The Cost-Effectiveness of Home and Community-Based Long-Term Care Services

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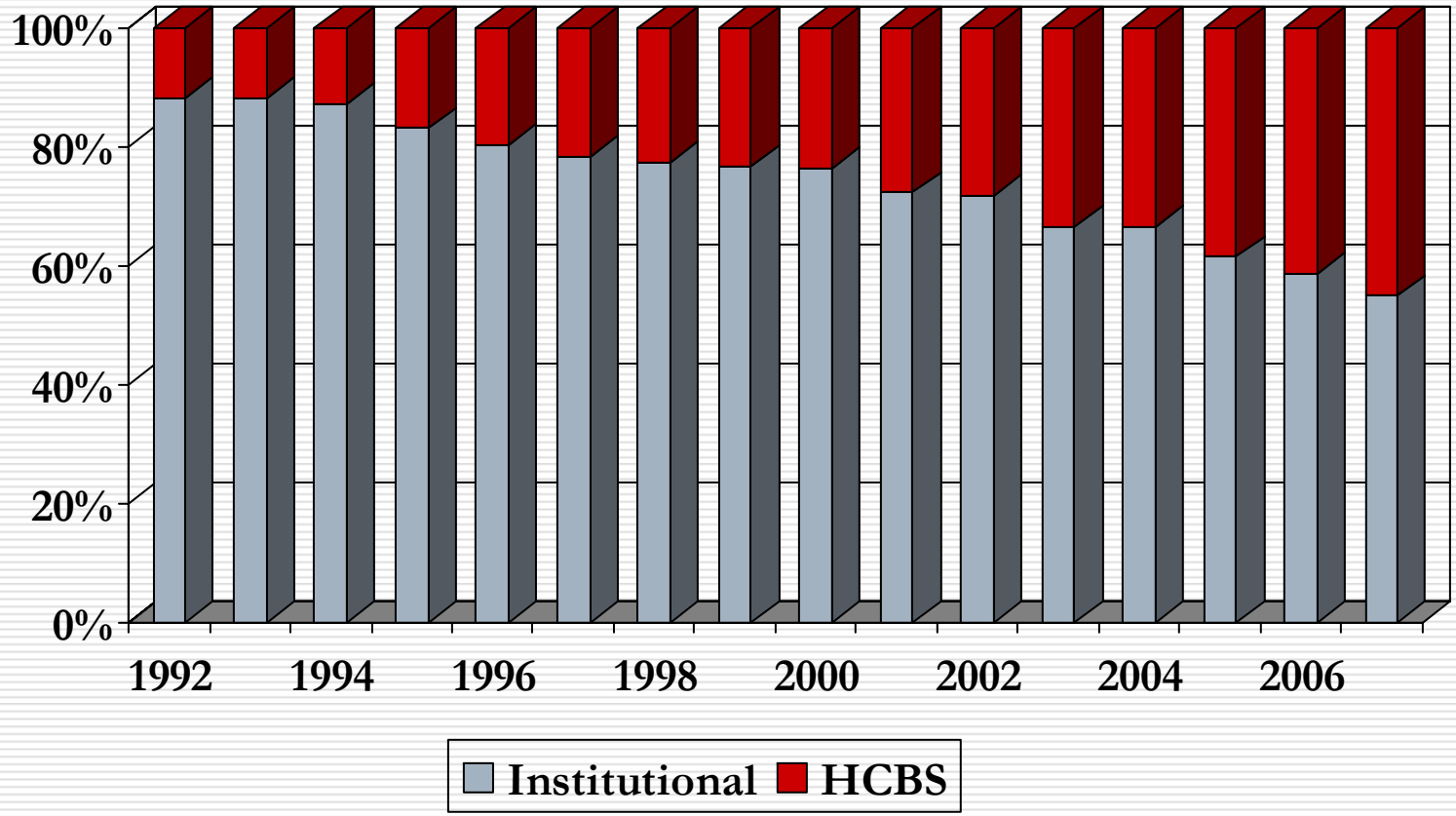
The Hilltop Institute Symposium
Home and Community-Based Services:
Examining the Evidence Base for State Policymakers
June 11, 2009

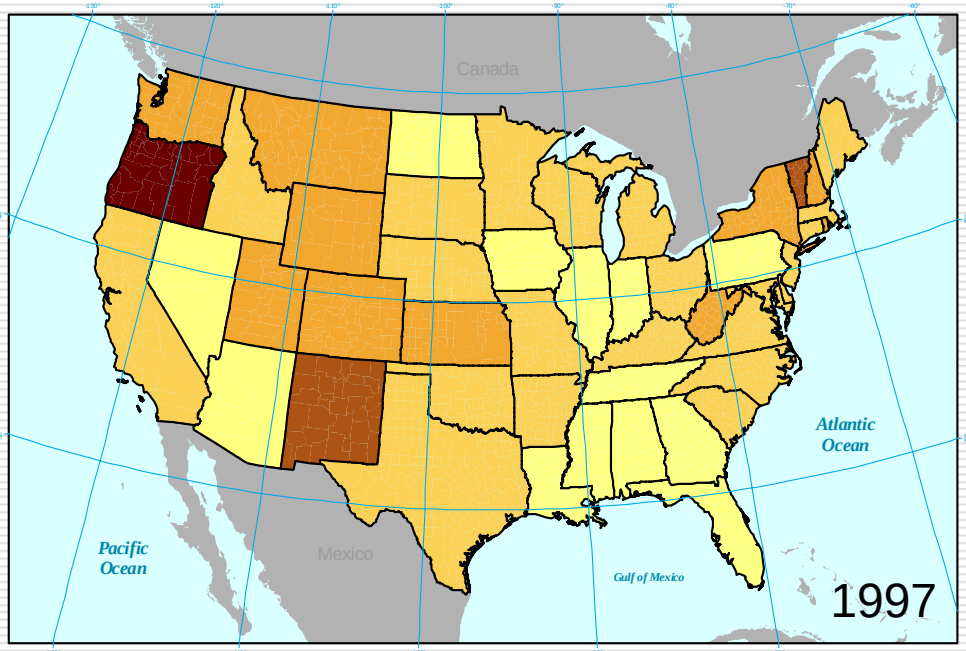
Rebalancing of LTC

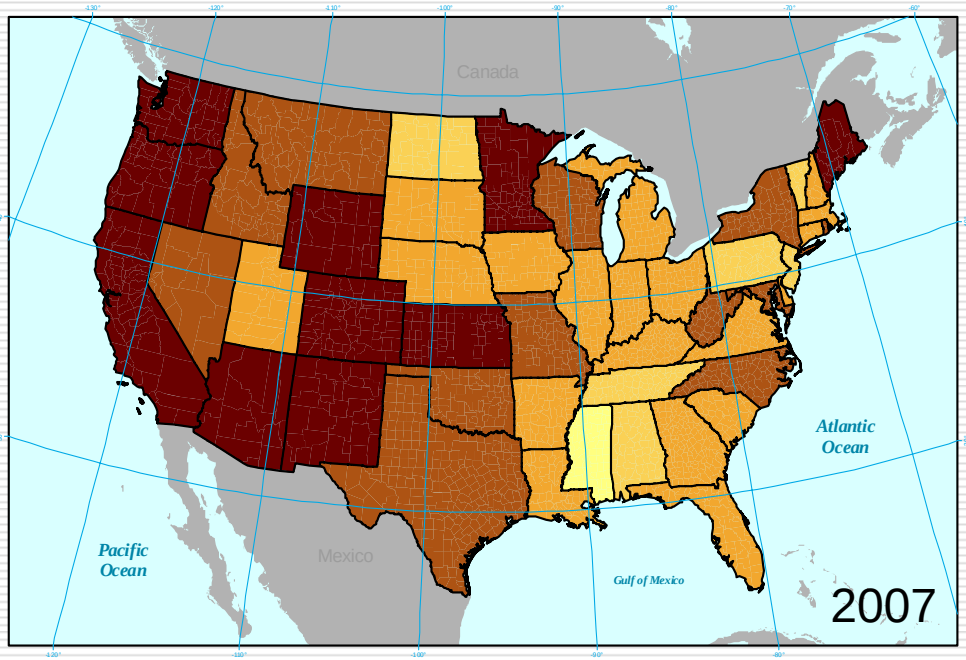
- LTC system historically dominated by nursing homes
- In recent years, huge growth in delivery of LTC in non-institutional settings
  - HCBS often preferred by consumers/families
  - Hope of lower cost HCBS
  - Also pushed as a civil rights issue, especially by the disability community
    - Olmstead decision

Rebalancing Medicaid LTC Expenditures



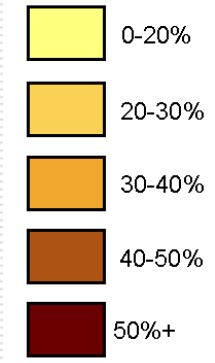
Source: Thomson Reuters via CMS Form 64





Percent of Medicaid LTC Spending for HCBS

	1997	2007		1997	2007
Alabama	17.5%	28.4%	Montana	31.3%	45.0%
Alaska	38.1%	62.6%	Nebraska	24.9%	37.6%
Arizona	6.5%	64.0%	Nevada	16.9%	45.3%
Arkansas	21.6%	30.1%	New Hampshire	35.7%	39.6%
California	20.3%	54.3%	New Jersey	24.1%	29.6%
Colorado	39.2%	51.6%	New Mexico	42.0%	72.9%
Connecticut	26.0%	35.5%	New York	34.2%	47.4%
Delaware	22.0%	35.4%	North Carolina	27.7%	44.9%
District of Columbia	5.6%	32.6%	North Dakota	18.1%	25.6%
Florida	18.0%	34.4%	Ohio	20.3%	30.1%
Georgia	18.1%	38.3%	Oklahoma	23.1%	42.5%
Hawaii	12.9%	39.9%	Oregon	50.3%	72.7%
Idaho	20.6%	43.6%	Pennsylvania	12.5%	28.3%
Illinois	11.2%	31.4%	Rhode Island	35.4%	45.6%
Indiana	7.8%	33.3%	South Carolina	20.9%	34.7%
Iowa	17.8%	37.7%	South Dakota	26.4%	39.1%
Kansas	31.8%	53.4%	Tennessee	9.3%	29.9%
Kentucky	24.0%	30.2%	Texas	24.0%	42.5%
Louisiana	9.4%	36.2%	Utah	31.0%	38.6%
Maine	28.1%	51.4%	Vermont	46.5%	28.5%
Maryland	28.4%	41.1%	Virginia	25.1%	39.6%
Massachusetts	25.0%	38.7%	Washington	35.9%	61.8%
Michigan	26.7%	33.3%	West Virginia	31.0%	41.4%
Minnesota	29.7%	62.9%	Wisconsin	28.3%	46.1%
Mississippi	4.5%	12.7%	Wyoming	38.6%	55.7%
Missouri	26.3%	44.9%			



Objective

- Home- and community-based services have clearly grown in use
- Given budget neutrality restrictions, there has been a lot interest in establishing that they also save $$$
  - Lower per-person cost, but potential moral hazard or "woodwork effect"
  - Challenge of "targeting" services to those at highest risk of institutionalization
- Review the evidence on this issue
  - Grabowski, D.C., 2006, "The Cost-Effectiveness of Noninstitutional Long-Term Care Services: Review and Synthesis of the Most Recent Evidence," *Medical Care Research and Review* 63(1): 3-28.
  - Update for recent research

Four Types of HCBS Evaluations

- Randomized, controlled experiments (e.g., Channeling)
- Medicaid waiver spending studies
- Capitation (e.g., PACE)
- Consumer-directed care (e.g., Cash and Counseling)

(1) Randomized Experiments

- Early demonstrations (e.g., Channeling) generally found that HCBS:
  - Slightly decreased NH use, but increased overall LTC costs due to "woodwork effect"
  - Little change in survival or physical/mental functioning
  - Improved client/caregiver welfare
  - Decreased unmet needs

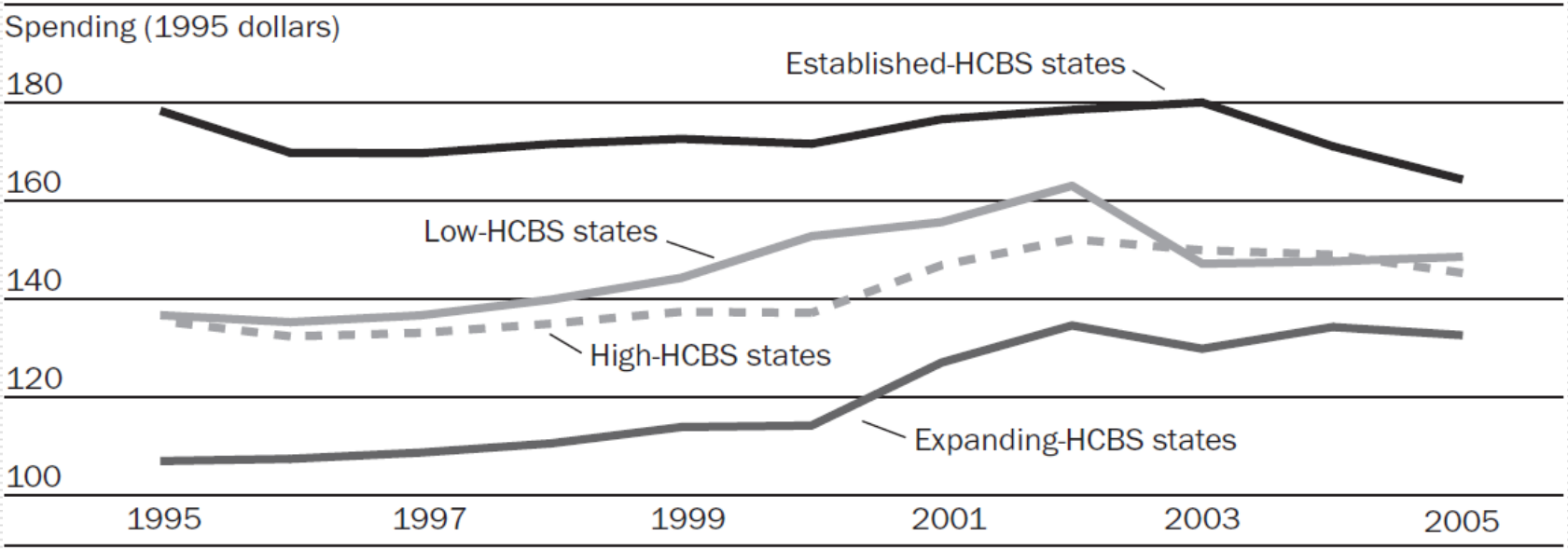
(2) Medicaid Waiver Spending

- GAO (1994) and Lewin/AARP (Alecxih et al., 1996) analyzed whether states (CO, OR, WA, WI) with large HCBS spending have lowered overall Medicaid LTC spending.
- These studies compare actual *versus* projected spending in the absence of the HCBS growth
- Both argue that greater HCBS waiver spending equates to lower overall state LTC spending
- However, results are based on a weak study design
  - Selection of states problematic
  - Assumptions underlying cost projections
  - States pursued packages of options
- Recent work by Kaye et al. (2009) addresses the first two concerns…

"Established-HCBS" states spend 10.7% more per capita in 2005 relative to "Low-HCBS" states, but had lower spending growth over 1995-2005 period

EXHIBIT 4

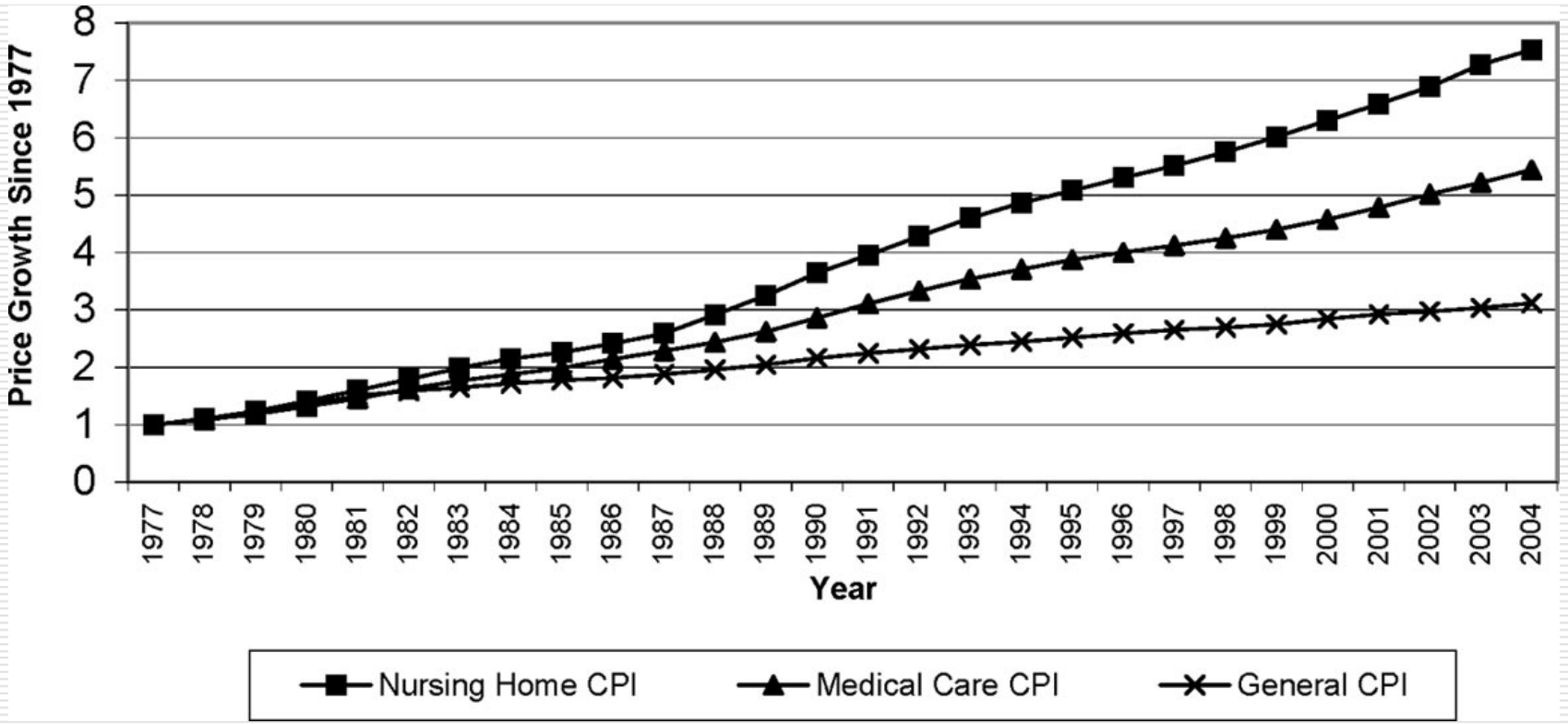
Mean Per Capita, Inflation-Adjusted Long-Term Care (LTC) Spending, Excluding Mental Retardation/Developmental Disability (MR/DD) Programs, In States With Low And High Home And Community-Based Services (HCBS), Fiscal Years 1995–2005



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

Kaye et al., 2009, *Health Affairs*

Explanation for spending growth result – inflation has been highest for institutional services



Stewart et al., 2009, *Medical Care*

(3) Capitated Programs

- Integrate acute and LTC services through managed care and the use of capitation payments.
- Recent demonstrations include: PACE, ALTCS, Wisconsin Family Care, Texas STAR+PLUS, MSHO, S/HMO II
- All these programs emphasize greater use of HCBS services

Capitated Programs (cont.)

	Effectiveness	Costs
PACE	+	+
ALTCS	+/–	–
Wisconsin	+	+
Texas	Stable	–
MSHO	Stable	+
S/HMO II	Stable	+

(4) Consumer-Directed Care

- Consumer-directed care gives clients control to recruit, train, hire, supervise and fire the provider of care.
- Natural experiment in California found greater client satisfaction without any decrease in safety or unmet needs (Benjamin et al., 2000 *HSR*)
- Randomized 3-state cash-and-counseling demonstration comparing agency and consumer-directed models
  - Generally indicated better outcomes under consumer-directed care, but higher Medicaid costs (Carlson et al., 2007 *HSR*; Dale and Brown, 2007 *HSR*)

Summary of the Literature to Date

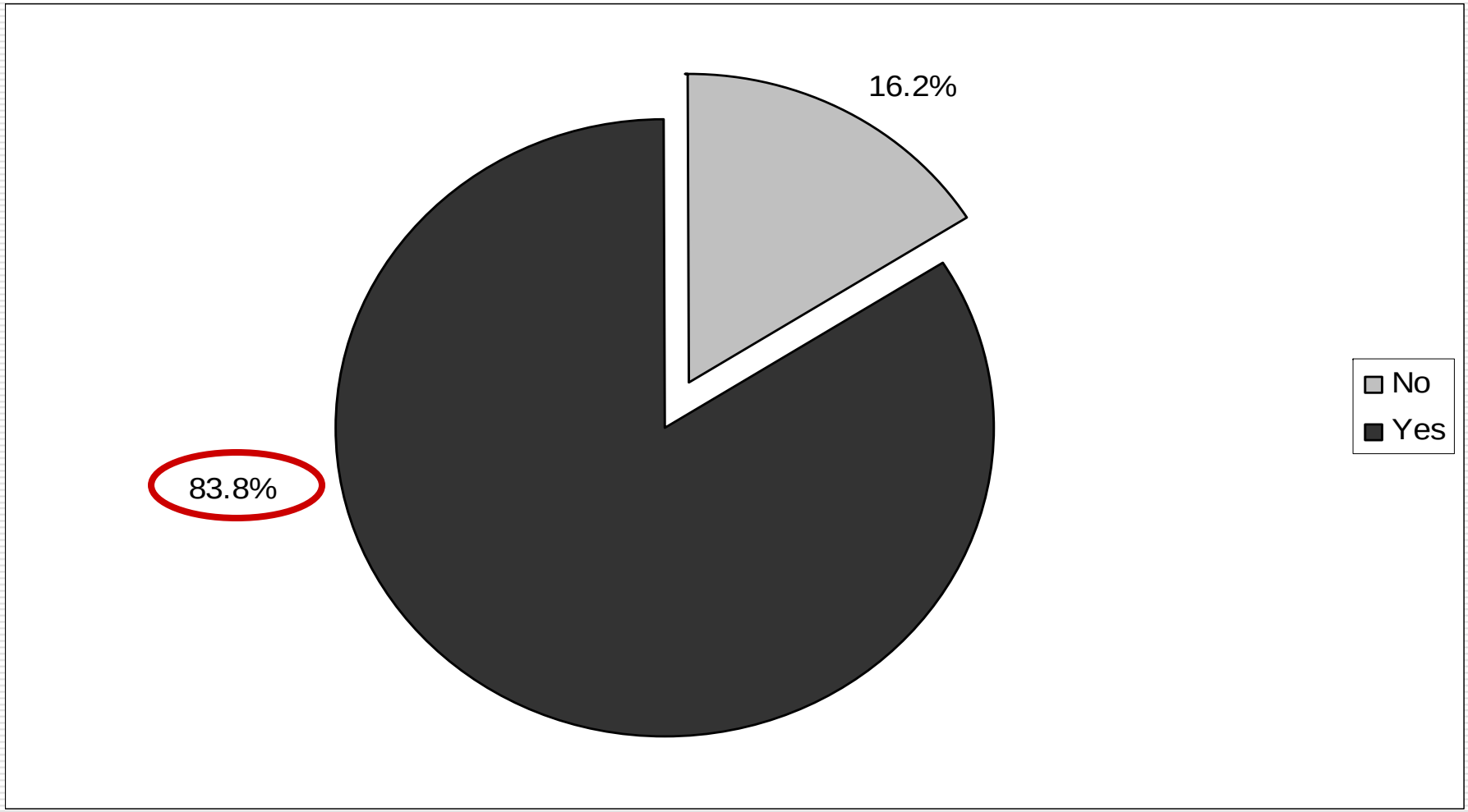
- Achieving cost savings with HCBS has proven difficult

- Relative to NH care, four different types of research have found:
  - HCBS associated with higher costs
  - HCBS associated with roughly similar care outcomes
  - HCBS associated with higher quality-of-life, satisfaction

Are We Asking the Right Question?

- For budgetary reasons, we often ask: "Do HCBS Save $$$?
  - The literature suggests no, but we persist with the need to establish cost savings:
    - State LTC program officer: "Why would we continue a program that *lost* money?"
- Perhaps we should be asking: "What are we getting in return for increased HCBS $$$?"
  - More difficult to answer
  - Society provides "nursing home care with little expectation of positive outcomes and complete certainty of increased expenditures." – Weissert et al., 1988 *Milbank Q*
  - LTC "Experts" clearly believe HCBS add sufficient value to warrant further expansion
    - Commonwealth Fund's LTC Opinion Leader Survey (N = 1,147)

Do you feel the LTC system should be rebalanced away from institutions toward HCBS?



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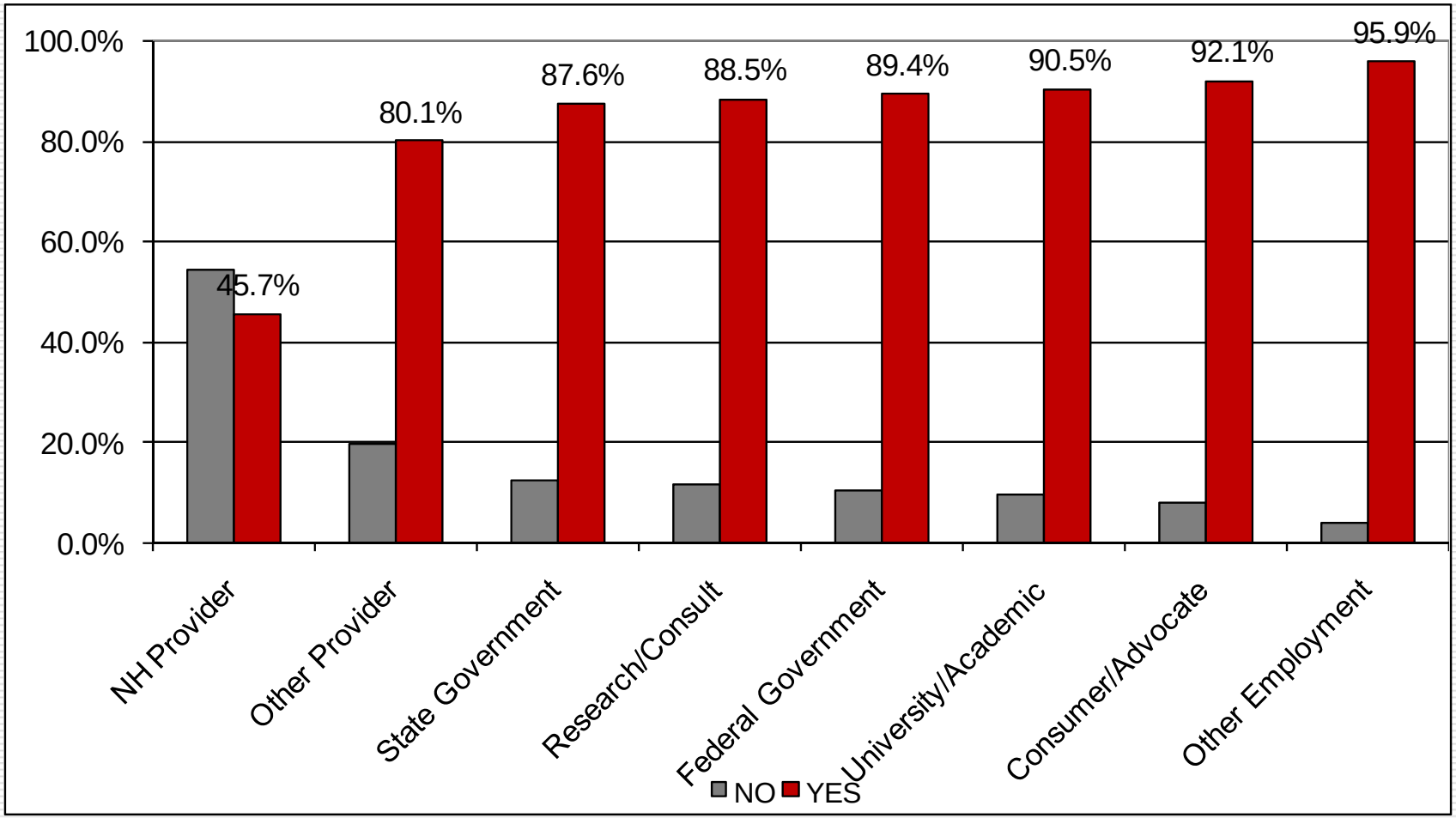

How effective would the following strategies be for rebalancing LTC toward HCBS?

	Percent 'Effective'/ 'Very Effective' [1,2]
Establish programs that offer a comprehensive package of HCBS (e.g., PACE)	76.8%
Expand eligibility of HCBS under Medicaid	76.5%
Provide single point of entry through which individuals may access needed services	71.5%
Increase rate of reimbursement for HCBS providers	67.1%
Limit supply of nursing home beds	20.9%

[1]Response Options: Not at all Effective, Slightly Effective, Moderately Effective, Effective, Very Effective

[2]Excludes those who thought system need not be rebalanced away from institutions toward HCBS

Myth of the "Win-Win": ↓ Costs, ↑ Quality

- Every innovation to improve LTC quality currently on the table has increased aggregate costs
  - HCBS
  - Capitation
  - Assisted living
  - Culture change
  - Cash-and-counseling
  - Care coordination models

- In LTC, you get what you pay for…

Moving Forward

- Future of Medicaid HCBS in a recession is unclear
  - Need to make the case for improved effectiveness

- Future of Medicaid HCBS in the context of a changing NH marketplace…
  - Assisted living will likely continue to siphon off private-payers
  - Medicare SNFs will likely continue to specialize
  - May leave NHs largely to Medicaid
    - Can states transition further individuals out of HCBS?