

Issues of Cost-effectiveness for Home- and Community-Based Services for Long-Term Care

Establishment of the Home- and Community-Based Services Waiver program

In 1981 Congress established the Home - and Community-Based Services (HCBS) Waiver program authorizing State's use of Medicaid funds to pay for home- and community-based services for individuals who would otherwise require nursing facility or ICF MR/DD services in an institutional setting. While the Federal waiver program allows the State discretion in determining what populations will be served and which services will be allowed, the Federal stipulations of the waiver require that: 1) room and board is not covered by Medicaid, 2) and the cost of providing home and community services must be cost-neutral to receiving services in an institutional setting.

Characteristics of the HCBS programs

Although individual waiver programs vary greatly, most seek to provide home- and community-based services to the broader population who might otherwise need institutional services. Broad categories of target populations for the waiver programs include: Aged/Disabled, ICF MR/DD, Disabled/Physically Disabled, AIDS and AIDS Related Care, Mental Health, TBI/Head Injury, and Special Care for Children. Typical services covered by the waiver program include: respite, environmental modification, case management, expanded medical equipment/supplies, expanded personal care, personal emergency response systems, transportation, homemaker services, adult day care, and habilitation.¹ Medicaid will pay for services provided in assisted living as long as the "homelike environment" is preserved.² However, waiver programs for home- and community-based services cannot include the cost of room and board. For persons receiving public assistance, Supplemental Security Income (SSI) or Social Security and/or pension funds may be available to cover their room and board expenses as in institutional care.³ Medicaid institutional long-term care received in nursing homes and ICF MR/DD are all-inclusive for medical, personal care services and room and board. It is estimated that 15 to 20 percent of the total average annual cost per recipient can be attributed to room and board expenses.⁴

Growth in HCBS and Institutional Care

Spending on HCBS has grown rapidly. In 1999 there were 214 Medicaid HCBS waivers in place across the U.S. providing services to 688,152 participants in targeted populations. Since 1992, the number of waiver participants grew 192 percent and waiver expenditures increased 387 percent.⁵ Over the period from 1991 to 2001, Medicaid spending on HCBS increased by about 16.6 percent per annum. The growth in HCBS Medicaid spending was driven predominantly by the rapid increase in the HCBS waiver program, which grew at an annual rate of over 24.9 percent over the period. By contrast, Medicaid spending on institutional care grew at a significantly slower rate of about 5.5 percent per annum over the period.⁶

Medicaid Spending for HCBS and Institutional Care

In Federal Medicaid reporting, institutional long-term care includes nursing facility and ICF MR/DD expenditures and HCBS expenditures include home health, personal care and waivers since 1985.⁷ In 2000, Medicaid expenditures for home care were \$19.7 billion, with 65 percent, or \$12.9 billion spent on home- and community-based services waivers. By contrast, Medicaid expenditures for institutional long-term care were \$49.8 billion in 2000. Between fiscal years 1990 and 2000 Medicaid long-term care expenditures for home care increased from 14 to 28 percent, while the proportion for institutional care fell from 86 to 72 percent.⁸

No Definitive Conclusion on the Cost-effectiveness of HCBS

Comparisons of the cost of home- and community-based services vis-à-vis institutional care are inherently difficult. No definitive conclusions have been made on the cost-effectiveness of HCBS when compared to institutional care,⁹ although some studies have shown that HCBS can be more cost-effective than institutional care under certain circumstances.¹⁰ The difficulties in determining the absolute and relative costs of providing long term care related services to different populations is due in part to the complexities of funding regimens, administrative structures of the programs, the organization and delivery of services, as well as methodological issues inherent in the evaluation of cost effectiveness. Although no definitive conclusions can be made, a number of results have emerged from the literature.

Identifying and Valuing Costs are Difficult

Large variations in the administration, funding, and organization and delivery of long term care make it extremely difficult to compare the cost-effectiveness of HCBS to care received in institutional settings. Developing a research methodology for identifying and valuing the plethora of costs associated with HCBS and institutional care (e.g. clinical services, housekeeping, maintenance, physiotherapy, medical equipment and supplies, transportation, home and personal maintenance, meal preparation and cleanup, respite care, and recreational activities), under a variety of settings and payment systems (e.g. Fee-for-service, HMO, SHMO, PACE, HCBS Waiver, Medicaid, Medicare, etc.) has proven to be a challenge. Due to the difficulty and cost of obtaining the necessary data, such studies have not been done.¹¹ Consequently, research methodologies and activities have been piecemeal, and frequently lack data that are of sufficient quality and comprehensiveness.

Case-mix Effects Cost Comparisons

As one would expect, research has confirmed that as client care needs increase, costs per client also increase¹². Much of the research into the cost-effectiveness of HCBS and institutional services, however, fails to take into account differences in case mix. Generally, clients in HCBS settings typically have lower care level needs. Consequently, simple aggregated comparisons of the cost of providing services to clients in community settings versus institutional settings without taking into account case mix over-estimates the potential cost savings of HCBS.¹³ Once case-mix differences are taken into account, cost differences – to the extent that they exist - are reduced.

Cost-effectiveness Comparisons Obscured by Cost-shifting

Although costs per HCBS Waiver clients are frequently cited as being lower than in institutional settings, care in HCBS settings often fail to fully capture actual spending that is shifted to other programs. For example, HCBS Waiver clients often have other health needs such as acute care, home health, personal care, targeted case management, and adult day care, which are often funded through the regular Medicaid program.¹⁴ In addition, HCBS Waiver clients may also be receiving formal services and/or assistance through Medicare, Supplemental Security Income, State supplemental income programs, Food Stamps, locally funded community support programs, etc., as well as services from a network of informal care givers.¹⁵ The shifting of costs to other non-Waiver HCBS programs thus gives off the appearance of offering lower costs per client, whereas in institutional care all such costs are included in the client per diem. To appropriately compare the two service settings, all costs must be captured in the research methodology.

Staffing Ratios Affect Costs Comparisons

In terms of staffing and caregiver services, HCBS generally have lower cost structures. HCBS settings are often able to reduce costs by having lower staffing levels, and offering lower pay and reduced benefits.¹⁶ Additional savings in HCBS settings are achieved through the substitution of formal caregiver services with informal caregiver services.¹⁷ Although HCBS appear to have lower caregiver costs than institutions, differences in staffing levels, ratios, training, and costs, in addition to lack of appropriate oversight,¹⁸ may have implications on the quality of care in HCBS settings.

¹ CMS (Centers for Medicare & Medicaid Services), 2003. *Home and Community Based Services: From Institutional Care to Self-Directed Supports and Services*. CMS Center for Medicaid & State Operations – Division of Disabled and Elderly Health Programs, May.

² *Understanding Medicaid Home and Community Services: A Primer*, October 2000, (US DHHS Office of the Assistant Secretary for Planning and Evaluation).

³ Ibid.

⁴ Lewin Group analysis of 2000 California OSHPD data; Health-Care Cost Review, Fourth-Quarter 2002, Global Insight, Washington, DC, 2002; Lubarsky, J., Analysis of cost report data, 2001.

⁵ Harrington, C. and Kitchener, M., *Medicaid 1915(c) Home and Community Based Waivers: Program Data, 1992 – 1999* (Department of Social and Behavioral Sciences, University of California, San Francisco, August 2001).

⁶ Computed by AHCA-HSRE using US DHHS CMS Form 64 data (various years). Growth rates were computed as semi-logarithmic trends.

⁷ CMS 2003. (See endnote 1).

⁸ Computed by AHCA-HSRE using US DHHS CMS Form 64 data, 2000.

⁹ Walsh, K. K, T. A. Kastner, and R. G. Green, 2003. Cost Comparisons of Community and Institutional Residential Settings: Historical Review of Selected Research. *Mental Retardation*, 41(2), pp. 103-122; Hollander, M. J., N. Chappell, B. Havens, C. McWilliam, and J. A. Miller, 2002. *Substudy 5: Study of the Costs and Outcomes of Home Care and Residential Long Term Care Services*. Victoria, BC: National Evaluation of the Cost-Effectiveness of Home Care; Hollander, M. J., 2001. *Substudy 1: Final Report of the Study on the Comparative Cost Analysis of Home Care and Residential Care Services*. Victoria, BC: National Evaluation of the Cost-Effectiveness of Home Care; Weissert, W. G., C. M Cready, and J. E. Pawelak, 1998. The Past and Future of Home- and Community-based Long-term Care. *The Millbank Quarterly*, 66(2), pp. 309-388.

¹⁰ Hollander, M. J., 2001 (see endnote 9); Weissert, W. G., T. Lesnick, M. Musliner, and K. A. Foley, 1997. Cost Savings from Home and Community Based Services: Arizona's Capitated Medicaid Long-Term Care Program. *Journal of Health Politics, Policy, and Law*, 22(6), pp. 1329-1349; Doty, P., 2000. *Cost-Effectiveness of Home and Community-Based Long-Term Care Services*. Washington, DC: US DHHS.

¹¹ Doty 2000 (See endnote 10).

¹² Hollander et al. 2002 (See endnote 9); Hux, M. J., B. J. O'Brien, M. Iskedjian, R. Goeree, M. Gagnon, and S. Gauthier, 1998. Relation between severity of Alzheimer's disease and costs of caring. *Canadian Medical Association Journal*, 159(5), pp. 457-465; Moore, M. J., C. W. Zhu, and E. C. Clipp, 2001. Informal Costs of Dementia Care: Estimates From the National Longitudinal Caregiver Study. *Journal of Gerontology*, 56B(4), pp. S219-S228; Rhoades, J. A., and B. M. Altman, 2001. Personal characteristics and contextual factors associated with residential expenditures for individuals with mental retardation. *Mental Retardation*, 39, pp 114 – 129.

¹³ Hollander 2001 (See endnote 9); Campbell, E. M., L. W. Heal, 1995. Prediction of cost, rates, and staffing by provider client characteristics. *American Journal of Mental Retardation*, 100, pp 17 – 35.

¹⁴ Lutsky, S., L. M. B. Alecxih, J. Duffy, and C. Neill, 2000. *Review of the Medicaid 1915(c) Home and Community Based Services Waiver program literature and program data*. Washington DC: US DHHS & The Lewin Group.

¹⁵ Doty 2000 (See endnote 10).

¹⁶ Campbell and Heal 1995 (See endnote 13); Schallock, M., and B. Fredericks, 1990. Comparative costs for institutional services and services for selected population in the community. *Behavioral Residential Treatment*, 5, pp 271 – 286.

¹⁷ Hollander et al. 2002 (See endnote 9).

¹⁸ GAO (United States General Accounting Office), 2003. *Long-Term Care: Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should Be Strengthened*. GAO-03-576. Washington, DC: GAO.