MR/DD agency contacts and, when feasible, with the other secondary data sources. After we collect fiscal and programmatic data from a state, a preliminary financial and programmatic profile is produced for internal review and reviewed by state MR/DD agency personnel.

### National Sources

Some state-by-state data utilized in this study were obtained from national sources. For example, Supplemental Security Income (SSI) and SSI state supplement data are obtained from *Social Security Statistical Supplements* (Social Security Administration, 2004) and employed in our profiles of the states. Also, to augment and cross-check some of the Medicaid-related ICF/MR and HCBS Waiver data we collect from the state agencies, we utilize *Medicaid Statistical Information System (MSIS)* beneficiary data and *CMS-64* expenditure data (Centers for Medicare and Medicaid Services, 2004a, 2004b; Eiken, Burwell, & Schaefer, 2004; Eiken, Burwell, & Walker, 2005). Some of the nursing facility data reported in our previous publications was based on the *CMS Online Survey Certification and Annual Review (OSCAR)* data set (e.g., Harrington, Carrillo, Wellin, & Shemirani, 2002). In various analyses, we also employ census,

demographic, income and poverty data (U.S. Census Bureau, 2004), statewide aggregate personal income (U.S. Bureau of Economic Analysis, 2005b), and states’ general fund expenditures (National Governors Association and National Association of State Budget Officers, 2004).

### Data Analysis

Data collected from the states were evaluated for the presence or absence of financial and participant trends within each state and across the nation. The 43 key program/budget data collection categories presented in *Table 1* and the 20 program/participant data categories in *Table 2* guided our analysis of the structure and financing of institutional and community services in the U.S.

### Financially-Focused Analyses

Public spending for institutional and community services was summarized statistically by level of government (federal, state, and local) and by revenue source. *Institutional* spending supports publicly and privately operated Intermediate Care Facility/Mental Retardation (ICF/MR)-certified and non-ICF/MR facilities for 16 or more persons. (Nursing facility spending was not included in this analysis). *Community* services spending supports residential services for 1-15 persons. This includes publicly and privately-operated ICFs/MR and Medicaid Home and Community Based Services (HCBS) Waiver funds, and other federal, state or local funding for a wide range of residential services and supports including group homes, apartments, foster homes, supported living/personal assistance, supported employment, family support, day programs, and related community supports. Community services analyses were also completed on spending in the states for 6-person or fewer residential settings, day programs and

“individual and family support” (i.e., supported living, supported employment and family support).

Fiscal effort (spending as a percentage of aggregate statewide personal income) was computed for each state and the U.S. for: a) community settings, b) public and private 16+ institutional settings, and c) total developmental disabilities spending in the states. “Unmatched” state and local funding potentially available to draw down additional federal financial participation under the Medicaid HCBS Waiver or the ICF/MR program was also estimated for each state.

### ***Participant-Focused Analyses***

We collected participant data in terms of “average daily” participants on a fiscal year basis for 24-hour residential services and “full-time equivalent” participants for day programs and supported employment, supported living, family support, and the HCBS Waiver. Compared to end-of-year or point in time data, these data produce more accurate daily cost of care statistics. We computed the average cost of care by state in, a) public and private institutions for 16+ persons, b) public and private ICFs/MR for 15 or fewer persons, and c) supported living settings. Participant utilization rates per state population were also computed for public and private institutions and non-specialized nursing facilities, for residential settings for 7-15 persons, for residential settings for six or fewer persons and for the HCBS Waiver program. In other analyses we estimated the number of persons with developmental disabilities living with aging caregivers in each state and nationally, identified completed and in-progress state-operated institutional closures in the states over the past 40 years, and summarized recent developments in MR/DD-relevant litigation in the states.

## **III. GENERAL TRENDS IN SPENDING**

### **National Trends**

Total public spending for MR/DD services in the U.S. grew from \$34.48 billion in 2002 to \$38.55 billion in 2004 (*Figure 2*). This was an increase of 5.7% after adjusting for inflation, and the slowest adjusted percentage growth rate in total MR/DD spending for any two-year period since we began collecting data for this study (1977-79). Real spending for the community services component of total MR/DD spending advanced 8.5% during the 2002-04 period. In contrast to the relatively vigorous overall growth of community spending, public/private institutional spending for persons in 16+ settings contracted 4.3% in adjusted terms. The proportion of total U.S. public MR/DD spending allocated for community services increased from 78% in 2002 to 80% in 2004, while public/private institutional spending declined from 22% to 20%.

During the 1980s, inflation-adjusted double-digit increases in public spending for community services were common, along with single-digit adjusted increases in spending for public/private institutions for 16+ persons. In the 1990s, community MR/DD spending also grew rapidly, at between 5-10% per annum in adjusted terms, but spending for 16+ institutional settings declined consistently from 1992 through 2004. The only exception to annual reductions in institutional spending since 1991 was in fiscal year 2001, when institutional spending increased by one-tenth of a percent in adjusted terms. The 25-year trend in year-to-year change in MR/DD community and institutional spending from combined federal, state, and local sources of funding is illustrated in *Figure 3* on page 9.

### **State Trends**

When we began the present study, we hypothesized that 15 states would reduce overall public spending for MR/DD services in 2002-03. This speculation was based on the similarities in general fund conditions in the states in 1982-83 versus 2002-03 (illustrated in *Figure 1*). Twelve states, in fact, did reduce overall financial commitments to MR/DD services between 2002 and 2003. The states were Oregon (8%), Oklahoma (6%), West Virginia (5%), Illinois (4%), Arkansas, South Carolina and Washington State (3%), Michigan (2%), and New York (1%). Virginia, Utah, and North Dakota reduced spending by less than one-half percent. Seven of these states (IL, MI, OK, OR, SC, WA and WV) also reduced total MR/DD spending over the two year period of the current study: 2002-04. The additional three states reducing MR/DD spending during 2002-04 were Alaska, Colorado, and Massachusetts.

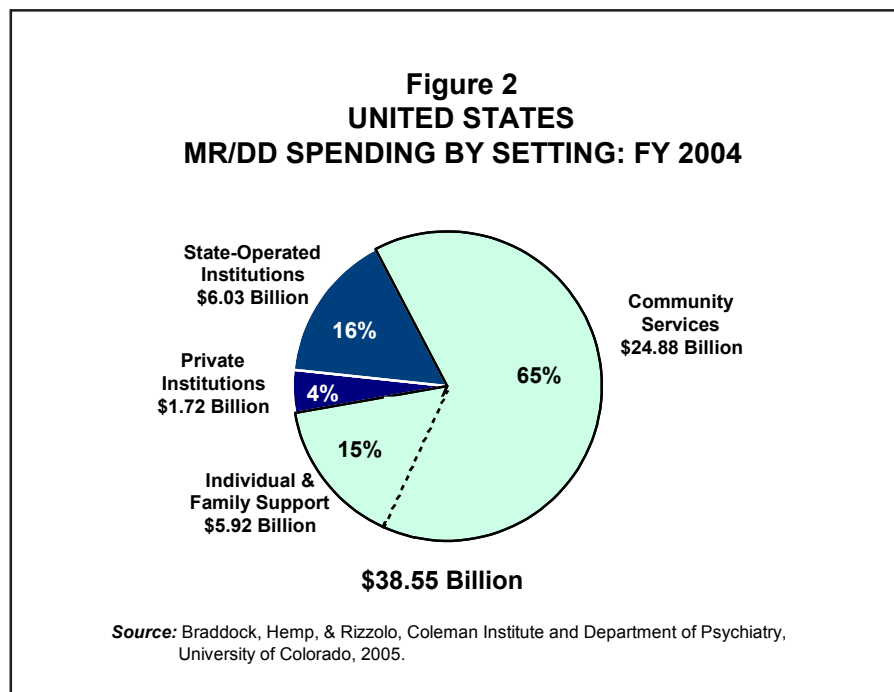
During 2002-04, the District of Columbia and Hawaii increased total MR/DD spending by 68% and 42%, respectively. Indiana, Louisiana, New Mexico, Wyoming, and Florida allocated an additional 18% to 29% and the following states increased spending by 10% to 14%: Idaho, Montana, Maryland, Arizona, Connecticut, Nebraska, Nevada, Wisconsin, Kentucky, North Dakota and California. The District's growth was primarily attributable to an inflation-adjusted 36% increase in spending for ICFs/MR for 15 or fewer persons, and these ICFs/MR served 30% more individuals from 2002 to 2004. Federal-state Waiver spending in the District grew 242% and there was

a 103% increase in the number of participants, albeit from a very small base in 2002 (162 individuals). The District became the last jurisdiction to implement the HCBS Waiver program in FY 2001.

Federal-state Waiver spending in Hawaii grew 77% from 2002 to 2004, and this increase (\$28.3 million, adjusted) constituted 93% of the total community spending increase in Hawaii. In the 16 other states that posted 10% or greater MR/DD spending increases, federal-state HCBS Waiver spending constituted between 36% and 95% of the community spending increases during 2002-04. In the states with 18% or greater MR/DD spending increases, federal-state Waiver spending constituted 86-95% of the states' 2002-04 community spending growth.

**Comparative Analysis of Institutional and Community Services: 1977-2004**

National data obscure state variability in the financing of institutional and community services. Data for 1977-2004 are presented for all 50 states, the District of Columbia and the



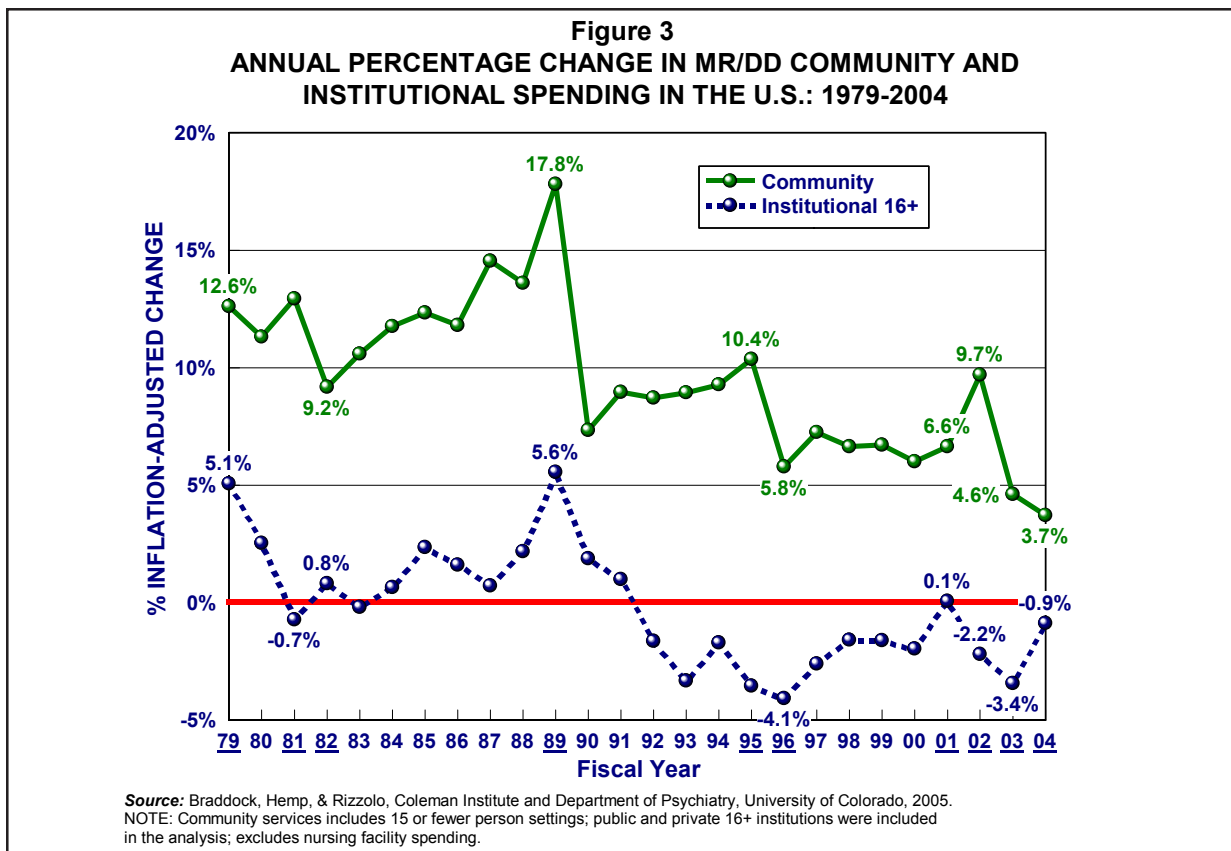
United States in *Figure 4*. Public and private institutional spending, defined in terms of facilities for 16 or more persons, is indicated in each state's graphic by the light gray bar. The black bar represents community services spending for individuals served in settings for 15 or fewer people and community day, sheltered work, and other non-residential services. The white subcomponent of the black community spending bar represents combined spending for supported living, personal assistance, supported employment, and family support.

The state-by-state data in *Figure 4* reveal two broad trends: Community services funding grew steadily in virtually every state during the past two decades and institutional spending declined in most states during this same period. Five empirical characteristics of states' patterns of financing institutional and community services are used to gauge resource allocation trends in the states over the past three decades: 1) the year

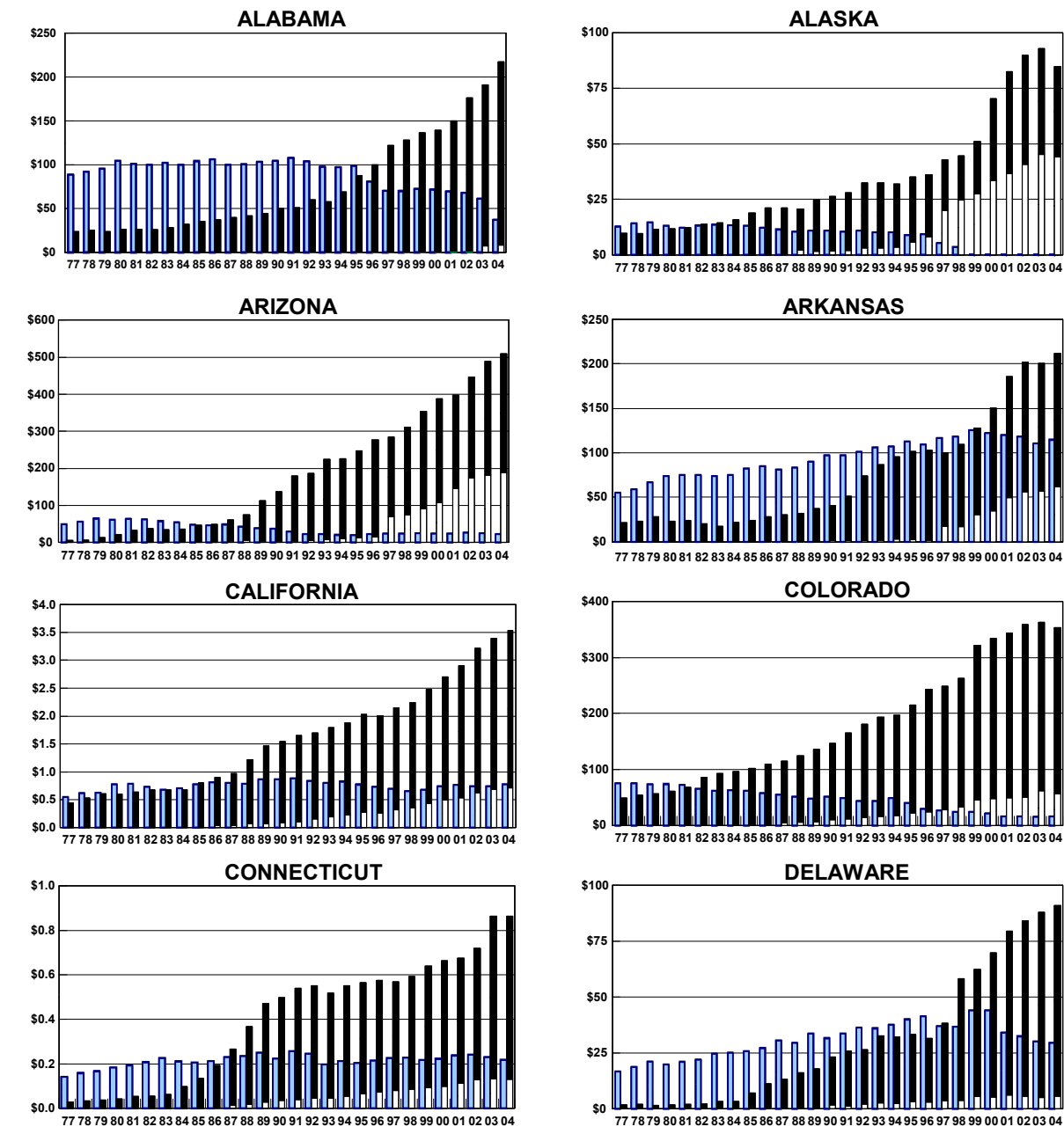
in which community spending first exceeded institutional spending; 2) the rate at which community services resources have grown over time; 3) the rate at which institutional spending has declined; 4) the proportion of total MR/DD resources in 2004 committed to community services versus institutional services; and 5) the extent of resource commitments in the states to individual and family support activities.

### Growth of Community Services

Public spending for community services in the U.S. first exceeded institutional spending in 1989. In 2004, all states but Mississippi were spending more for community services than for institutional services, although Mississippi has committed a significantly increased amount of public resources for community services over the past 10 years. Alaska, in 1981, and Colorado and Michigan, in 1982, were the first three states to



**Figure 4**  
**PUBLIC SPENDING FOR MR/DD SPENDING BY SETTING: FY 2004**



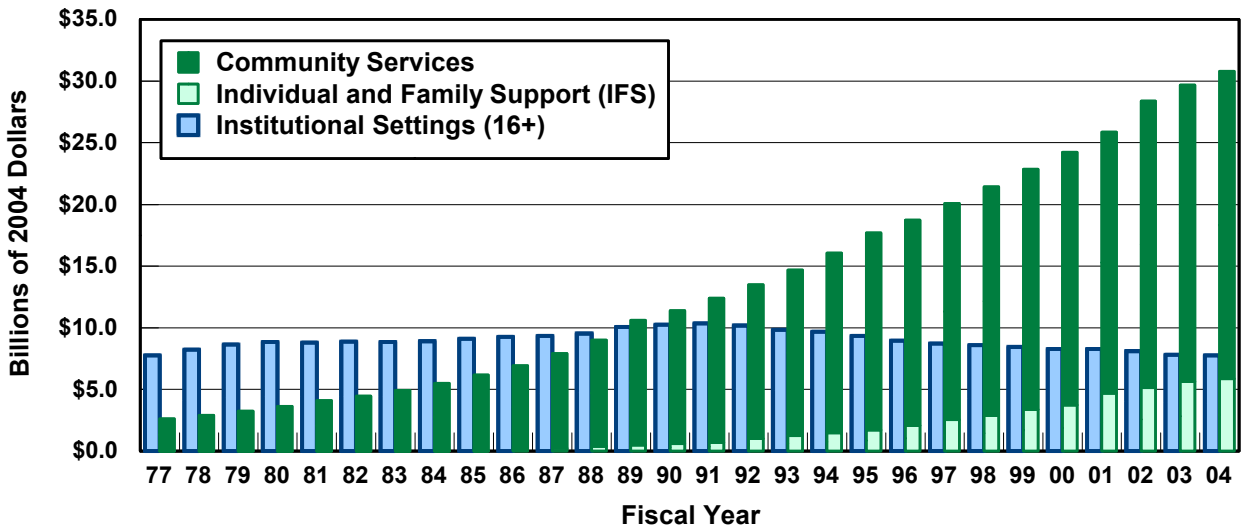
**LEGEND**

- Public/Private Institutions (16+) → [Blue bar]
- Community Services ← [Black bar]
- Individual & Family Support (a subset of Community Services) ← [White bar]

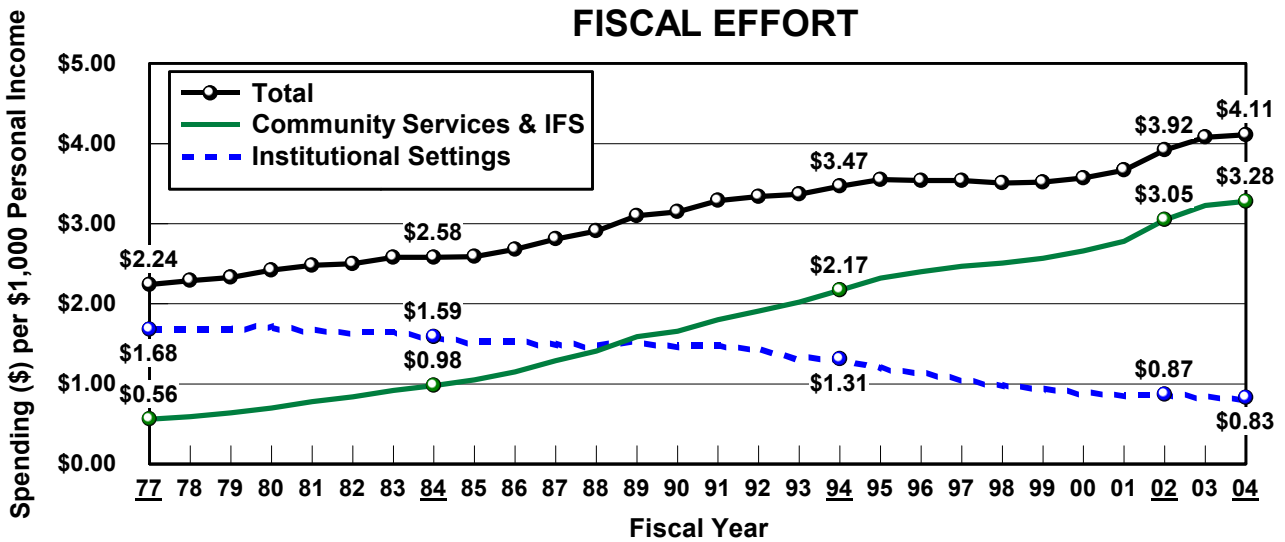
Public/Private Institution spending includes funds for residential facilities with 16+ persons; nursing facilities are not included. Community spending includes residential programs for 15 or fewer persons and non-residential community services. Individual and Family Support, a subcomponent of community services, consists of spending for supported living/personal assistance, supported employment, and family support. Spending for each state is in millions of constant 2004 dollars and, for CA, CT, FL, IL, MA, MI, MN, NJ, NY, OH, PA, TX, and the United States, in billions of constant 2004 dollars.

Source: Braddock, Hemp, & Rizzolo, Coleman Institute and Department of Psychiatry, University of Colorado, 2005.

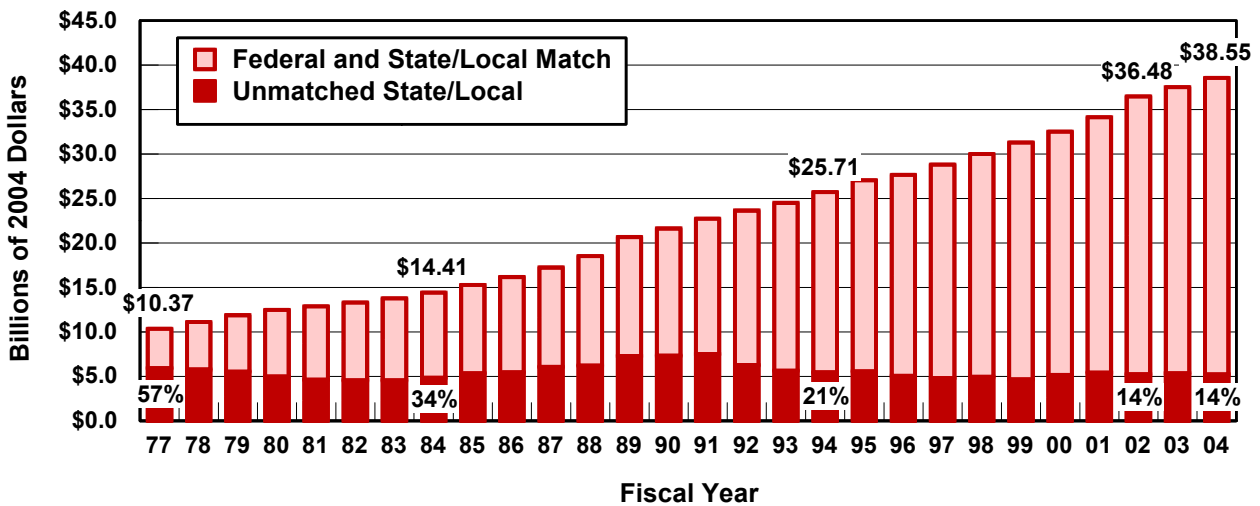
## TRENDS IN SPENDING



## FISCAL EFFORT

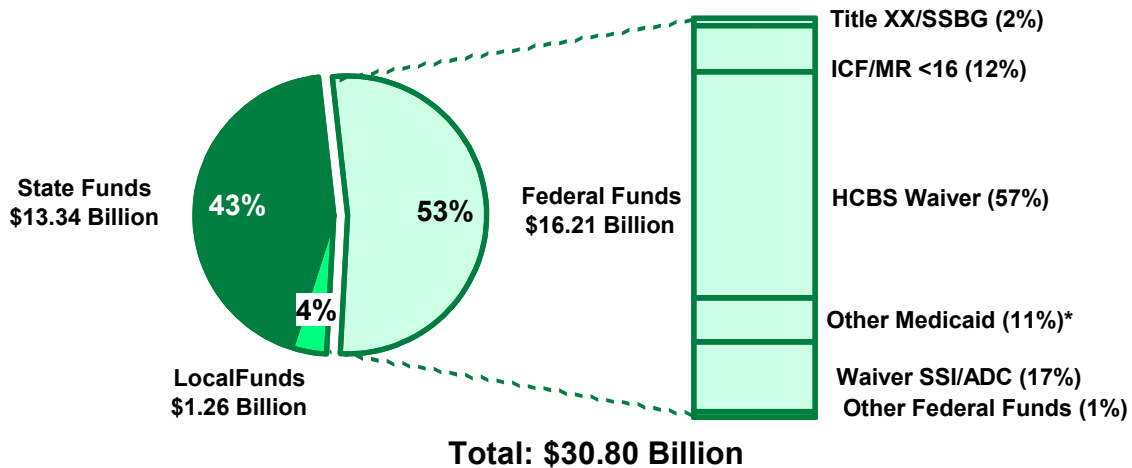


## TOTAL MR/DD SPENDING: MATCHED AND UNMATCHED FUNDS

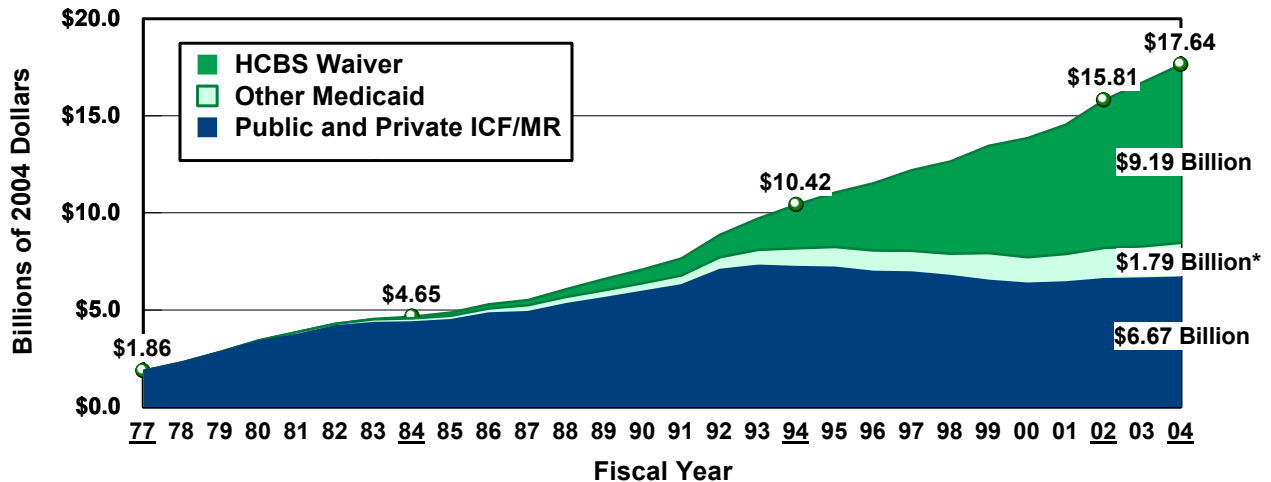


# TRENDS IN REVENUE

## COMMUNITY SERVICES REVENUE IN 2004

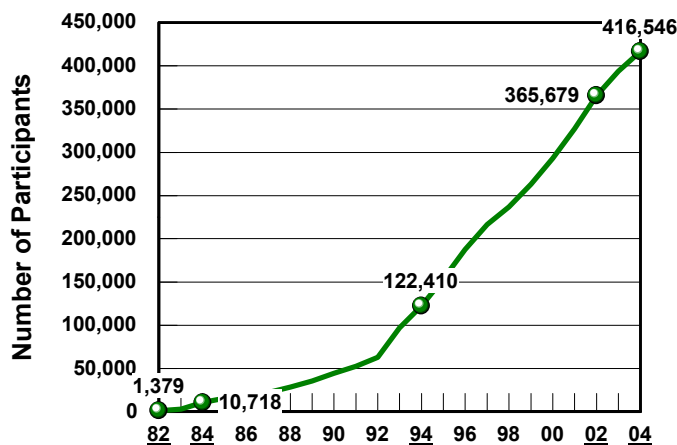


## COMPONENTS OF FEDERAL MR/DD MEDICAID REVENUE

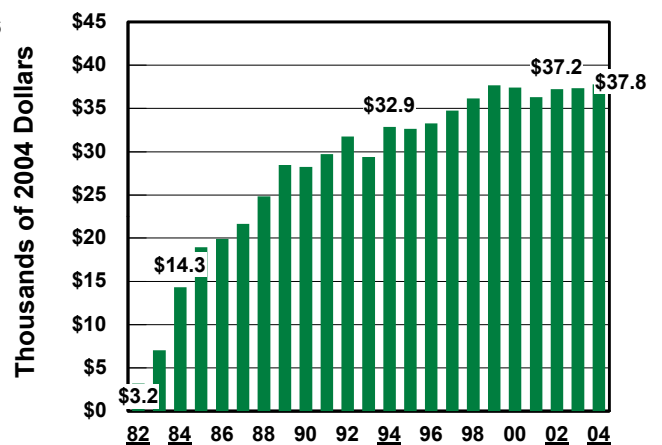


\*\*Other Medicaid\*\* in 2004 included \$0.58 billion (administration), \$0.50 billion (clinic/rehabilitative services), \$0.49 billion (case management), and \$0.22 billion (personal assistance).

## HCBS WAIVER PARTICIPANTS

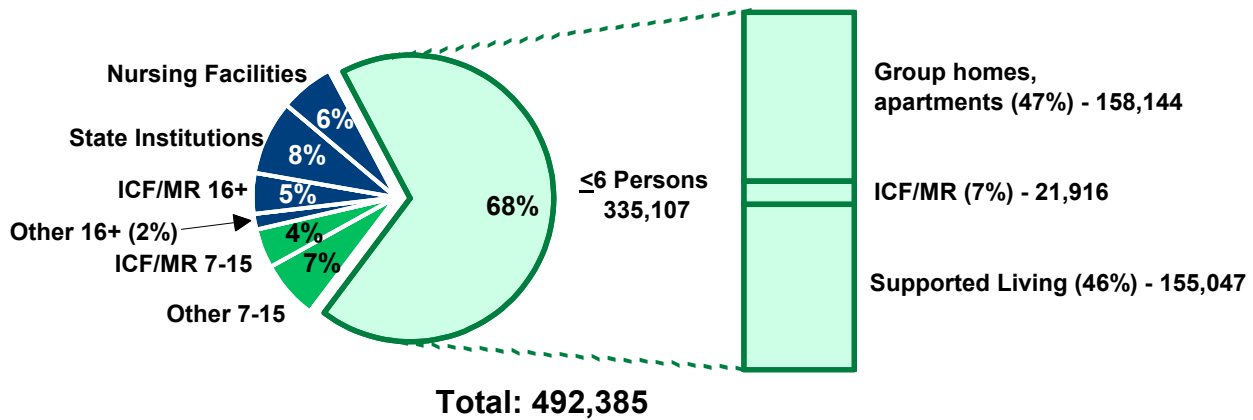


## WAIVER SPENDING PER PARTICIPANT



# TRENDS IN RESIDENTIAL SERVICES

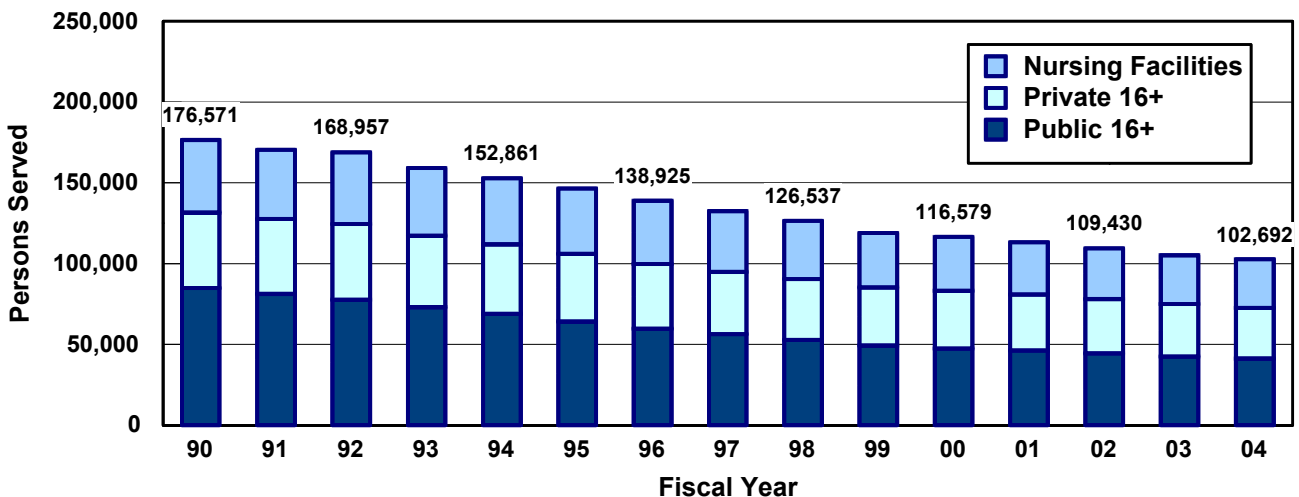
## PERSONS SERVED BY SETTING IN 2004



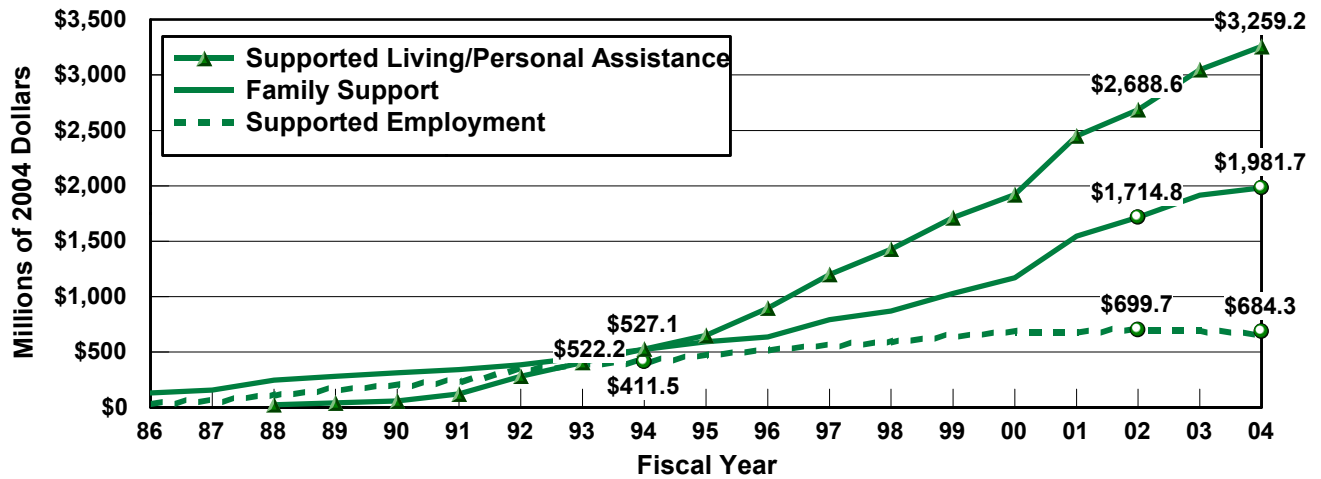
## PERSONS SERVED BY SETTING

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
<b>TOTAL</b>	356,101	359,663	368,555	380,916	390,911	402,647	414,000	419,681	431,240	461,762	473,344	481,070	492,385
<b>16+ PERSONS</b>	168,957	159,186	152,861	146,524	138,925	132,547	126,537	118,944	116,580	113,214	109,430	105,166	102,692
Nursing Facilities	44,525	41,944	40,979	40,444	39,286	37,690	36,198	33,719	33,381	32,332	31,403	30,136	30,062
State Institutions	77,600	73,032	68,867	64,175	59,763	56,331	52,742	49,294	47,397	46,304	44,451	42,402	41,214
Private ICF/MR	33,577	32,222	31,204	30,752	28,777	27,744	27,271	26,202	26,091	25,496	24,735	23,826	22,783
Other Residential	13,255	11,989	11,811	11,154	11,099	10,782	10,326	9,729	9,710	9,081	8,841	8,802	8,633
<b>7-15 PERSONS</b>	59,016	55,922	55,510	56,558	55,459	55,729	55,165	54,791	55,531	55,389	55,689	53,844	54,586
Public ICF/MR	4,450	4,765	4,417	4,446	1,591	1,606	1,443	1,269	1,379	1,373	1,350	1,295	1,301
Private ICF/MR	23,238	22,343	22,834	23,197	23,443	22,949	22,813	21,826	21,950	21,148	20,939	20,903	20,557
Other Residential	31,328	28,814	28,259	28,915	30,425	31,174	30,909	31,696	32,202	32,868	33,400	31,646	32,728
<b>≤6 PERSONS</b>	128,129	144,555	160,185	177,833	196,527	214,371	232,297	245,946	259,130	293,160	308,225	322,060	335,107
Public ICF/MR	461	539	551	775	983	1,275	1,192	1,079	1,137	501	857	912	902
Private ICF/MR	12,450	14,342	15,756	17,303	18,001	19,083	19,269	17,906	17,924	21,020	20,144	20,988	21,014
Other Residential	115,218	129,674	143,878	159,755	177,543	194,013	211,836	226,961	240,069	271,639	287,224	300,160	313,191

## PERSONS SERVED IN PUBLIC AND PRIVATE INSTITUTIONS AND NURSING FACILITIES



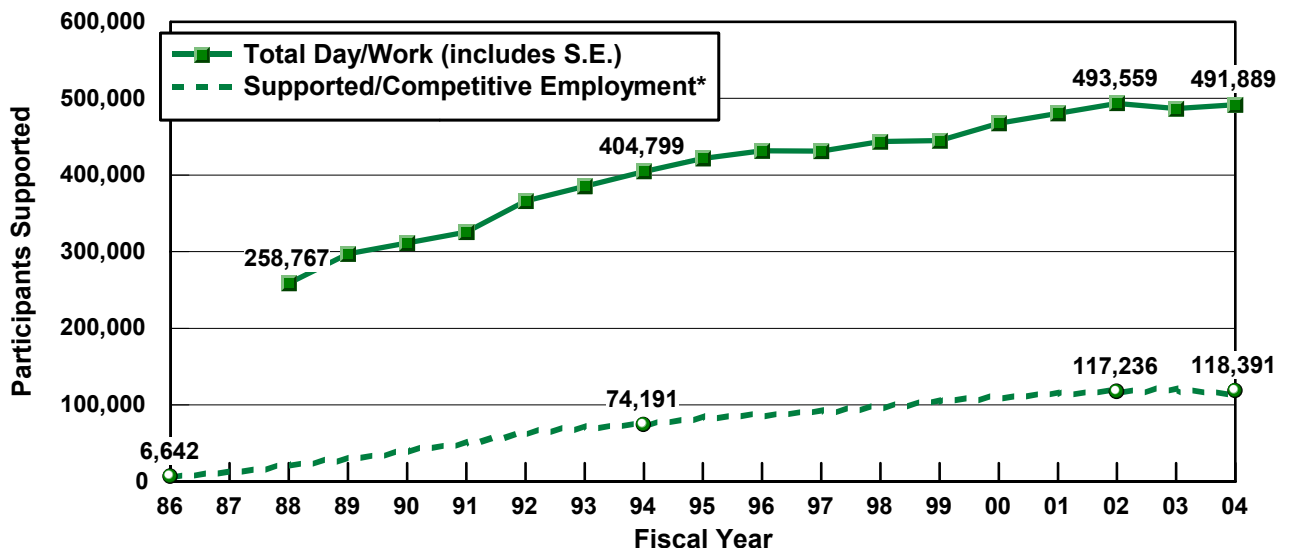
# INDIVIDUAL AND FAMILY SUPPORT



## PARTICIPANTS AND SPENDING LEVELS

	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
<b>TOTAL IFS (\$)</b>	1,120,845,610	1,345,683,300	1,654,198,181	2,101,887,281	2,424,530,733	2,905,826,510	3,364,773,543	4,340,155,075	4,824,120,880	5,526,677,898	5,925,261,404
<b>INDIVIDUAL SUPPORT (\$)</b>	720,157,487	878,364,776	1,141,052,275	1,448,455,270	1,694,921,292	2,025,159,037	2,322,197,197	2,909,615,197	3,203,068,855	3,658,049,187	3,943,511,837
Supported Employment (\$)	315,729,596	365,316,035	416,578,071	458,617,595	498,169,604	559,733,225	609,995,660	640,052,550	661,419,370	684,565,883	684,310,455
# of Persons	72,231	82,328	87,929	88,067	94,187	102,880	109,390	112,226	111,410	114,779	112,023
Supported Living (\$)	367,377,685	462,568,976	628,921,360	842,915,734	1,019,331,502	1,292,483,164	1,511,704,930	1,841,176,752	2,036,100,040	2,374,848,153	2,557,742,702
# of Persons	30,519	37,052	43,294	52,492	60,388	73,606	79,167	91,200	96,003	105,026	110,986
Personal Assistance (\$)*	37,050,205	50,479,765	95,552,843	146,921,941	177,420,187	172,942,648	200,496,608	428,385,896	505,549,446	598,635,151	701,458,681
# of Persons*	8,199	9,581	13,098	16,421	18,250	17,815	19,045	33,462	37,214	40,237	44,062
<b>FAMILY SUPPORT (\$)</b>	400,688,123	467,318,524	513,145,907	653,432,011	729,609,441	880,667,473	1,042,576,346	1,430,539,878	1,621,052,025	1,868,628,711	1,981,749,567
Total Families	211,190	233,875	255,253	272,180	281,303	313,072	341,464	372,429	393,729	394,001	395,978
Cash Subsidy/Payment (\$)	36,793,661	37,729,756	42,795,628	46,750,566	47,938,570	60,132,638	73,306,947	81,426,853	85,910,289	94,444,639	95,095,115
# of Families	15,268	15,943	17,495	19,015	21,011	24,257	27,912	31,044	30,986	32,299	33,334
Other Family Support (\$)	365,186,160	430,889,693	471,686,060	620,458,284	694,783,636	820,534,115	970,121,764	1,352,713,076	1,535,141,972	1,774,184,072	1,886,654,452
# of Families	218,109	245,096	267,449	300,080	311,773	295,492	319,417	347,921	370,520	372,883	372,719

## PARTICIPANTS IN DAY/WORK AND SUPPORTED EMPLOYMENT



\*Supported/competitive employment in 2004 includes 6,368 competitively employed workers assisted by MR/DD agencies in CT, KS, LA, NH, PA, and TX.