Comparative Effectiveness Research Review Disposition of Comments Report

Research Review Title: *Long-Term Care of Older Adults: A Review of Home and Community-based Services Versus Institutional Care*

Draft review available for public comment from March 5, 2012, to April 2, 2012.

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Comments to Research Review

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The tables below include the responses by the authors of the review to each comment that was submitted for this draft review. The responses to comments in this disposition report are those of the authors, who are responsible for its contents, and do not necessarily represent the views of the Agency for Healthcare Research and Quality.

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Commentator & Affiliation	Section	Comment	Response
Reviewer #9	Abstract	p. vi: “quantitatively synthesized results” should be “qualitatively synthesized results.”	Thank you for pointing out this typo. We have changed this word in the abstract.
Reviewer #9	Abstract	p.vi: The discussion of costs needs to be modified as indicated above.	We have revised the description of costs.
Reviewer #7 Public	Executive Summary	Executive Summary - What is Medicare part C lien? On avandia victims.	Thank you for your comment. This is outside the scope of the topic.
Reviewer #9	Executive Summary	ES-1: The discussion of PACE seem out of place and should be deleted.	We provide a brief description of PACE for those not familiar with the program since it was determined *a priori* to include relevant PACE studies (since the focus of the program is to keep individuals in home and community settings).
Reviewer #9	Executive Summary	ES-1: The discussion of Medicaid eligibility is not precisely correct. It should be modified to read, “To qualify for Medicaid-funded services in the community, individuals generally must have monthly incomes equal to or below the eligibility level for the Supplemental Security Income (SSI) program or incur large medical expenses that, when subtracted from their income, take them below the SSI level. For individuals in nursing homes, in order to qualify for Medicaid, individuals must have incomes below the cost of care and must contribute all of their income towards the cost of care, except for a small personal needs allowance. In both the community and nursing homes, individuals are allowed to keep only a small amount of financial assets (generally around $2,000 excluding the home).”	We have revised the discussion of Medicaid services in the ES and Introduction.
Reviewer #9	Executive Summary	ES-1: In general, the term “Section 1915(c) waivers” should not be used because it is too technical and requires a cumbersome reference to the Social Security Act. Instead, the term “Medicaid home and community-based services waivers” should be used. In addition, there are several other options for Medicaid coverage of home and community-based services, of which state plan personal care is by far the most important and should be discussed. These other options are described in: Janet O’Keeffe et al. (2010). Understanding Medicaid Home and Community-Based Services: A Primer. Washington, DC: U.S. Department of Health and Human Services. http://aspe.hhs.gov/daltcp/reports/2010/primer10.htm.	We have included a description of these other programs and made any necessary wording changes when describing these programs.
Reviewer #9	Executive Summary	ES-1: “Unlike NH costs, waiver programs do not cover housing costs” should be changed to “Unlike Medicaid coverage of nursing homes, Medicaid waiver programs do not cover room and board.”	We have revised this sentence.

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Reviewer #9	Executive Summary	ES-2: Reference 5 is not correct. The citation should be to reviews that were done in the 1980s and 1990s. Possible examples include: P. Kemper, R. Applebaum &M. Harrigan. (1987). Community care demonstrations: What have we learned? Health Care Financing Review, 8(4): 87-100; J.M. Wiener & R.J. Hanley, R. J. (1992). Caring for the disabled elderly: There's no place like home. In S. Shortell & U. Reinhardt (Eds.), *Improving health policy and management* (pp. 75–110). Ann Arbor, MI: Health Administration Press; and, R.A. Kane, R.L. Kane & R. Ladd. (1998). The Heart of Long-Term Care. Oxford University Press.	We have revised the Executive Summary.
Reviewer #9	Executive Summary	ES-2: The following sentence is out of place in its current location and is unclear: "There is some concern that case mixes differ too greatly between the modalities to allow for indirect comparisons." What is meant by "indirect comparisons"?	We have provided a description of what we meant by indirect comparisons.
Reviewer #9	Executive Summary	ES-2: The authors should explain their rational for this sentence: "We excluded short-stay NH residents and those receiving exclusively Medicare home-health services."	We have provided an explanation for this exclusion.
Reviewer #9	Executive Summary	ES-3: See the comment above regarding nomenclature about residential care facilities and assisted living facilities.	We have used the term assisted living throughout the report, but we specify upfront that we are using this terminology so it is clear to all readers.
Reviewer #9	Executive Summary	ES-4: "Safety" is not a harm. "Lack of safety" can be a harm.	We have changed the word "safety" to specify "accidents and injuries."
Reviewer #9	Executive Summary	ES-4: The meaning of "The methods and analyses were determined a priori" is not clear.	We have changed the methods section to make it clearer.
Reviewer #9	Executive Summary	ES-5: See the comment above about long-term care in other countries.	We have revised our description of the countries that were included in the review.
Reviewer #9	Executive Summary	ES-8: See the comment above on costs.	We have revised the description of costs.
Reviewer #9	Executive Summary	ES-9: It is not clear what is meant by "indirect comparisons."	We have provided a description of what we meant by indirect comparisons.
Reviewer #9	Executive Summary	ES-9: It not correct to say that the MDS has been "replicated" in the home care setting. It would be more accurate to say that the MDS has been "adapted" to the home care setting.	We have changed this wording.
Reviewer #1	Introduction	The introduction was clearly written including the definition of LTC and HCBS, the background, and the comparison of NHs and HCBS. The reason for the review and scope and key questions were also well written.	Thank you for your comment.
Reviewer #2	Introduction	Definition (page 1, line 2) - Long-term care also includes services and supports provided to family members and other unpaid caregivers.	We have included this in the definition of long-term care.
Reviewer #2	Introduction	Page 1, Line 22 - regarding nursing home settings, NH services can also include social activities, transportation, and family councils and support groups for informal caregivers.	We have included this in the definition of NHs.

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Reviewer #2	Introduction	Comparing NHs and HCBS - p. 4 (top paragraph) - The out-of-pocket and opportunity costs to families providing LTC assistance are relevant and important. Although the time commitment is challenging to measure the burden of family care, more work should be done in this research area. Family caregivers should no longer be viewed as just a "resource" for the older adult; rather they are recognized as individuals who may themselves need information, training, and support services. Family caregivers are acknowledged, their needs are assessed and addressed, and they have access to support services (such as respite care) to enable them to continue in their caring role.	Thank you for your comment. We agree that both the out-of-pocket and opportunity costs to families are important and we have noted this as a research gap in the Discussion section.
Reviewer #2	Introduction	Scope and Key Questions – Population Key Question 1 (p. 5) - noticeably absent is any literature describing the demographics of older adults using HCBS or residing in a NH, particularly income and racial/ethnic differences and disparities. Recent research by Vince Mor and colleagues at Brown University suggest growth of racial and ethnic minorities in U.S. nursing homes. This information is clinically useful, in addition to characteristics of patient physical and cognitive functioning, mental/health affect, and conditions/comorbidities.	We did not include descriptions of other demographic characteristics because most of the included studies were focused on the Medicaid population in specific regions. With the small number of studies and limited samples, we felt that this information was uninformative to include in the report, particularly because we could not do any quantitative synthesis of the results.
Reviewer #3	Introduction	In addition to saying what this review does, in light of the fact that policy makers and researchers are used to addressing this issue as what is the impact of HCBS, specifically viz. nursing home admission, etc. Otherwise, very well synthesized and summarized.	Thank you for your comment. The key questions did not aim to determine the efficacy of NHs or HCBS.
Reviewer #4	Introduction	Introduction provides a nice overview of the study and communicates the challenges of the project. Might have pushed a little harder on the overall challenges and limitations of the study.	Thank for your comment. We have discussed the challenges/limitations of the study in the Discussion section.
Reviewer #5	Introduction	I found the introduction clear and compelling. The rationale for the evidence review was clearly stated. The size of the LTC populations receiving NH and HCBS was clearly presented. So was the policy environment. This field is a maze, which the authors managed to present clearly and succinctly. One small critique -- the last paragraph of the introduction needs to be modified. The authors state, accurately, that thinking has shifted regarding the role of HCBS, so that its value is no longer judged solely or even primarily according to its capacity to be a lower cost substitute for NH care. However, not until page 49 do they indicate the 'new' value judgment that has taken its place next to "cheaper substitute" -- which is that HCBS in its own right is viewed as a preferred modality that enhances clients' quality of life. And that quality of life, in itself, is virtually viewed as living outside an institution.	Thank you for your comment. We have revised this part of the Introduction to reflect the value change that has occurred for HCBS.
Reviewer #6	Introduction	Good review. I have no recommendations for changes.	Thank you for your comment.

Commentator & Affiliation	Section	Comment	Response
Reviewer #8	Introduction	The introduction provides definitions of long-term care, HCBS and nursing home care. To the extent some who will read this report are less familiar with LTC, it would be helpful to add a brief discussion of financing. The authors do report some expenditure information, but the availability of LTC in private insurance, Medicare and Medicaid (and perhaps state funding) could be discussed. Currently, the report is rather Medicaid-oriented. Related to Medicaid specifically, there has been recent growth in states' use of the personal care benefit, relative to 1915(c) waivers. The report is also relatively silent on the significant federal, and to some extent state, policy efforts focused on the expansion of HCBS. Legislative changes and demonstrations in DEFRA of 2005 and the ACA of 2010 strongly encourage such expansion. Addition of these policy and legislative initiatives would strengthen the report.	We have added a brief description of the other funding mechanisms for LTC, as well as provided more detail about Medicaid and legislative changes.
Reviewer #9	Introduction	Introduction-2: It is imprecise to say that all disabled people “rely” on long-term care to assist them. Long-term care generally refers to paid services, which not all people receive.	We have revised this wording.
Reviewer #9	Introduction	Introduction-2: More recent data is available on the American Health Care Association website at http://www.ahcancal.org/research_data/oscar_data/Nursing%20Facility%20Operational%20Characteristics/OperationalCharacteristicsReport_Mar2012.pdf.	We have updated this information.
Reviewer #9	Introduction	Introduction-2: The data on the percentage of Medicaid long-term care expenditures that is for home and community-based services is misleading because it includes expenditures for people with intellectual and developmental disabilities, the vast majority of studies about whom are not included in this review. A more accurate percentage for 2010 would be that 35.7percent of Medicaid expenditures for older persons and younger people with physical disabilities. See Table AG of http://www.hcbs.org/files/208/10395/2011LTSSExpenditures-final.pdf.	We have updated this information.
Reviewer #9	Introduction	Introduction-2: The discussion does not make clear that Medicaid HCBS waiver participants must need a nursing home level of care in order to qualify. It also does not make clear that states are allowed to limit the number of people who receive services and to establish waiting lists, neither of which is allowed in the regular Medicaid program.	We have added this information.
Reviewer #9	Introduction	Introduction-2: Revise “Assessing the cost and effectiveness of HCBS has been difficult because findings across states has been inconsistent” to read “Findings across states have been inconsistent because assessing the cost and effectiveness of HCBS has been difficult.”	We have changed this sentence.

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Reviewer #9	Introduction	Introduction-3: The discussion of PACE is not relevant to this paper and should be deleted.	We provide a brief description of PACE for those not familiar with the program since it was determined *a priori* to include relevant PACE studies (since the focus of the program is to keep individuals in home and community settings).
Reviewer #9	Introduction	Introduction-3: The discussion of the Minimum Data Set is obsolete, although it reflects the data used in probably all of the studies cited. In October 2010, the MDS 2.0 was replaced by a substantially altered MDS 3.0, https://www.cms.gov/NursingHomeQualityInits /25_NHQIMDS30.asp#TopOfPage. As part of the change, it is not accurate to say that "the MDS relies exclusively on data derived staff observations….." The MDS 3.0 includes some resident report measures.	We have updated the description of the MDS to reflect that there are new measures in the latest version of the MDS.
Reviewer #9	Introduction	Introduction-3: As stated above, the MDS has not been replicated in home care; it has been adapted to home care.	We have changed the wording.
Reviewer #9	Introduction	Introduction-3: It is inaccurate to say that the paper analyzes societal costs. It only analyzes individual level costs with different levels of inclusion of costs. It does not analyze societal costs. See the discussion above on costs.	We have revised the description of costs.
Reviewer #9	Introduction	Introduction-4: See the discussion on costs above.	We have revised the description of costs.
Reviewer #9	Introduction	Introduction-4: The authors should explain why it is essential to account for heterogeneity in the population.	We have included an explanation of why accounting for heterogeneity is important.
Reviewer #10	Introduction	The background and importance of the study was concisely summarized and set a context for the study.	Thank you for your comment.
Reviewer #1	Methods	The methods used were good and the inclusion and exclusion criteria were justifiable and the search strategies were good. However, I thought that the international studies could have been excluded because the systems and settings are very different so they probably lack relevance to the US. The articles selected were fine and the outcomes measures were clear and appropriate. The descriptive statistics for significance were clear and appropriate.	Thank you for your comment. It was decided *a priori* to include international studies; we kept all non-U.S. studies separate when analyzing the findings.
Reviewer #2	Methods	Inclusion and exclusion criteria are justifiable, and the search strategies are explicitly stated and logical. Definitions or criteria for outcome measures are appropriate.	Thank you for your comment.
Reviewer #3	Methods	Inclusion and exclusion criteria were well formulated and I was able to understand them well. The flow chart of eligible studies and when and how they were excluded was readily understood.	Thank you for your comment.

Commentator & Affiliation	Section	Comment	Response
Reviewer #4	Methods	The search strategy and criteria were well conceived. The authors demonstrated a good knowledge of the potential literature and the challenges associated with the approach used. I would have liked to see the authors spend a little more time discussing the tremendous changes now being experienced in the provision of nursing home care in the U.S. The tremendous increase in short-term care means that any comparisons need to be examined carefully. On any given day there are many nursing home residents receiving rehabilitation for a short stay post hospital and in many studies they are lumped in with everyone else. This makes the comparison with home care programs even more difficult. Although there is no easy solution to this problem, a more extensive discussion about how this phenomenon impacts the research results would have been beneficial.	Thank you for your comment. We have added a description about the difficulty in determining LTC vs. the postacute care population to the Discussion section since it is not clear whether and how this may have impacted the studies that we reviewed.
Reviewer #5	Methods	The inclusion/exclusion criteria for articles reviewed are clear and justifiable. Search strategies are clear. The choice of and rationale for outcome measures is clear, and the discussion of outcome measures is sophisticated. The authors' methods for rating risk of bias are clearly stated, although I was not clear on whether 2 reviewers also were involved in rating the strength of a particular study. It would be helpful if the authors could clarify how many reviewers were involved in which ratings.	Thank you for your comment. We clarified the number of reviewers involved in ratings.
Reviewer #5	Methods	This was a qualitative review, as the evidence provided by the articles reviewed was not of a quality to support meta-analysis. I thought the authors did a good job of laying out and explicating methodological issues including selection bias, casemix control, right censoring due to attrition (e.g., death), sensitivity and uniformity of outcome measures, subgroup analysis, prospective cohort analysis and potential differences between new and existing users of NH and HCBS. I also think they did a good job of raising the ethical and practical issues involved in conducting RCTs in this field. The extreme unlikelihood of randomly assigning people to NH vs. HCBS suggests to me that the gold standard of evidence -- the RCT -- will virtually never be achieved. What are the implications for this and future evidence reports in this field?	Thank you for your comment. While we acknowledge the unlikelihood of RCTs in this field, it was outside the scope of the report to present solutions and recommendations to address this issue.
Reviewer #6	Methods	The inclusion and exclusion criteria are clear and justified. On page 4, lines 30-34, I do wonder why a person's SES status was not included. On page 53, lines 15-16, you do report as a research gap the lack of subgroup analyses by socio-economic indicators but I don't recall anything in the discussion (for this group or others) relating to this research gap.	Thank you for your comment. We have added socioeconomic status as a moderating characteristic upfront.

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Reviewer #6	Methods	Also, you omitted any mention of provider characteristics (on page 53, lines 15-16). That is, I assume why for the Zimmerman et al. study (and related manuscripts) findings related their examination of ALF size and/or “new” or “traditional” models were not reported? Spillman et al (2002) also stated they examined facility characteristics but I saw no mention of findings.	Examining provider characteristics was outside the scope of the review.
Reviewer #8	Methods	It is unclear to me why the review was limited to studies published in 1995 or later. The authors state that these are 'the most relevant to the current landscape of LTC" (ES-5) but no further justification is provided. Additionally, due to the time often required to have study findings reviewed and published, it is possible that papers published in 1995 reflect a LTC landscape of several years prior to 1995.	Since many reviews of earlier literature on HCBS versus NH (from the 1980s and early 1990s) had been published, it was decided to examine studies from 1995 and later. We do state the results of the earlier literature in the Introduction section.
Reviewer #8	Methods	Although the authors note lowering the inclusion criterion related to age for studies of PACE (p. 4), there appears to be only one published manuscript on PACE included. This illustrates some of the previous point. The authors note PACE "looms" in the backgrounds (p. 3). PACE as a model of care dates to 1971 and federal involvement with the model to 1983. As a model, there have not been substantial changes since the first demonstration projects. I believe that there has been substantially more published on the model than the single manuscript included in the review.	While there have been many other studies on PACE, no other PACE studies met the inclusion criteria for this review by explicitly comparing HCBS recipients and NH residents. Most other PACE studies compare PACE enrollees to non-PACE enrollees but do not distinguish where the individuals reside (i.e., in home and community settings or in NHs) so they were not eligible for inclusion in this review.
Reviewer #8	Methods	I am also unclear as to why the focus appears to be on Medicaid LTC. The authors note dropping Medicare home health on p. 5 as a response to key informant interviews. This decision deserves more explanation, given the services funded through Medicare home health, as well as the federal and beneficiary expenditures they represent. The "postacute care population" as an exclusion criterion needs to be defined.	The review was intended to focus on LTC, not postacute care so this was specified as part of the exclusion criteria (i.e., studies whose populations of interest were postacute patients were excluded). We provide an explanation and definition of the postacute care population in the Introduction and Methods sections.
Reviewer #8	Methods	A rationale for the countries used as an inclusion criterion should be added on p. 8.	We revised our description of the countries that were eligible for inclusion in the review.
Reviewer #8	Methods	On p. 9, it would be informative to add a table listing the exclusion criteria and the number of studies excluded for each criterion.	The Figure 2 in the Results section includes this information.
Reviewer #8	Methods	On p. 10, it would be useful to define a 'clinically meaningful conclusion' as it relates to precision.	We have revised the strength of evidence section to be more specific about how these criteria were applied in this review.
Reviewer #8	Methods	Direct and indirect costs discussed on p. 5 need to be more clearly defined. For example, do the direct costs of LTC include Medicare home health? Are acute care costs limited to Medicaid or do they include Medicare costs? What additional subsidies or transfer programs are included?	We have revised the description of costs.

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Reviewer #8	Methods	One of the explicit rationales for the expansion of HCBS as an alternative to NH care relates to individual preferences and related considerations of choice, satisfaction with care, etc. It is not clear why this was not included as an outcome measure.	These were included as outcomes of interest *a priori* (and were listed throughout the Methods section), but no studies provided sufficient evidence on these outcomes. We have listed this in the Discussion section as an important research gap to address.
Reviewer #8	Methods	Although moderating variables are discussed on p. 5, I don't believe these are carried forward in the actual analysis. "Race" should be clarified to include race and ethnicity throughout; rates of disability and use of LTC vary notably by race and ethnicity.	We specify that no subgroup analyses were done in any studies that were reviewed. We changed the term to race/ethnicity throughout the report.
Reviewer #9	Methods	Methods-8: It would probably be helpful to say that long-term care for people with intellectual and developmental disabilities are not included.	We did not explicitly exclude populations with ID/DD so this is not listed as an exclusion criterion. No studies that were included in the review specifically focused on this population.
Reviewer #9	Methods	Methods-8: As noted above, the listed countries outside of the United States do not have comparable health systems, but they are all economically developed countries with extensive health and long-term care services.	We changed the wording to reflect this.
Reviewer #9	Methods	Methods-10: As noted above, assisted living facilities are a subset of residential care facilities; the preferred term is residential care facilities.	We have used the term assisted living throughout the report, but we specify upfront that we are using this terminology.
Reviewer #10	Methods	The inclusion and exclusion criteria were justifiable and search strategies explicitly stated. I think, given the scarcity of good empiric work, inclusion of materials from the grey literature really helped to round out information coming from the peer reviewed literature. One of the conundrums the researchers faced in this study was the difficulty in defining terms since NH, AL and HCBS are really composites of services which may vary considerably depending on the policy and reimbursement environment. Likewise, because there were no RCTs and even other research designs were less than robust they were unable to do a quantitative analysis. They were therefore driven to use qualitative techniques – which they did most effectively.	Thank you for your comment.
Reviewer #1	Results	The results were clearly presented in the tables. It would have been useful to have added the sample size and the period of the data collection to Tables 16-18 and the Appendix D. Sample size is a critical variable in determining the value of the study. The period of data collection can vary widely from the date of publication.	We chose to keep the tables condensed and let readers followup with studies for this additional information. We did not quantitatively synthesize results.
Reviewer #1	Results	The large number of tables in the text of the report were difficult to deal with only subtle differences in the titles. One approach might have been to combine all the international and gray literature into the main table on each topic with a separate header for those sections (e.g. combine table 4, 5 and 6).	AHRQ's EPC formatting standards require the tables to be broken up so these tables were kept separate.

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Reviewer #1	Results	I would have liked more summary description of the 36 studies in the text before going into the findings on tables 4, 5 and 6.	We chose to provide more detail in the tables since there was substantial variation across studies.
Reviewer #1	Results	Probably Tables 16-18 should have been presented before Table 4-6.	We left Tables 16-18 where they were previously located since they describe the methods and outcomes for the longitudinal studies that are presented in the subsequent tables.
Reviewer #1	Results	The tables are nicely presented but the reader has to do a lot of work to determine which findings are higher and lower for HCBS and NHs from the tables. There needs to be more summary of the findings in the text for each set of tables so the reader does not have to do so much work.	A summary statement was added to the tables on sample characteristics to help with interpretation.
Reviewer #1	Results	It would have been easier to understand if Tables 16-18 describing the studies could have had the results presented on the same table. It is impossible to expect the reader to go back and forth between the design of the studies and the results tables especially since the outcomes are organized by type rather than study.	We chose to organize the tables by outcome so the results for each outcome were presented together and readers could easily refer to a specific outcome.
Reviewer #1	Results	On Table 19, it was useful to present the conclusions.	Thank you for your comment.
Reviewer #2	Results	The amount of detail presented in results section is appropriate for the stated outcome domains. However, the report would be enhanced by including a description of the sociodemographic characteristics (e.g., race/ethnicity) of the HCBS and NH samples reviewed.	We did not include descriptions of other demographic characteristics because most of the studies included in the review were focused on the Medicaid population in specific regions. With the small number of studies and limited samples, we felt that this information was uninformative to include in the report, particularly because we could not do any quantitative synthesis of the results.
Reviewer #2	Results	Figures, tables and appendices are adequate and descriptive. Key point emphasized: No studies addressed costs related to family burden. Few studies included satisfaction outcomes. The authors should consider mentioning that no studies included experience of care measures from the perspective of the older adult and also from the family caregiver.	We added this research gap to the Discussion section.
Reviewer #3	Results	The authors appropriately place a lot of the detail on each study into the tables which are qualitative rather than qualitative. This allows them to present the text summary in very simple textual form that the reader can then check by looking at the tables him/herself.	Thank you for your comment.

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Reviewer #4	Results	Results are presented in a clear and concise manner. Authors demonstrate that they understand the complexities of the data used in the studies reviewed. Again a bit more on how the data limitations impacted results would have been useful. For example, the authors acknowledge differences in measurement for ADL/IADL and cognitive functioning, but what does this really mean? We are still presented with results for example discussing how nursing home residents are more impaired on ADL functioning. My own research finds this and is reported in the review. But why what we don't know is how much of these differences are a result of measurement differences. They identify the problem, but don't really help in interpreting the results that they present in any significant way.	Thank you for your comment. It is not clear whether and how measurement issues may have impacted the results of these studies; we revised the Discussion section so that this is clearly stated.
Reviewer #5	Results	The authors did a nice job of summarizing the key findings under each topic area, with the exception of costs (I will return to costs at the end of this paragraph). Given the overall weakness of the evidence base, however, I thought it would be more appropriate to START OUT with their cautionary statement about the weak quality of the evidence and then proceed to the summary points rather than doing it as they do now. I realize this may violate some principle of how to present 'evidence' in an evidence report. However, as currently laid out a quick reader might jump to the conclusions that the key findings are what they are without reading further to discover that by and large -- for all of the outcome variables -- they are unsubstantiated.	Thank you for your comment. We have changed the order of the key findings and we have been explicit about the weakness of the evidence for each outcome.
Reviewer #5	Results	The one set of findings that I found confusing was the set on costs. I believe that section would benefit from a clearer up front statement of how the authors are using their terminology -- particularly in regard to their statement that "Compared with NH residents, HBCS recipients' health care costs were higher." Given that the results section is filled with reference to Medicaid LTC, Medicaid acute/ambulatory etc, Medicare acute etc, I found the previous statement too vague and in need of more specification. In fact, I thought the entire cost section was a bit confusing because the different terms kept 'jumping around.' I often could not tell which costs were being referred to in which sentence. Perhaps they could have a "mini-table" in the text organized not by article but by evidence, with specific type of cost on one axis and HCBS vs. NH on the other axis to help the reader wade through the findings. Their overall point, however, is well taken -- that costs have not been systematically studied nor do cost studies include indirect or family caregiving costs.	We have revised the section on costs.

Commentator & Affiliation	Section	Comment	Response
Reviewer #5	Results	One additional thought/question I had while reading the results section was the following: were there ANY, even one, study that approached a level of methodological rigor? If so, did those studies, however few, have consistent findings? I was left at the end feeling that if all of the studies are so bad, why even report on them at all. It is disconcerting, to say the least, to have a lucid summary of key findings with regard to each of the main questions 1 a-c and 2, consistently followed by the statement about weak evidence.	We are addressing the key questions that were determined prior to the review, so we are explicit about the lack of evidence for the outcomes we set out to examine.
Reviewer #6	Results	The results seem complete and contain the right mix of tables and text to describe studies and their outcomes. I have some minor comments on the tables. Page 28, lines 21-23, no results are recorded for subjective health impairment.	Thank you for your comment. The results for subjective health impairment were included on the same line, but they have been moved to separate lines to make it clearer in the table.
Reviewer #6	Results	On tables 13 and 14 it's hard to follow the results the way presented. It would be much easier (albeit longer) if each outcome were on a separate line. The difficulty with the current presentation is very evident in Table 15, lines 6-10. It takes time to figure out the results (requires looking back and forth, etc).	A summary statement was added to the tables on sample characteristics to help with interpretation.
Reviewer #6	Results	Also, I'm still not what "Transition" refers to in relation to these results.	The terminology has been revised to make it clearer.
Reviewer #7 Public: Steve Eiken	Results	The report does a good job of documenting the limits of research and the lack of hard data necessary to draw conclusions. Two statements are over-simplified, however. The first is: "When data on both HCBS and AL facilities were available in the same study, HCBS clients were more impaired." Tables 4 through 9 indicate mixed results, with the Florida Department of Elder Affairs finding more physical and cognitive impairment and Doty et al. finding more cognitive impairment.	Since the comparison of interest was HCBS vs. NH or AL vs. NH, we have removed these sentences to avoid confusion.
Reviewer #7 Public: Steve Eiken	Results	The second statement is: "the overall rate of harms, inappropriate medication use, and pain and shortness of breath were higher for HCBS clients than for NH residents." No study in the tables included "overall" rate of harms, which would include abuse and neglect. According to Table 25, the studies' findings were specific to medication use, pain, and shortness of breath.	We have revised the wording to reflect the specific harms that were reported.
Reviewer #8	Results	Results are organized by question, with key points and a more detailed synthesis, as well as summary information provided in tables. It would be helpful to make the key points more consistent. For example, the strength of the evidence was included as a key point for only 1 of 4 key questions.	We have revised the key findings so that strength of evidence is clear for each key question.
Reviewer #8	Results	The tables would benefit from adding a column or two that more clearly describes the study -- geographic location, eligibility, services, time frame, etc.	Appendix D includes more information about the individual studies.

Commentator & Affiliation	Section	Comment	Response
Reviewer #8	Results	Related, tables 4-15 are structured differently from tables 16-18, which differ from tables 19-29. I would try to make information more consistent across tables. If a particular column (e.g., bias) is relevant to only certain studies, it can be shown as NA for studies where it is not relevant.	These tables needed to be structured differently to present the information that was relevant for the particular key question. We added NA to the tables where necessary.
Reviewer #8	Results	On p. 14, "transitional care facilities" are introduced but never defined, and were not discussed in the earlier discussion of intervention and comparator.	The terminology has been revised to make it clearer.
Reviewer #9	Results	Results-15: As noted above, the way the discussion on costs is phrased is highly misleading. The analysis does not address system costs and the presentation is only of per person costs, which are often incomplete (not including housing, food, income, medical care, or one of the major payers). The conclusions should be specified much more precisely and their definitiveness toned down.	We revised the cost section and toned down the findings.
Reviewer #9	Results	Results-31: Table 16 would be much more useful if it were organized by domain so that studies of similar topics could be compared. Organizing the table by author name makes the information hard to use.	There was no consistent pattern of studies that examined all of the same outcomes, so we left these tables in alphabetical order.
Reviewer #9	Results	Results-40: Table 23 should name the countries of the two studies and spell out what RH stands for in the McCann et al. (2009) paper. Either define “dually registered” in the Rothera et al. (2007) paper or delete it.	We have revised the tables to address these points.
Reviewer #10	Results	The amount of detail provided to support their conclusions and description of results was excellent. The tables are extremely useful. They were constructed to enable me to quickly and easily understand the merits of each individual study and compare them. By relegating all the details to the tables one was not overwhelmed with information in the text – the tables provided the details while the narrative summarized and synthesized the highlights and take home points which contributed greatly to readability and clarity. I thought their literature review was very comprehensive – the problem is not that – rather the problem is that there is not a lot out there. It is a very sparsely populated area of inquiry.	Thank you for your comment.
Reviewer #1	Discussion	The discussion is clearly written but very limited. For example, the summary of conclusions Table 30 has very limited information. There is no summary of which and how many studies support the key findings to each of the questions.	We have revised the summary of conclusions to be specific about how many studies supported the findings.

Commentator & Affiliation	Section	Comment	Response
Reviewer #1	Discussion	The research gaps are well developed but again there is a heavy reliance on the summary data in table 31 with limited discussion. I think the many gaps deserve more text in the discussion section. The discussion and conclusions all seem consistent with the review of the studies. Clearly the authors have done an enormous amount of high work on the report. The only issue I have is whether it could be more clearly presented.	We have added more to the text of the discussion section.
Reviewer #2	Discussion	Discussion (page 48, line 15). The authors make the important point that most studies did not report whether participants received any informal care. Yet the studies also did not report whether or not the family or informal caregiver's needs were assessed and addressed so that they were better prepared to continue in their caregiving role without being overburdened.	We have added this as an important outcome to study.
Reviewer #2	Discussion	Discussion (p. 48, line 12). Most studies did not provide detailed descriptions of settings and services received, and none examined the person and family's experience of care.	We added this to the Discussion section.
Reviewer #2	Discussion	Discussion (page 48, line 44). The authors note that complete descriptions of HCBS clients (or NH residents) are rarely presented in the analyses. Including any descriptive data on the sociodemographic characteristics of the samples would strengthen and inform this report.	We did not include descriptions of other demographic characteristics because most of the studies included in the review were focused on the Medicaid population in specific regions. With the small number of studies and limited samples, we felt that this information was uninformative to include in the report, particularly because we could not do any quantitative synthesis of the results.
Reviewer #2	Discussion	Research gaps (page 50). Research gaps are well done. Would add experience of care measures from both the individual and family as a research gap. As well, regarding the methodological issue of "define interventions," it is also critically important to include service interventions for family caregivers to test whether assessing and addressing family needs reduce the negative physical and emotional effects of caregiving, and reduce risks that impede their ability to provide care.	We have added this research gap to the Discussion.
Reviewer #2	Discussion	Discussion section reference (p. 55, Reference 2). Co-authors include: Feinberg, L, Reinhard, S, Houser, A, and Choula, R.	We have revised this reference.

Commentator & Affiliation	Section	Comment	Response
Reviewer #3	Discussion	The implications of the major finding refer both to the inadequacy of the research and evidence base as well as the substantive issue. By and large the authors felt that other than saying definitively that NH patients are sicker and more impaired that HCBS patients, the evidence base for determining which was a superior service on a number of different parameters. Since I know this literature reasonably well, I was not surprised, but still a bit depressed about how sparse the literature is on this topic. What is sad is that the question (NH vs. HCBS) is still framed as "which is better" since the populations are very different and, by and large, few individuals will choose a nursing home if they can possibly.	Thank you for your comment.
Reviewer #4	Discussion	Yes the findings of the study are clear. The authors appear to really be on top of the existing literature. I am not sure that the authors pushed as hard as they might have on future research implications. For example, are there any existing data that could help address some of these critical questions? What types of new studies could we do to address the fundamental questions?	Thank you for your comment. Presenting solutions or recommendations was outside the scope of the study.
Reviewer #5	Discussion	In general, with the exception of the cost findings section, I think this report is a model of lucidity. One also gets a clear sense of the general limitations of the studies as a whole, and grouped by question. Moreover, the authors cite a set of very specific methodological issues (which I noted above re selection bias, measures, data collection, etc.) which would need to be addressed in order to conduct rigorous research going forward.	Thank you for your comment.
Reviewer #5	Discussion	One thing that was lacking was any sense of which factors might be most important to address in developing stronger evidence, given the limitations on RCTs. Perhaps this is going beyond the mandate of the reviewers, but at some point experts concerned about evidence in this field will have to address such questions as: "can administrative/observational data be used effectively, if ever? And if the answer is yes, which I think it must be, then what specifically must be done to obtain maximum rigor? Also, how many good studies are required for strong evidence? And should we be doing ongoing person-centered data collection rather than institution-centered data collection – with oversampling of people at risk for HCBS or NH use in order to address some of the issues of uniform data collection, prospective cohort analysis, etc.?	Presenting solutions or recommendations was outside the scope of the study.
Reviewer #6	Discussion	There should be some discussion of the lack of subgroup analysis prior to the research gap noted on page 53, lines 15-16. I was surprised when I saw this gap because I had noted no mention of socio-economic indicators but then saw it listed as a gap.	We have added this gap to the Results and Discussion sections.

Commentator & Affiliation	Section	Comment	Response
Reviewer #6	Discussion	Related to my comments in methods (above), I am surprised that consideration of provider characteristics is not noted as a research gap. Including provider characteristics in outcome analyses would be challenging but an important consideration given what we know about provider characteristics and outcomes. You do discuss on page 51, lines 48-57, the need for evaluation of settings "in terms of privacy, autonomy, and independence-enhancing amenities is important" and I totally agree. The future research section is clear and easy to understand.	Thank you for your comment. We have added this as a gap. Research gaps will also be further addressed in the Future Research Needs report to follow.
Reviewer #7 Public: Kathleen Connor	Discussion	Despite the thoroughness of the study, more questions remain than answers. Studies seem to imply that the nursing home residents are more impaired than community based residents. Is this due to pre-existing conditions? Or due to the need for more complex care? Do the NH residents decline to need more care? Or are they much more ill requiring more care than those being cared for in a home based system? While the cost of medical long term care is expensive; neither Medicare nor Medicaid has been shown to have significant reductions in cost regardless of whether the patient is in a NH or HBCS. The aggregate of long term elder care studies have not provided any firm conclusions about how settings have influenced the decline of the elderly with functional limitations.	Thank you for your comment. Our conclusions were limited given the small number of studies and the weaknesses of those studies.

Commentator & Affiliation	Section	Comment	Response
Reviewer #7 Public: American Health Care Association	Discussion	The American Health Care Association (AHCA) believes the Draft Review reflects an unbiased assessment of the information and data that is currently available about the quality of care in a nursing home (NH) versus home and community based services (HCBS). We appreciate the evaluation of the available literature and research on this topic conducted by the Agency for Healthcare Research and Quality (AHRQ). AHCA has two comments regarding the Review: (1) Key Question 1c. What are the harms to older adults as a result of HCBS and NHs? The draft review states: "Hypothetically, loss of identity, helplessness, and depression are risk of NH care (and perhaps some AL environments as well). These outcomes are rarely looked at as harms, and indeed, sometimes investigators use depressive affect to risk-adjust away the impact of negative self-report when in fact the setting may cause the depressed affect. A distinction must be made between endogenous and situational depression." Loss of identity, helplessness, and depression are indeed serious challenges in the NH setting, and should be a priority in assessing outcomes. However, loss of identity, helplessness, and depression are presumably significant challenges for debilitated elders receiving HCBS also. The distinction between endogenous and situational depression is crucial, but more nuanced than is suggested here. Considering the many triggers for depression in the population at issue (death of spouse and same-age friends, increasing ADL dependency/helplessness, chronic illness, social isolation, sensory and cognitive losses), it seems important to determine which settings are better at addressing those issues for individuals with similar levels of impairment. For example, social isolation, loneliness, and anxiety about needing help and being unable to access it may be more prevalent in the HCBS population, while loss of identity and self-worth may be more prevalent in the NH population.	Thank you for your comment. We added more description about depression for both HCBS recipients and NH users to the Discussion section.
Reviewer #7 Public: American Health Care Association	Discussion	(2) Key Question 2. Comparative costs of NH and HCBS per person and in the aggregate from an individual and societal perspective. AHCA is pleased the draft review identifies the need to consider all costs associated with HCBS when making the comparison to NH costs. We believe this is extremely important. We also encourage additional research on the soundness of claims submitted for HCBS services. Because the program operates in a way that is very different from nursing homes (that is, the recipient of services can "sign off" on service provision, without any concomitant monitoring of quality or completeness of service) there may be a disparity in the claims submitted as compared to the actual services provided.	Thank you for your comment. This is outside the scope of the study.

Commentator & Affiliation	Section	Comment	Response
Reviewer #8	Discussion	The authors conclude that studies directly comparing HCBS and NH care are few, limited in geography, and are likely biased. The strength of the evidence across studies and key questions is low. The authors provide a good summary of research needs in Table 31 and provide a reasonable discussion of these identified needs. Having said that, I'm not certain much is provided in terms of recommendations as to ways to move forward with this research. The authors briefly suggest the use of more prospective studies. Although such studies could address several of the research issues highlighted, they are expensive, and require a fair amount of time to conduct. One of the reasons studies are currently limited, particularly with respect to geography, is likely because national surveys such as the Health and Retirement Survey are not designed to support this type of LTC research. Might some thought be given to ways to modify, or fund supplements to a national survey to conduct the needed research?	Thank you for your comment. Presenting solutions or recommendations for research gaps was outside the scope of the study.
Reviewer #9	Discussion	Discussion-47: A more extended discussion of quality of life and the lack of measures for it would be helpful.	We have stated the importance of quality of life measures.
Reviewer #9	Discussion	Discussion-47: The second sentence of the 4th paragraph needs to be edited.	We have revised this sentence.
Reviewer #9	Discussion	Discussion-49: The discussion of “ideal types” is unclear. How would this analysis be done?	We included a description of ideal types.
Reviewer #9	Discussion	Discussion-51: It is not inappropriate to exclude measurement of IADLs from nursing homes because it is true that residents have little opportunity to prepare food, spend money (Medicaid residents only have about $40 a month as a personal needs allowance), and do housekeeping.	We point out the limitations in comparing HCBS recipients and NH residents given the differences in tasks performed in each setting.
Reviewer #9	Discussion	Discussion-51: The meaning of “Given the current attention to how some RCF or AL services are institutional in nature, further segmentation is likely to occur” is unclear.	We have revised this sentence.
Reviewer #9	Discussion	Discussion-52: It is not obvious that measuring IADLs would show a benefit to HCBS and the authors should not speculate on the results of a study that has not been done.	We removed this part of the sentence.
Reviewer #9	Discussion	Discussion-52: The authors should explain why randomization is not practical or ethnical.	We have added an explanation.
Reviewer #9	Discussion	Discussion-52: Most readers will not be familiar with frontier analysis; it needs some explanation. The discussion of the need to address deaths and transfers should be revised to better explain what is being proposed.	We have included a description of this.
Reviewer #9	Discussion	Discussion-52: Quality of life and social functioning outcomes deserve more than one sentence.	We have stated the importance of quality of life measures.

Commentator & Affiliation	Section	Comment	Response
Reviewer #9	Discussion	Discussion-52: The harms listed are also risks of home and community-based services. For example, people living alone in the community can be isolated, lonely, and depressed.	We have noted this in the Discussion.
Reviewer #9	Discussion	Discussion-53: See the comments above on the cost analysis.	We have revised the section on costs.
Reviewer #9	Discussion	Discussion-54: The paragraph on Mary Naylor's study is out of place and does not describe the point of the study. This paragraph should be deleted.	It is standard to include ongoing studies that may add to the evidence, so we have left this paragraph in the report.
Reviewer #10	Discussion	The conclusions were clearly stated and well organized. There were many limitations to this study which they discussed. The suggestions for research were organized into a table which made it very easy to see what research would elucidate the gaps in the current literature. In my view nothing was obvious that ought to have been included	Thank you for your comments.
Reviewer #1	General	The purpose of the study and the target population were clearly presented. The key questions were appropriate and explicitly stated. These key questions were reported in the executive summary, the text, and in the discussion section. I thought the questions did not need to be repeated in the discussion section. I also thought the executive summary was too long but it was clearly written.	Thank you for your comment. We followed EPC guidelines for the Discussion and Executive Summary sections.
Reviewer #1	General	Overall, the quality of the report with its methods, results, and discussion is very good. But the complexity of the information and the presentation method of relying primarily on tables makes it difficult for a reader to comprehend. Certainly the findings are very important to researchers and useful in developing a future research agenda.	Thank you for your comment.
Reviewer #2	General	The report is a well-written systematic review of HCBS versus institutional care for older adults. On page ii, line 3 - the information in this report is helpful to both health care and social service decisionmakers, including patients and their families. On page ii, line 5 - the information is useful to improve the quality of health care and long-term care.	Thank you for your comment.
Reviewer #2	General	The report is well structured and organized, and the main points are clearly presented. This report will make a contribution to policy and practice decisions about how long-term services and supports are delivered. A strength of this report is the recognition of the unpaid contributions of family and informal caregivers to the costs of HCBS and NH. To be most effective, HCBS should also include explicit supports provided to family members and other unpaid caregivers.	Thank you for your comment.

Commentator & Affiliation	Section	Comment	Response
Reviewer #3	General	This is a policy relevant report and not a clinically relevant one since there is little to characterize what constitutes the "interventions" being compared. Indeed, that is one of the problems identified by the authors. The basic research questions are well formulated and framed and seemed to have guided their literature search process. It is difficult to estimate the impact that such a report will have for a number of reasons. First, the state of the evidence for estimating the advantages and disadvantages of NH vs. HCBS is very weak, for the obvious reason that no one is randomly assigned to enter a nursing home!! Second, the move toward further investment in HCBS in all states and at the federal level is pursuing apace, regardless of the evidence simply as a matter of preference. One concern I have with the report, precisely because it is not clinically focused, relate to the discussion and implicit future research recommendations. The authors propose a large prospective cohort study with independent data collectors using a common protocol, following patients in nursing home and in HCBS and then using the baseline or some such information to construct comparable comparison groups, perhaps using a propensity score structure. This is based upon measurement differences that they suggest may have influenced some of the biases in the studies they reviewed, but there is no specific location in the review methods that this issue of measurement biases was extensively discussed.	Thank you for your comment. It is not clear whether and how measurement issues may have impacted the results of these studies; we revised the Discussion section so that this is clearly stated.
Reviewer #3	General	Another point that this reviewer felt was missing in the discussion (and perhaps even in the framing of the overall questions) relates to between person comparisons vs. population differences in experience and the impact of policy changes and how we understand their consequences. The EPC and CER approach to comparing the outcome and cost experience of individuals served in NHs and by HCBS programs differs from a population focused program evaluation that sometimes is used to address the same kinds of question using the advantage of states' natural experience. That is, there are various studies that have looked at increases in states' HCBS spending affects the number and mix of nursing home patients residing in nursing homes, particularly among the long stay population. Indeed, it took this reviewer a little time (and I needed periodic reminding) that the review was about "head to head" comparisons of NH and HCBS rather than asking the equally daunting question of what is the effect o HCBS on those exposed, including the likelihood of entering a nursing home.	Thank you for your comment. The key questions did not aim to determine the efficacy of NHs or HCBS.
Reviewer #3	General	I found it easy to read; the tables are great – a real resource for the field.	Thank you for your comment.

Commentator & Affiliation	Section	Comment	Response
Reviewer #4	General	Overall this is a very nice piece of work. It is comprehensive and in my view the authors communicate that they both understand the research results and the complexity of the literature. It is easy to follow and makes a very nice contribution to the literature. My only criticism is that I thought the report could have pushed harder on the policy and research implications of the study. For example, while the report does an excellent job of describing the different measures and instruments used in various settings, it does not take us very far in addressing the possible research or policy solutions to addressing this rather large challenge. Although I recognize that this study is not designed to solve these problems, I hoped that the study would have at least helped us along the way towards some ideas for a solution. A similar criticism involves the excellent point surrounding the lack of RCT studies to actually compare outcomes. Again I think the report could push further and maybe put forth some potential solutions. For example, while we are not in a good position to randomly assign individuals to nursing homes or home care, might we be able to use data already in existence to better study this questions. The National Cash and Counseling Demonstration showed an impact on institutional use-- at least in the Arkansas site. Could an analysis of those controls placed in nursing homes compared to intervention participants remaining in the community possibly provide some insight into this question? I am not sure of the answer to this question, but again a bit more on policy and research solutions would have been good.	Thank you for your comments. An extensive discussion of the policy and research solutions or recommendations is outside the scope of this review.
Reviewer #4	General	The report is solid. Again, might have pushed a bit harder on the policy implications of the study. For example, what changes are possible at the federal and state levels to address some of the measurement and data comparability questions identified in the review?	Thank you for your comment. Presenting solutions or recommendations was outside the scope of the study.

Commentator & Affiliation	Section	Comment	Response
Reviewer #5	General	My answer to this question depends on the definition of 'clinically meaningful.' The report asks the most important substantive and methodological questions. It does not, however, provide any satisfying answers to the important substantive questions it lays out – largely due to the "low strength of evidence due to small number of studies and high risk of bias." If clinically meaningful means that one should be able to draw valid practice or policy implications from the evidence, the report is frustrating and must be viewed as 'not meaningful." The report does lay out a number of important methodological questions which must be addressed to move forward on the evidence front in the field of long-term care. It also omits a few important methodological questions, which I will discuss later in this review. Otherwise, the report is lucid and well organized -- more lucid than a number of Evidence Reviews I have read.	We have clarified that the purpose of the report is not for clinical decisionmaking but rather for policy and research decisionmaking.
Reviewer #5	General	The questions it sought to answer are clearly spelled out, as is the target population (users of NH and HCBS). The audience for the report is less clearly spelled out, although frequent reference is made to policy makers. The research gaps section is presumably directed to both research funders and to researchers, although no distinction is made.	We have clarified the audience for the report and stated that the purpose is for policy and research decisionmaking.
Reviewer #5	General	I found the report to be well structured and organized and the points to be clearly presented. The findings will not be very useful to policymakers or practitioners because the evidence base is so weak. Ideally, research funders would collaborate with policy makers going forward to assess what kinds of information will be most important for future policy decisions and to make a plan for allocating resources for obtaining the data and the needed research. It also occurs to me that in the future the most appropriate and useful comparisons likely will not be between NH versus HCBS but rather within the NH and the HCBS sectors between different combinations of interventions, resources etc. And these kinds of within sector comparisons may, in some instances at least, be more amenable to randomization.	Thank for your comments. The Future Research Needs report that will be following this review will address some of these issues.
Reviewer #6	General	This is an excellent well-done report. It is meaningful as it highlights how little evidence is available on benefits/costs of HCBS versus NH services, which is an important message for policymakers and researchers. The key questions are appropriate and clear.	Thank you for your comment.

Commentator & Affiliation	Section	Comment	Response
Reviewer #6	General	The report is well organized and presented. Conclusions can inform policy by clarifying how little evidence there is regarding the benefits of HCBS versus NH LTC. In relation to this, gaps in knowledge and recommended research note important considerations that are not necessarily on the radar of policymakers; for example, the need for the inclusion of societal cost when examining costs of HCBS versus NH LTC.	Thank you for your comment.
Reviewer #8	General	The focus of this review, the effectiveness of HCBS relative to nursing home care, is an important and long-standing policy issue. The target population is adults age 60 and over. Although much of the long-term care literature focuses on this age, or 65 and older in particular, developing the rationale for this age in more detail would be helpful. To the extent that disability onset varies by characteristics such as race and ethnicity (this is why some demonstration PACE sites set a lower age threshold), a more explicit rationale for the specific age range would be helpful.	Using an age range of 60 and older was recommended by the technical expert panel in the development of the protocol since some Medicaid HCBS waivers being eligibility at age 60 and since Older Americans Act funding uses an age of 60 as a cutoff. We have explained the reason for the age threshold of the target population.
Reviewer #8	General	The audience appears to be policy makers, individuals and their families who are faced with LTC decisions, and perhaps, the research community. This could be state more explicitly. The key questions are appropriate. I raise some issues related to measurement in my discussion of methods.	We have clarified the audience for the report and stated that the purpose is for policy and research decisionmaking.
Reviewer #8	General	The report is generally well structured and organized (with the exceptions noted above). The report will be more useable and likely to inform policy if the above points are addressed.	Thank you for your comment.

Commentator & Affiliation	Section	Comment	Response
Reviewer #9	General	In general, this is a useful synthesis of the literature. It appears to be thorough. Except in some parts, the writing is not too technical for a broad policy audience. However, there are several areas needing improvement. As will be detailed below, there are a large handful of factually incorrect statements, mostly related to Medicare and Medicaid policy. The report is very repetitive, often using exactly the same words repeatedly, with no difference is level of detail. The most serious issue relates to the discussion of costs, which is highly misleading, at least within the long-term care policy world. The paper only addresses per user costs, which is the least important measure. The authors should read: J.M. Wiener and W.L. Anderson. (2009). Follow the Money: Financing Home and Community-Based Services. State College, PA: Pennsylvania State University. http://www.hcbs.org/moreInfo.php/type_tool/198/ doc/2777/Follow_the_Money:_Financing_Ho me_ and_Community-Bas, pp. 7-11. As the discussion in this paper makes clear, when policymakers talk about total costs of home and community-based services versus nursing homes, what this mean is a comparison of the system-wide costs that occur when the availability of home and community-based services is expanded compared to when it is more minimally available. Simply put, the problem is that given a choice between nursing home care and no services, many people will choose no services because of the undesirable aspects of nursing home care. However, when given a chose between nursing home care and home care, many people who would not otherwise be institutionalized will choose home care. In this case, the increased cost of the new users may more than offset what may be relatively small reductions in nursing home use. Moreover, given the small number of articles identified, more tentative conclusions are warranted, especially since there is not a standard methodology of what costs to include (e.g., housing, income, food stamps, Medicare, etc.).	We have included a description of the potential for increasing system costs for Medicaid when HCBS is more widely available and more individuals use HCBS in the Discussion section. The focus of the review is at the individual level, so we still examine per user costs. We have revised the description and discussion of costs.
Reviewer #9	General	Although the nomenclature in the field is confused, in general, the broader term that should be used is “residential care facilities.” Assisted living facilities are a subset of residential care facilities. "Assisted living facilities" is not a meaningful term because regulatory requirements vary widely across states and a facility that would be considered an assisted living facility in one state would not qualify as an assisted living facility in another state.	We have used the term assisted living throughout the report, but we specify upfront that we are using this terminology.

Commentator & Affiliation	Section	Comment	Response
Reviewer #9	General	In the discussion of long-term care in other countries, the paper argues that Canada, Australia, Britain, Norway, Sweden, and other countries have "comparable health systems." This is not accurate. Their organization and financing is not comparable to the United States. It is accurate to say that these are all economically developed countries with well-established health and long-term care systems.	We have revised our description of the countries that were included to reflect this.
Reviewer #9	General	A possible reference in the grey literature that I did not see mentioned is: E.G. Walsh, M. P. Freiman, S. Haber, A. Bragg, J. Ouslander, & J.M. Wiener, J. M. (2010). *Cost drivers for dually eligible beneficiaries: Potentially avoidable hospitalizations from long-term and post-acute care settings*. Report for the Centers for Medicare & Medicaid Services. Waltham, MA: RTI International. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads//costdriverstask2.pdf.	This reference does not directly compare HCBS and NH users since it uses different measures and models for each group. Therefore, it is not included in our review because it is not possible to make direct comparisons between the populations of interest.
Reviewer #9	General	Except for the comments made above, the report is clear and simply written.	Thank you for your comment.
Reviewer #10	General	This report is really less about clinical outcomes and more the comparison of 3 sites (i.e. Assisted Living (AL), Nursing homes (NHs) and Home and Community Based Services (HBCS)) of care for adults over the age of 60 using long-term services and supports. It was revelatory to discover that there is scant evidence on the relative merits or potential harms for these very common and very costly services, despite the best efforts of the research team. Whether the findings will be enough to influence policy decisions is open to question since a number of the findings from the study go counter to accepted assumptions or are inconclusive. The population is well defined however, in order to include PACE studies, they have defined "older adults" as 5 years lower than is common – i.e. age 60 rather than 65.	Thank you for your comment.
Reviewer #10	General	I am somewhat concerned however that this review included studies from outside the US based on the, in my opinion, erroneous assumption that the US health system is comparable to the health systems in other countries such as Canada, UK, and other European countries. There is a considerable body of evidence that the US health care system is financed very differently and fares poorly in a number of areas of comparison so mixing those studies with studies within the US may have influenced some of the findings. On the other hand the literature is so relatively weak and there are so few studies altogether that it probably didn't make a significant difference. The key questions are appropriate and clearly stated.	We have revised our description of the countries that were included and we kept all non-U.S. studies separate when analyzing the findings.

Commentator & Affiliation	Section	Comment	Response
Reviewer #10	General	As noted above the report was very well organized which facilitated its review despite its length. The conclusions drawn by the authors were logical extensions from the work they reviewed and presented. However, as they pointed out so many policies in the LTC field were developed without resources to research findings and it is likely that policy decisions will continue to be informed by the preferences and beliefs of policymakers rather than by the evidence presented here.	Thank you for your comment.