The woodwork effect in Medicaid Long Term Services and Supports

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Long-term services and supports (LTSS)

• Include a broad range of services and supports that assist low-income persons with disabilities of all ages to achieve their goals of living, learning, earning, and participating

• Personal care, nursing services, assistive technology, home/vehicle adaptation, caregiver supports, case management and service coordination (US DHHS, 2010)

• LTSS are provided in community settings (least restrictive) and institutions (most restrictive)

• LTSS are a major outlay ($203 bil. in 2009), amounting to 10% of national health expenditures. Government pays for two-thirds of LTSS mainly through the Medicaid program
Long-term services and supports

• Personal spending is 23%, with a lot of that incurred as out-of-pocket spending during the first 6 months of nursing home placement, as residents become impoverished and then Medicaid steps in and picks up the tab

• Government and personal spending are the tip of the iceberg

• The economic value of unpaid informal caregiving by family and friends is estimated at $354-$375 billion

• Informal caregiving helps to hold down government costs but comes at a significant expense to caregivers who experience reduced earnings, out of pocket costs, and physical and emotional stress
Medicaid LTSS

• On an individual basis, providing LTSS in the community is generally less costly than placing people in institutional settings

• Most people do not want to go to an institution and a lot of people in institutions want to return to the community

• So why not expand community LTSS and avoid placing people in institutions?
There is a high demand for LTSS among persons living in the community who are not likely to go into an institution, many of whom are receiving help from family members.

Working age adults with physical and mental disabilities other than IDD also desire LTSS although they do not have a high likelihood of being institutionalized—some need LTSS to go to school, work, or otherwise participate in the community.

Some might like to relieve their spouses, parents, and other family members by using an attendant (substitution) or use an attendant to supplement such help (supplementation).
Woodwork effect

• If a greater number of persons get community LTSS than the number of institutional placements are reduced, then expanding community LTSS could cost more. The government would pay for help that is being provided for free, what some economists call a “moral hazard” and policymakers more colloquially call a “woodwork effect” (Pauly, 2004)

• A review of demonstration results suggests that expanding community LTSS can result in a woodwork effect, especially when such services are not targeted towards persons with high levels of need (Grabowski, 2006) who are less likely to go into an institution
Medicaid community LTSS

Three approaches to providing community LTSS

• Personal care services (PCS) optional benefit
  – CA (In-Home Supportive Services) operates the largest program (423,000 participants, 46% of all national participants and 43% of national expenditures)
  – 31 other states have the PCS benefit

• Home and Community Based Waivers
  – All states except VT and AZ have HCBS waivers

• Home health services (all states)
Growth in LTSS

• When first established, Medicaid only provided LTSS in institutions
• In 2007, Medicaid served 2.9 million persons in the community and 1.2 million people in institutions
• Since 1995, Medicaid spending on community LTSS was 19% of all LTSS spending; by 2009 it was 45%
• The community shift has been larger for the IDD population than the non-IDD population (working age people with disabilities with conditions other than IDD and older persons)
• In 2009, 66% of LTSS spending for the IDD population went to community whereas only 35% went to community for the non-IDD (aged/disabled)
Historical note

Expanding community LTSS is part of the history of waves of de-institutionalization:

A. Persons with mental illness in the 1970-80s
B. Persons with intellectual and developmental disabilities (IDD) since 1990
C. Adults with physical disabilities and older persons since 2000 (non-IDD). A slower, more deliberate process.

De-institutionalization of SMI did not occur through Medicaid which does not pay for IMDs but has for the other groups
Analysis

• What has been the impact of the growth in community LTSS on total spending?
• Since de-institutionalization and growth in community LTSS occurred earlier for the IDD population does the impact on spending differ between the IDD and non-IDD populations?
• We now have 15 years of annual trend data on Medicaid expenditures overall and for institutional and community spending separately
• In this analysis, I look at Medicaid expenditure trends separately for IDD and non-IDD (Aged/disabled) populations
• I am using the same expenditure data as Steve Eiken, that states report to Medicaid (Form 64)
Analysis

- Expenditures are per capita for the US (minus VT and AZ populations)
- Adjusted for cost inflation (using the Consumer Price Index (CPI) for medical care services) and reported in 2010 $
- Some smoothing adjustments were made for incomplete or missing data, introduction of managed care (in HI, RI & NM) and for nursing home upper payment limits in 2001-2002 that impacted nursing home and total expenditures
Results

- Trend in community LTSS as percentage of total LTSS from 1995-2010:
  - For IDD population, from 30 to 67 percent
  - For non-IDD (aged/disabled), from 17 to 35 percent
- For both populations, the growth has been consistently steady
- The growth in community LTSS occurred earlier for the IDD than non-IDD population and was very rapid from 1995-1999
- During that time, community LTSS grew slowly, then increased faster starting in 2000
Figure 1. Percentage of Medicaid long term services and supports expenditures on home and community services for persons with intellectual and developmental disabilities (IDD) and persons with disabilities other than IDD, 1995–2010 (2010 data are preliminarily estimated).
IDD population

• A consistent trend of greater community LTSS spending and lower institutional spending ($r=-0.92$, $p<.001$)

• In 2001, community spending exceeded institutional spending

• Total spending increased by 30% which suggests that a woodwork effect occurred
Figure 2. Medicaid long term services and supports expenditures for persons with IDD, 1995–2010 (2010 data are preliminary)
Non-IDD

• From 1995 to 2000, not much change in either institutional or community LTSS spending.
• From 2001 to 2010, there is a substantial growth in community LTSS and a substantial reduction in institutional spending ($r=-0.92$, $p<.001$)
• The correction for Upper Payment Limits suggests that nursing home spending would have declined in the absence of states using the UPL provisions
• One might argue that since 2002, there have been savings. But that is affected by the UPL adjustment. I am more comfortable concluding there is no evidence of a woodwork effect in the non-IDD population.
Figure 3. Medicaid long term services and supports expenditures for persons with disabilities other than IDD, 1995–2010 (2010 data are preliminary)
Overall

• It is important to disaggregate the IDD and non-IDD populations. When they are combined, it would appear that a woodwork effect occurred for the entire Medicaid LTSS population with about a 14% increase in expenditures, when in fact, an increase only occurred for only the IDD population
Figure 4. Medicaid long term services and supports expenditures for all persons, 1995–2010 (2010 data are preliminary)
Conclusions

• For the IDD population, other data on participation suggests many more persons were served in the community than institutional placements were reduced (Lakin et al, 2010). According to Lakin, regulations in 1994 essentially abandoned the requirement that the expansion of community LTSS should be strictly matched by reductions in institutional placements.

• For the non-IDD population, expansion of community LTSS appears to have been more strictly tied to nursing home placement reductions, but the data can not suggest anything about causality.

• Imposition of nursing home payment reforms, that is, prospective payment to control expenditures, originally implemented under Medicare have also diffused to the Medicaid program helping control expenditures and use. The factors responsible for declining nursing home use rates are not clear (Wiener et al, 2009)
Conclusions

• It has been suggested (Weissert) that this analysis fails to take into account the growth in assisted living that has taken place, mainly without Medicaid funding. People may spend down their income and assets in assisted living rather than in nursing homes. Not being quite as expensive as nursing facilities, that would buy more time for people to spend down, reducing Medicaid nursing home expenditures.

• To investigate this possibility, I obtained data on assisted living and residential facility units for 46 states (the five states with missing data were DC, MA, MI, MT, NE) for 2002, 2004, and 2007 (Mollica, Sims-Kastelein, & O'Keeffe, 2007).
Conclusions

• The number of assisted living units was divided by the state population in each year and the percentage change in per capita assisted living units was calculated from 2002 to 2007. On average, while per capita nursing home spending (UPL adjusted) declined by 16.1 percent from 2002 to 2007, per capita assisted living units increased by only 1.7 percent. I conclude that it is unlikely that growth in assisted living units can account for the substantial reduction in Medicaid nursing home spending that occurred from 2002 to 2007. Weiner and colleagues (2009) also found no relationship between nursing home use rates and assisted living (or anything else, including HCBS expenditures).
Conclusions

• For the non-IDD population, the trend suggest that community LTSS expenditures are on track to exceed nursing home expenditures perhaps by 2016.

• However, that may be jeopardized by states cutting back on community LTSS.
Conclusions

• Both CA and WA have tried to cut community LTSS but have been prevented by lawsuits that have been decided in favor of plaintiffs by the 9th circuit Federal court of appeals. Governor Gregoire of WA has signaled she may appeal to the Supreme Court with the urging of Governor Brown of CA

• In contrast to cutting community LTSS, a new study suggests that a better strategy for states is to continue to rebalance LTSS gradually to the community (Kaye, 2012)
Conclusions

• The history of IDD is different. In 1967, most individuals with IDD were served in large, expensive, state facilities generally of poor quality. States had an incentive to close them. Families had an incentive to avoid placing their children in them. Once community LTSS were made available, families desired to use them.
Conclusions

• There does not seem to have been much concern expressed over the woodwork effect for the IDD population. The strict cost neutrality was abandoned for that population due changing service goals and to a new valuation of community inclusion and participation.

• As for the non-IDD population, policymakers can breathe some relief that there is no sign of a woodwork effect occurring.
Conclusions

• Community inclusion and participation have gained as values for people with disabilities of all ages. That requires a broader cost benefit framework. Outcomes such as increased earnings among people who live in the community with LTSS versus those without LTSS can be quantified.
Conclusions

• For older Americans, often the only outcome valued is living in their own homes safely while the freedom to control their lives and participate in family and community events is not valued, and that has been deemed a form of ageism (Kane et al., 2007). For younger persons with physical disabilities, the cost-effectiveness of LTSS is increased when that results in their finishing school and establishing a productive career. Further, the costs to family caregivers, in lost wages, injury and reduction in health must also be part of the equation.
Conclusions

• The woodwork effect, expressed as a trade-off between community and institutional use of LTSS, does not capture these broader set of values. The development of an appropriate cost benefit/effectiveness framework that applies to all persons with disabilities needing LTSS should be a high priority.